UNIVERSITY OF SOUTHAMPTON

VALUING THE CARERS:

AN INVESTIGATION OF SUPPORT SYSTEMS REQUIRED BY MENTAL HANDICAP NURSES WORKING IN RESIDENTIAL SERVICES IN THE COMMUNITY

VOLUME TWO

DAVID THOMAS SINES

A Thesis Submitted In Candidature for
the Degree of Doctor of Philosophy
at the University of Southampton

February 1991

Chapter Eight

The Survey Sample - General Characteristics, Attitudes and Staff Training Needs

This chapter considers the general characteristics of the survey population. It commences with an analysis of the workforce characteristics and moves on to present findings relating to the attitudes that they held in respect of community care. The final section presents issues relating to staff training and job performance in the community.

Community Staff - Characteristics

The **survey sample** consisted of **thirty six nursing staff** working in a variety of community based residential services and **twelve of their managers.** All respondents had worked in hospitals for people with mental handicaps and had gained experience of work with mentally handicapped people. All were either currently working in, or managing community based residential services.

The time each person spent working for their current employer is summarised in the following table:

TABLE 8.1

Length of service with current employer:

	%MANAGERS N=12	%STAFF N=36
<6 months	-	11
7-12 months	8	5
1-3 years	8	5
4> years	83	77

(All columns may not add up to 100% due to rounding).

It can be seen that the majority of the sample had spent over four years working for their current employer. If one assumes that all staff received three years continuous employment with their Health Authority to complete nurse training then it can be deduced from this table that recruitment appears to have taken place in the new service, for the greater part, amongst a pool of staff who had worked previously in long stay hospitals.

An equal distribution was found for the amount of time that staff had spent working in hospitals with the majority having spent an average of five years within institutions. Three quarters of the managers had had over six years **experience of working in hospitals** and this possibly reflects the traditional method of career advancement which depended on experience at different levels of the organisation.

The pace of the development of community based services has been inconsistent throughout the country, with some services starting their hospital closure programmes in advance of others. The pace at which new services were commissioned will obviously influence the time that members of the sample had spent in their new roles. The frustration faced by residents and staff may be increased by inordinate time delays associated with commissioning programmes and by funding difficulties. Staff also expressed some concern regarding the recruitment of suitable staff to the new projects which can also cause delay in opening some of the services.

Two thirds of managers had **worked in the community** for two years, whilst their staff had an average of one year or less. This may be explained by the need to recruit service managers ahead of their staff to lead and to manage the development of community based projects before the residents and staff move in. The average time delay between the appointment of managers and their staff is usually twelve months. (This appears to be

accounted for by the time it appears to take to establish and to ensure that commissioning programmes are prepared before staff are appointed).

TABLE 8.2

Length of service in the community:

	%MANAGERS N=12	%STAFF N=36
<6 months	16	19
7-12 months	16	47
1-2 years	33	14
2> years	33	19

(All columns may not add up to 100% due to rounding).

Managers will also be involved in the **selection of residents** and staff. Their early appointment appears to be an essential component of a successful service. However few respondents in the present study noted this; in answer to the commentary type questions 92% of the total sample failed to suggest that the early appointment of staff and managers was important. Just over one quarter (27%) noted that secondment to their new houses prior to the move was essential if the transfer to the community was to be made as easy as possible. Hence early appointment of managers and staff would appear to be of some significance.

The type of positions held by staff and managers varied greatly between the six groups in the sample. The following table presents the distribution of staff and managers to different posts:

TABLE 8.3

Present post held in the community:

	%MANAGERS N=12	%STAFF N=36
Director/Asst	58	-
Person in Charge	25	36
Dep/Asst PiC	17	44
Team Leader	-	14
Senior Care	-	6

The difficulties associated with assigning titles to posts has already been considered in chapter six, and it can be seen that a significant number of people in both the manager and staff categories share the same job titles. The reason for this relates to the assignment of specific tasks to staff in each of the six services which are not adequately reflected in the job titles. Consequently a staff member with the title 'Person in Charge' may be responsible for a restricted range of management functions and may have to account to their 'manager' for the majority of management decisions. A 'Person in Charge' in the management category may have responsibility for the management functions of one or a range of houses and may be based away from their houses. Care was undertaken to ensure that respondents were appropriately included in the staff or management depending on their specific tasks and responsibilities.

The majority of all respondents had held relatively senior positions in the hospital with only 22% having held junior posts in the hospital. It may be assumed that managers would recruit the more able and senior staff to work in the community in response to the more strict criteria used for recruitment to these posts. (However 89% of the sample did not mention the importance of using a pre-employment attitude screening assessment for prospective employers). It is also true that the majority of qualified staff in the whole mental handicap service gain more rapid promotion to charge nurse level than their colleagues on other parts of the nursing register.

From an analysis of the posts held in the hospital, it might be assumed that staff transferring to the community had previous knowledge of 'ward management' and of organising resident care. (When starting a new service it would appear to be natural enough to select people with some client and management experience). It was also interesting to note that 11% of all respondents had experience as domiciliary nurses working in the community. The new residential developments may offer these specialist nurses new opportunities to apply their skills in residential services.

Length of Previous Service

The final question asked of respondents in respect of their past employment history related to the total length of service they had working with people with mental handicaps:

TABLE 8.4

Length of service working with people with a mental handicap:

	%MANAGERS N=12	%STAFF N=36
1-3 years	-	3
4-5 years	-	6
6-10 years	17	31
10> years	83	62

(All columns may not add up to 100% due to rounding).

From the results obtained so far it would appear that the workforce in the community was characterised by previous hospital experience, an average of six years working with people with a mental handicap and an average of two years experience of work in the community. The type of position previously held by staff varied greatly, although the majority were graded at charge nurse level or above and consequently had experience of ward/community home management.

An example of the importance of **previous hospital experience** was also given by Leonard (1988) in her research on the transfer of mentally handicapped children to the community.

Leonard found that a positive association existed between previous hospital based experience and ability for nurses to provide excellent role models in the community. Of a survey of thirty community based schemes for children, she found that those that best matched the philosophy of community care were managed and staffed by ex-hospital nursing staff (p57).

She found that a positive association existed between previous hospital based experience and ability of nurses to provide excellent role models in the community. Of a survey of thirty community based schemes for children, she found that those that best matched the philosophy of community care were managed and staffed by ex-hospital nursing staff (p57).

Another example is provided by Allen et al (1988) in a study of work patterns and experiences of staff in hospital and community services for people with mental handicaps, found that their qualified sample were relatively young with an average age of 26 years. Age was not isolated as a variable in the present study but there are some similarities in respect of the sample and previous experience. They found that three quarters of their sample had worked in hospitals (they also included social workers and unqualified staff) and noted an important association between length of previous service and the success of community based care.

What is clear from the results of the present sample is that a wealth of experience existed amongst the nurses arising from their work with people with mental handicaps. All the managers had more than six years service and similarly 92% of the staff were able to transfer an average of six years experience together with their skills, knowledge and interest in caring for people with mental handicaps from the hospital to their new work in the community. Consequently there is no reason to suppose that Leonard's findings that mental handicap nurses continue to play a positive role in the community, should not be replicated in other services of a similar nature.

Staff Attitudes to Community Care

This section is concerned with the perceptions that staff and their managers have about the **quality of life** for their residents in the community. It attempts to answer their

feelings about the merits of community care and hospital based care.

Allen et al (1988) in their most informative study on the effects of relocation of staff and people with mental handicaps form a long stay hospital to the community in Kent noted that staff who had had experience of working in hospitals had a more optimistic view of residents than had people who had not worked in hospital. They noted that ex-hospital employees in the community services were slightly more in favour of the provision of community based services (p46).

They also found that staff working in the community were optimistic about their own services and that they provided a valuable form of care to their clients. They believed that the public would accept their clients in time but noted that those staff who had worked in hospitals in previous jobs were less convinced in respect of community acceptance. Both their hospital and community groups believed that not all people with mental handicaps should be discharged from hospital. They found, like this survey, that there was a general commitment to community care but there was a significant belief amongst staff that it would not take over completely to serve the needs of all people with mental handicaps. The findings in this study are very similar in that 45% of the total sample were unsure whether community care would meet the needs of all people with mental handicaps. Allen's is the only other published study to consider staff feelings following hospital closures and it is significant that their findings were so similar.

A series of questions were asked of all respondents regarding their attitudes to people with mental handicaps and their transfer to life in the community. The results proved to be of interest and provide insight into the ways in which staff and their managers regard the quality of life for the people they care for. The results are presented in Tables 8.5 and 8.6.

TABLE 8.5 - % SCORES BY MANAGERS

Responses to statements relating to the type of service they provide in the community:

N=12	Agree	Tend to agree	Uncer-tain	Tend to disagree	Disagree
It is inevitable that MH people will not be properly cared for in the community	-	-	8	42	50
MH people are safer in hospital	-	8	-	33	58
Only a community based service can provide the life that MH people should enjoy	42	33	17	8	-
There will never be the right facilities for MH people in the community	-	8	33	25	33
People will be able to respond more readily in a community home	58	33	8	-	-
Community services will always be preferable to instit/hospital care	58	33	8	-	-
Specialised hospitals are the best places for MH people	-	-	-	8	92
Small community units are bound to run more effectively than large hospitals	42	42	8	8	-
Clients will develop new skills when taught appropriately in the community.	100	-	-	-	-
Clients will appreciate attractive surroundings when provided.	83	17	-	-	-
Participation in the community will enhance opportunities and skill	100	-	-	-	-
Experience of living in family groups will encourage independence	100	-	-	-	-

(All rows may not add up to 100% due to rounding).

TABLE 8.6- % SCORES BY STAFF

Responses to statements relating to the type of service they provide in the community:

N=36	Agree	Tend to agree	Uncer-tain	Tend to disagree	Disagree
It is inevitable that MH people will not be properly cared for in the community	-	8	3	36	53
MH people are safer in hospital	-	11	3	33	53
Only a community based service can provide the life that MH people should enjoy	36	19	14	19	11
There will never be the right facilities for MH people in the community	3	11	11	47	28
People will be able to respond more readily in a community home	44	36	8	8	8
Community services will always be preferable to instit/hospital care	50	36	11	3	-
Specialised hospitals are the best places for MH people	-	6	-	19	75
Small community units are bound to run more effectively than large hospitals	39	39	11	8	3
Clients will develop new skills when taught appropriately in the community.	58	28	-	-	14
Clients will appreciate attractive surroundings when provided.	47	39	3	3	8
Participation in the community will enhance opportunities and skill	61	28	3	-	8
Experience of living in family groups will encourage independence	50	42	-	-	8

(All rows may not add up to 100% due to rounding).

Nearly all respondents (100% of managers and 92% of the staff) were positive about the effects that community care would have in providing people with new **opportunities to acquire independence** as they shared experiences of living in family groups in local neighbourhoods. (All managers and over eighty five per cent of staff also agreed that community living would enhance skill development and appreciation of the benefits of homelike surroundings).

Overall it would appear that both staff and their managers were in favour of care in the community as opposed to hospital based care regimes. This is confirmed by the following analysis of a question asked if specialist hospitals were the best places for mentally handicapped people to live (only two staff members of the sample agreed with this). In support of the 'care in the community model' three quarters of managers and 83% of staff felt that community based services ran more effectively than hospitals.

One third of the present sample considered that the community would provide for enjoyable lives for people although just under one half of staff and one quarter of managers were unsure whether the community would provide any more enjoyment for their clients than was provided in the hospital (due to the possible lack of opportunities for them to integrate in leisure and occupational activities).

When asked if it was inevitable that all people with mental handicaps would be transferred to the community staff members of the sample appeared to be slightly more optimistic that people with mental handicaps would transfer to the community. Half of the managers were either unsure or felt it unlikely that hospitals would close compared to 41.6% of their staff. Staff were in closer contact with their residents and may have used their first hand experience of the way people had adapted to life in the community. (Managers, being more involved in

policy decisions and more aware about financial strategies may have been more cautious about the 'reality' of hospital closure programmes which were deemed to be more expensive than hospital care models). This may account for the slight differences in both sets of responses.

The question of the quality of community care services was also raised. Almost half of the staff were doubtful if community care would result in a high quality service compared to one third of their managers. These findings were supported by comments received during the course of the informal group discussions when a number of respondents expressed their concern about the acceptance of their clients by the general public (one tenth of the staff stated that whilst they enjoyed participating in the life of the community with their clients, they had encountered difficulties with public attitudes).

TABLE 8.7

The move to the community will result in a poor service?:

	%MANAGERS N=12	%STAFF N=36
Very unlikely	8	14
Not likely	58	39
Unsure	17	33
Quite likely	17	11
Very likely	-	3

(All columns may not add up to 100% due to rounding).

Caring for mentally handicapped people in the community also raises a series of questions about their safety, standards of life and social opportunities. These were approached by asking respondents to state their reactions to a series of questions, as shown in Tables 8.8 and 8.9:

On the question of community acceptance the following results were obtained:

TABLE 8.8

Will people accept mentally handicapped people in the community?:

	%MANAGERS N=12	%STAFF N=36
unlikely	25	30
Unsure	25	19
Quite likely	33	47
Very likely	17	3

(All columns may not add up to 100% due to rounding).

These results confirm the fact that staff and their managers are ambivalent in their feelings regarding **public acceptance of people with mental handicaps.** Approximately half of all respondents are either unsure or believe that the community will not accept them as equal partners and neighbours. (Staff may be more pessimistic than their managers about public acceptance).

Despite these feelings respondents appeared to be more optimistic about the quality and value that could be attached

to the lives of their clients in the community. The following table suggests that approximately 60% of all respondents believe that people with mental handicaps will be able to lead valued lives in the community.

TABLE 8.9

People will be able to lead valued lives in the community?

	%MANAGERS N=12	%STAFF N=36
Very unlikely	8	3
Not likely	-	22
Unsure	33	11
Quite likely	42	39
Very likely	17	25

(All columns may not add up to 100% due to rounding).

Consequently it appears that when asked about the **quality of life and care** in the community the great majority of staff and managers denied that community care would inevitably be inadequate.

On the question of safety and the provision of a 'risk-free' environment 92% of managers suggested that there were no greater risks from living in the community than there were in hospital and 86% of staff replied similarly. Safety may not be an issue for staff in the community, but quality of life is!

One third of the total sample considered that the community would provide for enjoyable lives for people although just under one half of staff and one quarter of managers were unsure whether the community would provide any more enjoyment for their clients than was provided in the hospital (due to the possible lack of opportunities for them to integrate in leisure and occupational activities).

Clearly respondents felt that their clients would be able to respond more positively and readily in a community home, and their feelings in respect of community care are a clear indication of support for their services and philosophy of care.

The Relationship between Staff attitudes and Dependant Variables

Staff attitudes to community care were cross-tabulated with three dependant variables:

-**Job Satisfaction** (Tables A8.3 [managers] & B8.3 [staff] ;

-**Propensity to Leave** ((Tables A8.18 [managers] & B8.18 [staff];

-**Total Years Service (Tables A8.31 [managers] & B8.31 [staff].**

[As one might expect with such a small sample it is difficult to determine exact significance between variables. Non-parametric tests for significance were used and in respect of very small numbers containing a minimum of four cells, **The Fisher Exact Probability Test** (Siegel 1956 p96-104) was used. The full results of cross-tabulations may be found in **Appendix Eight**].

The only result that was statistically significant (P= 0.0053) was the relationship demonstrated for staff between their attitude to community care and their propensity to leave the service. From Table 8.10 it can be seen that all staff who never consider leaving their jobs held positive attitudes towards community care and of the possible scenario that all people with mental handicaps will eventually leave hospital to live in local neighbourhoods. (This result compares with the fact that one quarter of those who sometimes considered leaving their jobs felt that a move to the community was unlikely for all their clients.

TABLE 8.10

Relationship Between Propensity to Leave and Attitude to Community Care (staff).

Relationship Between Staff Views on Scope for Community Care of People with a Mental Handicap & Staff Propensity to Leave.

Leaving	Not Likely		Likely		Very Likely		**Row Total**	
	No	%	No	%	No	%	No	%
Never	0	0	3	37.5	5	62.5	8	22.2
Very Rarely	8	53.3	7	46.7	0	0	15	41.7
Sometimes	3	23.1	7	53.8	3	23.1	13	36.1
Column Total	11	30.6	20	47.2	8	22.2	36	100
Significance	**P= 0.0054.**							

For those staff who possess positive attitudes to community care there will be a slight increase in job satisfaction and on the whole they will be less likely to contemplate leaving the service. Positive staff attitudes appear to be important if valued and effective services are to be created and maintained and consequently staff commitment to the principles of community care may be significant prep-requisites for the successful integration of people with mental handicaps in their new homes.

For service users staff commitment to the philosophy of ordinary living is obviously important and it is encouraging to note that the majority of staff and their managers were optimistic about the degree to which their clients could be integrated into the community. [It is particularly interesting to note that there appears to be no relationship between total years service and attitudes to community care (even more so when one considers the fears expounded by some theorists who suggested that older staff with institutional experience might not have held positive attitudes about the new service)].

In-Service Training and Preparation for the Community

The provision of **training** was mentioned as an important indicator of job satisfaction by staff: 50% of managers and 28% of staff mentioned this during the course of the informal interviews. They felt that it helped to consolidate their skills, prepared them for work in the community and assisted in maintaining morale. Brown and Shaw (1987) in a study of social work practice in the north of England, found that the structure of training can make an important contribution to maintaining morale and motivation when changes are confronted in service provision and may counteract 'certain feelings of uncertainty for all staff' (p12). They found that it also had the secondary advantage of helping people who work with

mentally handicapped people to make decisions about their futures and needs (p12).

Nearly all of the sample emphasised the importance of in-service training and preparation for transfer to the community. The most illuminating results came from the open ended questions (the results of which are presented in Appendix five): 25% of the managers and 28% of the staff wanted a personal training plan to prepare them for transfer to the community and 50% of the managers and 25% of the staff also maintained that priority should be given to providing new staff with an 'intensive' induction training programme.

[It should be noted that forty five members of the sample had a **professional nursing qualification** and in keeping with current agreements within the profession, no distinction was made between those nurses with first or second level registration].

The question of training was considered and several questions were asked of respondents in the structured part of the questionnaire in respect of this issue:

TABLE 8.11

Have you received in-service training in the last year?:

	%MANAGERS N=12	%STAFF N=36
YES	92	78
NO	8	22

TABLE 8.12

How many days training have you received in the last year:

	%MANAGERS N=12	%STAFF N=36
< one day	8	25
1-5 days	33	17
6-10 days	33	23
11-20 days	25	23
21-30 days	-	11

(All columns may not add up to 100% due to rounding).

The vast majority of staff had access to in-service training during the course of their employment in the community. The amount of time spent in structured training sessions varied between respondents: just over half (58%) of managers had six days or more which was exactly the same as the staff. Perhaps what is of concern is that one quarter of staff had less than one days training in the past year, compared with the recommended minimum of ten days per year which is recommended by the majority of Regional health Authorities. Despite this, the majority of staff and managers were satisfied with the content and overall provision of their training:

TABLE 8.13

How satisfied were you with the most part of that training?:

	%MANAGER N=12	%STAFF N=36
Very satisfied	8	11
Satisfied	75	66
Unsure	17	17
Not very satisfd	-	3
Very disatisfied	-	3

The results presented in table 8.13 demonstrate that most of the staff and managers were satisfied with the amount and content of the training received. Allen et al (1988) found that staff who had received training during the previous year were significantly different from those who had received no training. They were more likely to have received feedback about their job performance and were more independent in performing tasks. They were also more able to understand the nature of their work and were more confident (p.160). They found that such staff were more likely to make an actual contribution to the decision making process of the organisation and felt more positive about the support they received from their superiors. They also had higher expectations of the development potential of their residents.

The Relationship between Job Satisfaction and Staff Training

For staff (Table 8.14) it would appear that there was suggestion of a negative relationship between the two variables and that the highest job satisfaction scores were demonstrated by those staff who received less than one training day in the past year (41% of respondents).

In contrast, for managers (Table 8.15) job satisfaction appeared to increase with the amount of training provided with an optimum amount appearing to be between three and seven days on average per year.

TABLE 8.14

The Relationship between Job Satisfaction and Days Training (staff).

Job Satisfaction	Days Training: < 1		2 - 5		6 - 10		11 - 20		21>		Row Total	
	No	%	No	%	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	10.5	4	21.5	5	26.3	6	31.6	2	10.5	19	52.8
% Satisfied for more than 80% of the time	7	41.2	2	11.8	3	17.6	2	11.8	3	17.6	17	47.2
Column Total	9	25	6	16.7	8	22.2	8	22.2	5	3.9	36	100

Significance **P= 0.1953**

TABLE 8.15

The Relationship between Job Satisfaction and Days Training (managers).

Job Satisfaction	Days Training: One Day		2 - 5 Days		6 - 10 Days		Row Total	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	62.5	2	25	1	12.5	8	66.7
% Satisfied for more than 80% of the time	0	0	2	50	2	50	4	33.3
Column Total	5	41.7	4	33.3	3	3	12	100

Significance **P= 0.1054**

These results are surprising since so many respondents mentioned the need for training during the course of the informal interviews. Consequently one would have expected a significant relationship to have emerged between perception of job satisfaction and the amount of training received, if only in the form of expressed concern about the lack of training.

However, one possible explanation for this could be the nature, content and applicability of the training received by staff. (Several respondents mentioned that they found the training offered inadequate and often divorced from their actual needs in the community). For managers the majority of their recent training experiences had been in the form of management courses which may have been more in line with their expressed needs and thus they were able to demonstrate more positive feelings about the relationship between job satisfaction and training time. For these reasons the results arising from this analysis should be treated with some degree of caution.

The Relationship of Staff Training with Other Dependant Variables

Newer staff appear to receive less days in-service training than their more experienced colleagues (Table B8.30). On average nearly half of those employed for less than ten years received one or less days training per year compared to two thirds of the more experienced staff group who received between five and twenty days.

Unfortunately no specific information is available to determine the nature of these training courses and hence it is difficult to draw conclusions from these results, however it may be that managers assume that newer staff received a firmer induction to the principles of community care than their more experienced colleagues and hence scarce training resources may have been concentrated on the latter.

Whilst no significant relationship existed between total service and the amount of **training** managers received (P= 0.4868, Table A8.30), it is interesting to note that more experienced managers appear to receive approximately one tenth more training time than their less experienced colleagues. (This may be due to the fact that service planners and administrators consider younger staff to be better prepared for community care due to more recent attendance of qualifying training courses [a new RNMH training curriculum was introduced in 1982 based on principles compatible with community care]).

Key Training Needs

In the present study staff noted a number of **key training needs.** These were presented during group interviews and as answers to a number of open questions included in the questionn aire. The results were mentioned by staff and are presented below in priority order as determined by respondents:

* public relations
* risk taking
* advocacy
* normalisation and choice for residents
* budget management
* preparation for increased responsibility
* personal planning

It can be concluded that the most important training needs were associated with aspects of **'ordinary living'** in the community. Normalisation, risk taking, advocacy and public relations were the key skill areas identified in this category. (It is of interest to note that these skills appear to be more important to staff than those more routine tasks and identified by Jay (1979) which related to household management and home making).

These results support the findings of Mansell (1987), Allen et al (1988) and Ward (1984).

Clearly, working in the community demands new skills and presents new challenges to staff. My perception of these skills ranged from knowledge of household management, budget control and direct care procedures. Ward (1984), in a study of staff training needs in one of the Bristol community based mental handicap services found that staff required all of these skills if they were to function effectively in their new roles. She also found that staff needed to address the practical realities of risk taking and normalisation since she found that the interpretation of 'normalisation' in practice had been a source of considerable conflict and concern for many staff when they first moved to the community. This was noted by Allen et al (1988 p166) and by Mansell (1987). Disputes around the theme of normalisation require staff to have access to experiential learning opportunities and courses and a number of respondents in this study confirmed this (8.3%).

Training in these areas (and in those identified by staff in this sample) is clearly desirable if people with mental handicaps and their staff are to work to best effect to encourage maximum integration in the community. This is confirmed in the following quotation from Allen et al (1988):

> 'the limitations of staffing and training resources in a reducing service make the efficient use of existing expertise of even greater importance. Two conclusions follow from this. Firstly, the informal training function of qualified staff could be enhanced by ensuring that qualified staff receive appropriate in-service instruction; this study has shown the wide range of effects shown by those who had received any recent in-service training...The more effective management of staff in the advanced stages of a reduction and/or closure

programme demands the development of management skills at this level' (p167-8).

Possibility of Seeking Re-Employment in the Community

This chapter ends on an optimistic note. Despite the challenges presented to and demanded of staff in their jobs, by far the majority of respondents stated that they would **reapply to work in the community** if they were to leave their current jobs:

TABLE 8.16

Possibility of seeking further employment in the community:

	%MANAGERS N=12	%STAFF N=36
Not very likely	8	-
Unsure	17	11
Quite likely	17	17
Very likely	58	72

Summary

Each respondent had worked in a long stay hospital within which specific work routines and practices were expected. These care regimes were carefully conditioned over many years within the institution and served to control working systems. In the community new skills and attitudes were required to match the

philosophy of 'ordinary living' which underpinned the philosophy of the service.

The pace of development of these new services has not always kept abreast with associated hospital closure programmes. As a result staff have sometimes been confused and concerned about their role and about the quality of care that has been provided for their residents during the closure period. This has led to difficulties in recruiting suitably qualified and motivated staff to work in some of the new services.

Staff were able to transfer a range of expertise and experience from the hospitals in which they trained to the community, and this was seen by many managers as invaluable in supporting people with mental handicaps in their new homes.

A number of new skills were required by nurses as they prepared to work in the community. These skills related to budget management, risk taking and the implementation of 'normalisation' practices. The majority of staff in the present study were satisfied with the in-service training that they had received but a significant number of respondents had received less than five days training in the past year (more experienced managers and staff receive marginally more training time than their junior colleagues).

Three quarters of managers and all but one tenth of staff indicated that they are either quite likely or very likely to seek re-employment in community based services for people with a mental handicap. This result is either a clear statement of support for community based services which demonstrates the commitment that mental handicap nurses have for their new role outside hospital or it may be a reflection of the nurses' acceptance of the lack of other alternative models of service provision within which to work and to deploy their skills.

Chapter Nine

Job Characteristics

This chapter is concerned with the **nature of the job** undertaken by nursing staff in the community and commences with an account of the way in which staff spend their time in their new jobs.

Developing a Closer Working Relationship with Clients

Working in the community provided staff and managers with increased opportunities to **engage in more direct contact** with their clients. This was reported by respondents to be one of the best features of their new role: 33% of staff and 25% of their managers referred to the importance of direct contact and of being able to witness improvements in their clients' quality of life and skills. As one respondent said:

> ' the most positive feature of my current work is that I now have time to spend with the people I work with. They are all so different here compared to the hospital where we gained little satisfaction from watching people deteriorate or engage in meaningless activities to relieve the boredom of their day. Now I can work individually with people and see the results of my work. John can now feed himself and I never believed that Peter would be able to go up stairs to bed. We used to push him around in a wheelchair at the hospital'.

Several respondents commented on the rights of their clients to enjoy valued lives in the community. In order to encourage their involvement in community activities this often required staff to work flexible hours, and occasionally to return to work after they had finished their shifts to take people out to clubs and activities:

'I frequently return to work in the evenings to take Sharon out to the pub with my family or to the cinema. We used to do that at the hospital too, but it never felt right there, you were an intruder when you returned to the ward after your duty had finished. Sharon comes home for Sunday lunch when I am off and she really seems to love it. I don't regard it as work, but not charity either, sometimes I feel that people take us for granted when we say we 'work' such long hours but what can you do? If we don't do it then there are not enough staff to take people out to enjoy themselves socially. After all that is what the community is about isn't it? We all believe that some voluntary effort on our part is needed and I don't just mean our time. Some of us bake at home and buy little treats to bring in for our 'family tea' and we often buy things for our clients in our own time when shopping for the family. My father also helps and cuts the front lawn at weekends; he loves it, gives him something worthwhile to do.'

This member of staff reflects the theme presented by many staff about the **amount of 'voluntary' time that they spend in their services.** This theme appeared to be important and the following tables attempt to provide some understanding of the extent to which voluntary time was provided to the six services beyond their salaried, rostered hours .

TABLE 9.1

Do you ever work hours for which you are unpaid at work?:

	%MANAGERS N=12	%STAFF N=36
YES	83	86
NO	17	14

TABLE 9.2

How many voluntary hours per month do you work on average?:

	%MANAGERS N=12	%STAFF N=36
<5 hrs month	17	22
6-10 hrs month	8	22
11-20 hrs month	-	8
21-30 hrs month	42	33
>30 hrs month	33	14

(All columns may not add up to 100% due to rounding).

These results demonstrate that the vast majority of staff and managers work beyond their salaried hours in order to provide additional services to their clients. The extent to which they gave their time differed slightly between both groups of respondents; three quarters of managers working between twenty one and more than twenty hours per month compared to half of the staff members who worked the same number of additional hours as 'volunteers'.

It should be remembered that these figures may all have been affected by the fact that each of the six services was engaged in a post-commissioning phase at the time of the study (the average 'age' of the six services was two and a half years). It might therefore be that staff and managers were working particularly hard to establish their new services and in so doing were prepared to give more of their time. Whether this trend continues as services become established remains to be seen although some of the 'older' services noted no difference in the number of voluntary hours provided by their staff.

Job Variety

The fact that nurses and their managers are working many hours without pay is an indication of their sustained interest in providing high quality services to people with mental handicaps. One of the reasons given for this during informal interviews was the fact that 'there never appeared to be enough time in the working day to undertake the numerous tasks and functions that were expected of staff in the community' (comment from one staff member). Not all respondents regarded this as unacceptable and for some it would appear that one of the attractions of the job is that there is much variety in respect of the work and tasks expected of and performed by, staff and managers.

The very nature of working in the community demands that the workforce is flexible and adaptable and this aspect of the job explored in the following analysis of responses received to questions asked on the subject of job variety:

TABLE 9.3

How much variety is there in your job?

	%MANAGERS N=12	%STAFF N=36
A Little	-	5
A moderate amount	8	14
Quite a lot	17	25
A great deal	75	57

(All columns may not add up to 100% due to rounding).

Over 80% of all respondents believe that their current roles provide them with a significant amount of variety. Some degree of variety is clearly important to them and a series of cross tabulations were examined in order to establish possible relationships with a number of dependent variables (job satisfaction, propensity to leave and total years service).

For managers the picture was rather different and although no relationship was found between job variety and job satisfaction there was some suggestion that a wider range of tasks was associated with occasional feelings of leaving the service. Whilst there was no apparent relationship between job variety for those managers who 'never or rarely' thought about leaving their current employment all managers who 'sometimes' considered leaving their jobs were engaged in a wide variety of tasks and responsibilities.

TABLE 9.4

The Relationship between Propensity to Leave and Job Variety

Job Variety

Leaving	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	3	50	3	50	6	50
Sometimes	0	0	6	100	6	50
Column Total	**3**	**25**	**9**	**75**	**12**	**100**

Fisher's Exact Test P= 0.09091

One significant result was identified between the number of years service worked by managers and their perception of job variety:

TABLE 9.5

The Relationship between Total Service and Job Variety

Total	**Job Variety**					
	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Up to and 1ncluding 10 yrs	2	100	0	0	2	16.7
Over 10 yrs	1	10	9	90	10	83.3
Column Total	3	25	9	75	12	100

Fisher's Exact Test P= 0.04545

Nearly all respondents (90%) with more than ten years service reported that they had a great deal of variety in their working lives compared to those with less service, of whom all reported that they did not have a great deal of variety at work. These results are not really surprising since one would expect longer serving managers to have engaged in a wider variety of tasks than those staff with less service since most managers would expect to be promoted to supervisory positions after a minimum of six or seven years service. Accordingly as their skills and competence develop in managerial matters the number of things that they are expected to do will increase.

The Balance Between 'Client' and 'Non-Client Activities

All staff and managers who 'sometimes' considered leaving their jobs were engaged in a wide variety of tasks and responsibilities, some of which involved **non-client activities:**

TABLE 9.6

How much of your time is spent in non-client activity?

	%MANAGERS N=12	%STAFF N=36
A Little	-	-
A moderate amount	-	31
Quite a lot	42	49
A great deal	58	31

(All columns may not add up to 100% due to rounding).

All managers and 85% of staff indicated that a significant proportion of their time was spent on such activities which provided little opportunity for direct client activity. However the answers given by staff in the unstructured interviews suggest that they have more time with clients than they had had in hospitals. The unstructured interviews provided some interesting results which assist in understanding the nature of non-client activities (the following percentages have been extrapolated from the frequency of responses given to each topic area by respondents [see Appendix Five):

TABLE 9.7

ACTIVITY	%STAFF (N=36)	%MANAGERS (N=12)
Financial procedures	11	8
Clerical tasks	33	37
Domestic tasks	11	-
Administrative tasks	17	8

(Respondents could give more than one answer to the question, hence the entries do not add to provide a column total).

Many **management tasks** are required of qualified nurses working in houses which may be essential features of the day to day running of the service. This is illustrated by the following quotation from one respondent:

> 'Much of my time is spent in rushing around trying to meet the basic requirements of running this house. I am employed to manage 'care' and to consider the quality of their lives. What people tend to forget is that much of time we need to ensure that there is enough money in the house, that it is accounted for and that we send reconciliation sheets to confirm details of expenditure for audit. I also have to work out staff duty rotas, allocate leave, supervise and teach staff and attend meetings. The role of the qualified nurse in the community is a combination of the hospital roles of the Nursing Officer, Charge Nurse, Hospital Administrator and Finance Officer. Sometimes we have difficulty in setting our priorities but we always try to involve our clients as much as possible'.

The degree to which they were able to engage in **interpersonal contact with their clients** is demonstrated in the following table:

TABLE 9.8

How much of your time is spent engaged in interpersonal activities with clients?

	%MANAGERS N=12	%STAFF N=36
Very little	25	8
A little	25	8
A Moderate amount	33	19
Quite a lot	-	36
A great deal	17	28

(All columns may not add up to 100% due to rounding).

Despite the actual nature of their many tasks staff were able to spend a significant amount of their time in interpersonal contact with their clients. However, for the managers it may be inferred from this small sample that less than a fifth spent 'a great deal' of their time working with clients.

The Relationship Between 'Non-Client Activities and Dependant Variables.

Striking the balance between client directed and non-client related activities appears to be an issue referred to by many staff and managers and in view of its importance as a variable the degree to which respondents were engaged in non-client

tasks was related to their perception of job satisfaction, their propensity to leave and to their total years service.

Managers

Managers who were involved in 'some or a great deal' of these activities (Table B8.5, P= 0.5807) appeared to be satisfied with their jobs and less than one fifth of staff with more than ten years service stated that they had little involvement with non-client aspects of their job [compared to one half of staff with less than ten years service (Table B8.33)]. The extent to which staff were involved with these activities did not appear to affect their **propensity to leave** the service (Table B8.20).

TABLE 9.9

The Relationship between Total Service and Job Variety (managers).

Job Variety

Total	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	2	100	0	0	2	16.7
Over 10 years	1	10	9	90	10	83.3
Column Total	**3**	**25**	**9**	**75**	**12**	**100**

Fisher's Exact Test P= .04545

The relationship between total years of service and the amount of **non-client contact** involved in everyday work demonstrated a marginal increase of approximately 10% away from a client orientated focus as total service increases (Table A8.33).

Staff

More experienced staff were also more likely to engage in a **variety** of tasks at work (Table B8.32); less than one tenth of experienced staff stated that they had little variety in their work compared to one third of their junior peers.

As for their managers it might be expected that as staff gain in experience that they are expected to undertake a wider range of tasks and responsibilities. Thus, more junior colleagues might be expected to undertake more routine tasks associated with household management or direct care with their clients. Similar experiences were noticeable in hospital, requiring students and newly qualified staff to undertake a restricted range of jobs, leaving the more experienced team members to engage in more diverse, and sometimes interesting tasks. One measure to support this theory was the degree to which staff experience was related to the extent to which they engaged in **non-client activities**:

TABLE 9.10

The Relationship between Total Service and Non-Client Contact (staff).

Total	**Non-Client Contact**							
	Little		Quite A Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	7	50	3	21.4	5	28.6	14	38.9
Over 10 years	4	18.2	11	50	7	31.8	22	61.1
Column Total	11	30.6	14	38.9	12	30.6	36	100

Significance **P= .0973**

From this table it can be seen that 83% of staff with more than ten years service spend a considerable amount of time engaged in non-client activities compared to just over fifty per cent of staff with less experience. It might be assumed that non-client activities include a wider range of tasks such as administrative responsibilities and household management. These additional tasks increase the range of tasks that staff are engaged in and support findings to suggest that job variety increases with length of service.

No relationship existed for managers in respect of their total number of years service, although for those who sometimes considered leaving the service two thirds reported that they were engaged in a 'great deal' of non-client tasks (Table A8.20). One manager confirmed this view:

> 'Since leaving the hospital my work has become diverse to the point of the ridiculous. There are clear confusions about balancing priorities between tasks that require the use of my clinical and supervisory skills with residents and with those tasks that are purely managerial. Of the latter some appear to be delegated from the Health Authority and are not even relevant to our work in the community. Deadlines operate and it seems that more important matters relating to our clients and staff are relegated to second place.'

Job Satisfaction and Non-Client Contact

The degree to which staff and their managers engaged in non-client directed activities was also related to the extent to which they felt satisfied with their jobs. Table 9.11 presents the findings from the relationship between these two variables and the result appears to be statistically significant:

TABLE 9.11

The Relationship between Job Satisfaction and Non-Client Contact (managers).

Non-Client Contact

Job Satisfaction	Quite a Lot		A Great Deal		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	1	12.5	7	87.5	8	66.7
% Satisfied for more than 80% of the time	4	100	0	0	4	33.3
Column Total	5	41.7	7	58.3	12	100

Fisher's Exact Test **P= 0.01010**

When analysing these results it should be noted that the majority of mental handicap nurses enter the profession following voluntary work or experience as direct care assistants in mental handicap hospitals where opportunities to work on a 'hands-on' basis with their clients figure as the central feature of their work. Career progression to managerial levels was traditionally associated with regular client contact through visits to ward areas and associations with residents at social functions held in hospitals. In the community managers were not only based apart from their residents and staff but were only encouraged to make contact with them through the forum of supervisory meetings/visits to houses (with agendas which mostly related to issues of resource management and quality control). It is hardly surprising, therefore that

community managers found their new roles different and that they missed the direct care component of their previous roles.

Interpersonal Support at Work

The very nature of working in small houses in the community ensures that the number of people with whom staff work on any one shift will probably be fewer than found in hospital:

> 'what I really miss is the opportunity to meet my old friends and colleagues in the hospital. There we used to 'belong' to one shift or the other and we looked forward to travelling to work together on the hospital transport. We were able to unwind after the day with a few laughs but now I go home to my family without having had the chance to share my day with friends. In the hospital we also had the chance to work with different people. Sometimes that was a confounded nuisance but it did ensure that you never short of conversation or the chance to meet new people. In this job you work with the same people all of the time. It is a case of tolerating those that you dislike and hoping to work with your friends. The worst problem is having to work on your own. That can be really lonely.'

Perhaps one of the most startling results from the study is that nearly all respondents (92% of managers and 82% of staff) stated that they spent a significant amount of their time working alone. For some this may be the result of the **isolated nature of the work** that managers perform as peripatetic support workers to the staff employed in local houses.

The following tables indicate the extent to which respondents work alone and identify the number of colleagues with whom they work during each average span of duty:

TABLE 9.12

How much of your time do you work alone?

	%MANAGERS N=12	%STAFF N=36
A Little	8	8
A moderate amount	-	8
Quite a lot	33	19
A great deal	58	63

(All columns may not add up to 100% due to rounding).

TABLE 9.13

How many staff work with you for each average shift?

N=36	% STAFF
Work alone	14
One	61
Two	14
>Four	11

Some managers believe that their role is similar to travelling salesmen or area managers for site workers in industry or construction:

> 'I spend much of my time in the car travelling between houses and then I sometimes wonder whether I am a 'stateless' person, with no right to be in people's homes and also without an office that I can call my own. I visit my base (a desk in an open plan health centre office area) at the end of each day and then continue my work schedule in accordance with my own plans for the day. It can be stimulating and challenging and I enjoy the autonomy but it can also be very lonely!.'

For staff the periods of working alone will vary depending on the tasks to be performed during the day. The introduction of individual approaches to care will mean that for the average house two staff may be engaged in one to one activities with residents outside the house for significant periods of time during each shift. This may leave one member of staff, often a qualified member, to stay behind to 'mind the shop' and to care for the remaining people whose turn it is to remain at home that day. Whilst allowing staff the opportunity to catch up on their 'paper work' the prospect of spending two or three hours alone regularly during each shift can be daunting as one member of staff suggested:

> 'At first I liked the opportunity to work on my own with the residents. After the noise of the hospital there was a sense of relief to control my working day and to leave behind the constant threat of interruption. However, it can be really lonely to work on your own with one or two people who have difficulty in communicating with you. There are times when I have felt so lonely that I have telephoned friends and family just to hear a voice that brings me back into the world 'of the living'. I much

prefer the way we work but I do wonder what would happen if one of us had an accident or fell ill whilst we are alone?'

It can be seen from the results contained in Table 9.13 that 14% of staff regularly work alone for the most part of their shift, whilst the majority (61%) work with one other colleague. Assuming that the average number of people resident in each house was set between five and six then it may be assumed that the average staff/resident ratio was 1:2.5 per each house shift.

For managers working alone appeared to have some effect on their level of job satisfaction (Table A8.7, P= 0.1618); all managers who said that they were satisfied for less than 80% of the time worked alone 'quite a lot' or 'a great deal' compared to three quarters of staff who were satisfied for more than 80% of the time. [There was no apparent connection with their propensity to leave (Table A8.21)].

The relationship between **years service and working alone** was, statistically significant for managers. Managers were asked how much time they spent on their own and from the results presented in Table 9.14 it can be seen that all managers with over ten years service work alone for a considerable proportion of their time compared to 50% of those managers with less experience. This result might be anticipated in respect of issues relating to delegated **authority** for decision making, **responsibility** and accountability which one might expect to increase with years of experience and service.

TABLE 9.14

The Relationship Between Total Service and Working Alone (managers).

How Often Do You Work Alone?

Total	Little		Quite A Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	0	0	1	50	2	16.7
Over 10 years	0	0	4	40	6	60	10	83.3
Column Total	1	8.3	4	33.3	7	58.3	12	100

Significance **P= 0.0542**

For staff despite a statistically insignificant association between job satisfaction (Table B8.6) and working alone there appears to be some suggestion that isolation from colleagues reduces feelings of satisfaction at work (there is a 13% difference in job satisfaction scores for those who spent little time on their own).

Support from the Boss

The importance of receiving support from line managers was mentioned by many respondents during the course of the interviews. Support may be provided either directly through the provision of regular supervision from managers working along side their staff or through peripatetic visits and telephone conversations with them. Consequently staff members of the sample were asked a series of questions relating to their perception of the type of support that they received from their bosses at work. The results are presented in the following tables:

TABLE 9.15

How often is your boss on duty with you?:

Proportion of Time	%STAFF
<50%	64
50%	19
50%>	17

n=36

More than eighty per cent of staff receive direct support and supervision from their bosses for less than fifty per cent of their working week. (Conversely 17% receive **direct support from their bosses** for more than fifty percent of the time). However just over half (58%) of staff do have regular contact with their bosses and engage in conversation with them frequently as shown in table 9.21. The very nature of work in the community might therefore reduce opportunities for staff and their bosses to make frequent and regular contact. Visits from the boss and professional support appears to provide staff with sufficient levels of supervision and feedback:

TABLE 9.16

How often do you have a conversation with your boss?:

N=36	%STAFF
Once a month	3
Once 2-3 weeks	22
Once a week	17
Several times/week	33
3-4 times/week	25

One question was included to assess the degree to which respondents considered that they were satisfied with the support and feedback that they received from their bosses:

TABLE 9.17

How satisfied are you with the support received from your boss?

	%MANAGERS N=12	%STAFF N=36
Sometimes	33	22
Usually	33	28
Always	33	50

(All columns may not add up to 100% due to rounding).

Nearly 80% of staff felt satisfied with the support offered by their bosses as compared with a 66% satisfaction rate recorded by the managers themselves in respect of the support they received. These results are therefore encouraging and confirm that despite the dispersed nature of the community services, staff are still able to receive support from their managers. The way in which support is provided may be different than that received when they worked in hospital (the provision of on-site supervision may be reduced in the community). Of equal importance is the extent to which staff believe that they know when their managers are satisfied with their work and the extent to which they receive feedback on their performance.

Feedback on Performance

During the course of the study comments were received from staff and their managers regarding the extent to which they received feedback form their line managers. The results varied between the two sample groups with the managers considering that they knew when their bosses were satisfied with their performance for 82% of their working time; this compares with 58% of staff who were not so clear of their bosses perception

of their performance. The results are presented in Table 9.18.

Table 9.18

Are you usually aware when your boss is satisfied with your work?

	%MANAGERS N=12	% STAFF N=36
Always Know	8	8
Usually Know	67	40
Sometimes Know	8	10
Often in Dark	8	8
Usually Don't Know	8	8

(All columns may not add up to 100% due to rounding).

These may be further explained by the following quotation provided by one member of staff:

> 'I sometimes wonder if our managers really know what we do here. We are not so visible like the General Hospital is. Our policy restricts the number of visitors we allow to come to the house and most of our work is concerned with day to day functions in the house. We seem to be judged more on our ability to perform tasks which are 'measurable' in the central office, such as statistical returns, paperwork and audit procedures. We don't see as much of our bosses as we would like since they have so many responsibilities in 'the central office'.

(Interestingly enough no significant relationship existed between job satisfaction, propensity to leave, total length of service and the amount of feedback staff and managers received from their bosses - Tables A8.7 & B8.7; A8.22 & B8.22; A8.35 & B8.35).

Feedback on Performance - Issues of Support and Achievement

Hingley (1986) suggests that support at work may be as important as adequate staffing numbers. His research identified the need for support at a number of levels. In the workplace support was seen as involving someone who could give advice and direction about work related problems in a constructive way (p53). Benton (1972) found that nurses ranked the provision of adequate staffing numbers as second out of a list of sixteen factors. In this study constant reference was made to the importance of staff availability to realise the objectives of community care and this would appear to be highly significant.

Within the sample all respondents reported that there were many opportunities to use their own initiative at work which resulted in all but two managers and one staff member believing that they were very **satisfied with their actual accomplishments** at work. Sarata (1974) noted the importance of **client progress** as a determinant of job satisfaction for nurses. He suggests that administrators should strive to ensure the creation of an atmosphere in which employees' frustrations concerning client progress are freely expressed and examined.

His hypothesis was confirmed during the informal interviews (see Appendix Five) and is demonstrated by the following quotation:

'One of the best things about this job is the sense of achievement and challenge that we face each day. You never know what will happen when you come on duty and this is possibly due to the number of choices that we and the residents are encouraged to make each day. One day you can be teaching someone to cross the road with the minimum of supervision and another you can be taking people on holiday to Germany. The removal of so many old policies and procedures makes life more interesting and you really feel that your skills and imagination are tested'.

In the face of this the importance of developing their own skills was widely recognised and understood. This is probably an essential component of community care when so much of the success of the schemes depends upon the experience and initiative of the staff.

With such reliance upon their own resources and initiative it is important for staff to perceive that they are actually supported in their day to day work and it is reassuring to note that over eighty per cent of both groups expressed satisfaction in relation to the **relationships enjoyed with fellow work colleagues.**

Cullen and Woods (1983) in a study in a mental handicap hospital, noted the importance of positive monitoring and praise for staff as an essential determinant of job satisfaction. They felt that staff required professional supervision to guide them through the new requirements of working in the community. Similar findings were reported by Benton and White (1972) who discovered that nurses placed much emphasis on receiving feedback and appreciation for their work from the public and from their managers. They also found that nurses will overcome difficult work conditions if they perceive

that their efforts will be praised by their superiors and have positive outcomes for their residents.

One other measure of achievement was provided by asking respondents how they felt that the public perceived the value of their work. Bearing in mind that respondents were somewhat ambivalent about their new roles in the community it was encouraging to note that they demonstrated high satisfaction ratings of 100% and 86% respectively. Similar ratings were received in respect of the challenges that their jobs provided with all but one staff member finding their work more than stimulating.

Whilst managers may predict their staff needs, it would appear that the most appropriate way to ensure the cooperation of staff is to encourage them to identify their own needs. The National Health Service, in common with other businesses, is currently encouraging staff to introduce individual performance review systems. These have assumed precedence over the older system of staff appraisal. In the community, it is suggested that feedback on personal performance is of particular importance to staff who may work in isolated settings. The introduction of **staff development/ performance reviews (SDPR)** is one system that might be employed by managers to combine feedback on staff performance and assist staff to identify their training needs to meet pre-set performance objectives.

The use of such systems is accepted to some extent in the NHS. Staff and their managers were asked if such a system was in operation in their service:

TABLE 9.19

Is an SDPR system in operation in your service:?

	%MANAGERS N=12	%STAFF N=36
YES	58	53
NO	42	47

Despite some discrepancy between the responses given by managers and their staff, it may be concluded that a bare majority of just over half of staff and managers had access to an official feedback system. The frequency of the interval between each SDPR was also checked:

TABLE 9.20

SDPR Interval:

	%MANAGERS N=12	%STAFF N=36
every 6 months>	8	8
7-12 months	58	31
Over one year	33	61

(All columns may not add up to 100% due to rounding).

However, whilst two thirds of the managers report that the SDPR system operates at least annually, the actual time interval since their last review appears to have been much longer: three quarters of the managers (75%) stated that their last SDPR had taken place more than one year ago, despite the fact that it is

recommended by Regional Health Authorities that they should take place at least annually.

Staff experience revealed some discrepancy between theory and practice but they were closer in their estimate of the time intervals between their last review; 62% of the sample reported that their last review had taken place more than a year before, whilst 28% had received one in the last six months.

The discrepancies might be explained by the high incidence of new staff in the community services. Two thirds of staff (66%) had started work in the twelve months leading up to the study. Since the majority had transferred from hospital employment it is most likely that they had received exit interviews before they left. Most would also have been formally interviewed for their new positions and these would have constituted an official opportunity to assess individual training needs and to set development and performance objectives.

There is some cause for concern though, in respect of the time interval between SDPR interviews for managers. Of these two thirds (66%) had been in post for at least one year before transfer to the community and yet for three quarters of the sample their last SDPR interview had been held over a year before. The example set by senior managers may therefore present another reason for the longer time interval experienced by staff.

Support and Contact with Peers at Meetings

One way of ensuring that staff and managers meet colleagues and receive interpersonal support is through the medium of structured in-house and external meetings. These meetings may provide an opportunity for staff to meet with peers and visiting specialists and during the course of the informal interviews several respondents referred to the importance of

these occasions. (This implies, however, that staff and their managers regard attendance at meetings as a 'blessing' and not as an additional pressure or 'chore').

Consequently this chapter ends with a consideration of the number of opportunities that are extended to staff and managers to attend out of house meetings:

TABLE 9.21

How many out of house meetings do you attend each month?

	%MANAGERS N=12
None	33
1-3	8
4-6	17
7-10	25
>10	17

Two thirds of managers had the opportunity to attend an average of between six and eight meetings per month (however, one third of the managers in this study had no opportunity to attend out-of-house meetings at all). This may have offered some opportunity to 'escape' from the pressures of 'in-house' responsibilities and may have enabled managers to meet colleagues from the multidisciplinary team or from other parts of the service to share ideas and experiences:

'I always look forward to meeting my colleagues from other disciplines. It offers a refreshing change to the day to day problems of managing mental handicap services. It also provides me with the chance to share ideas and future plans, and more often than not I receive positive feedback about other work which is more progressive than that taking place with other client groups'.

The staff appear to have had similar opportunities to attend external meetings and their average attendance was between one and three meetings per month (67% of the staff sample). Once again one third of the sample did not attend out-of-house meetings.

TABLE 9.22

How many out of house meetings do you attend each month?

	%STAFF N=36
None	33
One - three	50
Four - Five	11
>Five	6

In fact the majority of staff stated that the main reasons that they attended meetings were to represent the needs of their residents and as such they attended, on average between two and three personal planning meetings per month. This constituted a significant proportion of the meetings that they attended away from their houses. One member of staff stated:

'the only time that we get to attend meetings outside of the house is to present the needs of our clients at their IPP meetings. Otherwise our managers get to represent us on more important issues relating to service planning or management.'

Summary

This chapter has demonstrated that, generally mental handicap nurses are in favour of community care. They are often isolated in their jobs and spend a significant amount of time working alone with their residents either in their houses or with them in the community. Most appear to recognise the benefits of community participation and have noted that their residents are able to make major advances in acquiring more independence and new skills compared to when they lived in hospitals.

There appears to be considerable scope for variety at work and although this is welcomed to some extent, there is some suggestion that conflict between client and non-client directed aspects of the job may be a source of concern for some staff and managers and may occasionally increase the likelihood of them thinking about leaving the service.

Length of service was identified as a dependent variable and when correlated with a number of independent factors a number of interesting results were noted. In the first place managers appear to be less satisfied with their jobs as their length of service increased although more experienced managers are less likely to leave their jobs. Managers also engage in a wider variety of non-client associated tasks as they become more experienced and are likely to be left alone to work unsupervised. Longer service also appears to improve managers' understanding of their roles and of other people's expectations of their contribution to the service.

For staff, longer service increases their propensity to leave and makes no difference to their perception of job satisfaction. More experienced staff were also found to engage in a wider variety of tasks which were most likely to involve non-client activities. However staff with less than ten years service are more likely to be clearer in respect of the nature of their responsibilities, of their scope of authority and of the expectations of others than their longer serving colleagues.

Many staff missed the interpersonal aspects of support that they found to be readily available to them when they worked in hospital. A balance must therefore be struck which allows staff the flexibility to use their initiative at work but also to receive the support from colleagues that they require on a regular and consistent basis.

Support from managers, whilst highly rated when it is provided, is not always sufficient to meet the needs of staff working in isolated settings and the quality of feedback about performance could be improved.

It is also interesting to note that all services had introduced personal plans for their residents and yet nearly half of the staff did not have access to a staff development/performance review of their own. However, staff development reviews and 'feedback from the boss' did not appear to be significant in determining job satisfaction or propensity to leave. Nevertheless during the course of informal interviews respondents stated that it was important to provide staff and managers with regular feedback, encouragement and support during the transition period from hospital to the community. The SDPR system is one approach which many services are adopting within the National Health Service to ensure that staff receive effective feedback and information about their personal performance and role in the organisation. It also

provides an opportunity to share personal training and development needs.

Staff work long hours and a significant proportion of these are unpaid additions to the official working day. They appear to share with their managers a major commitment to their work and to their clients which implies that they are proud of their service. A considerable degree of success also appears to be shared in response to their efforts which is shown by the improved quality of life that is enjoyed by their clients. Few regard the hospital as a preferable option to community care and despite the additional demands of working in the community, few would return to work in the institution, if the option were available. The following remarks appear to summarise the feelings of respondents:

> ' The work in the community is diverse and challenging. I go home feeling much tireder but more fulfilled. You feel able to accomplish something at long last and despite the fact that we are often left to our own devices, we seem to pull our weight to get things done with the instead of doing it all for them. I wouldn't go back to the hospital anymore than they would, (the residents) would you if you had such a nice place to live and work in as this? Mind you they are bloody lucky to have us with them, we give a lot of our time, but they're family aren't they?'

Chapter Ten

Job Satisfaction, Responsibility and Role Effectiveness

In this chapter specific features relating to work in the community are considered. These include the extent to which staff are satisfied with their work, their perception about the clarity of their role and responsibilities and the degree to which they believe that they are effective in their work.

Job Satisfaction

Job satisfaction was assessed through a number of methods which ranged from the use of a structured set of seventeen questions measured on a five point scale (adapted from Allen 1988) to a series of open questions and informal comments from respondents. Respondents were asked to respond to a series of job factors on a scale which ranged from 'very dissatisfied' to 'very satisfied'. The results are presented overleaf in tables 10.1 and 10.2.

The first item referred to **income** and it must be acknowledged that all of the respondents were employed as nursing staff in the National Health Service at a time when a major revision of pay structures was being introduced. This process commenced in April 1988 and required the assignment of clinical grades to each postholder. This exercise proved to be a mixed blessing. Some staff for the first time received financial recognition for their experience and responsibilities, but for others the review resulted in disillusionment, a perceived loss of status and a backlog of appeals. At the time of writing the new pay structure has only been in existence for eighteen months and for the majority of staff their new grades were only assigned within the last twelve months.

TABLE 10.1

Job satisfaction - % responses by managers.

N=12

How satisfied are you with the following aspects of your work?	very satisfied	quite satisfied	neither one or other	quite dissatisfied	very dissatisfied
Income	42	25	-	25	8
Job security	8	50	33	8	-
Number of Hours Worked	-	50	25	8	17
Flexibility of Hours	-	50	25	8	-
Ease of travel to Work	8	75	17	-	-
Management and Supervision by your Superiors	8	50	17	25	-
Relationships with Fellow workers	25	58	8	8	-
Opportunities for Advancement	33	50	17	-	-
Respect for the sort of work you do	42	58	-	-	-
Your own accomplishments	17	67	17	-	-
Developing your Skills	8	83	8	-	-
Having challenges to meet	25	75	-	-	-
The actual tasks you do	17	75	8	-	-
The variety of tasks	33	67	-	-	-
Opportunities to use your own initiative	50	50	-	-	-
The physical work conditions	-	67	17	17	-
Your work in general	17	83	-	-	-

(All rows may not add up to 100% due to rounding).

TABLE 10.2

Job satisfaction - % responses by staff.

N=36

How satisfied are you with the following aspects of your work?	very satisfied	quite satisfied	neither one or other	quite dissatisfied	very dissatisfied
Income	14	58	8	19	-
Job security	36	58	6	-	-
Number of Hours Worked	5	78	6	6	6
Flexibility of Hours	22	64	6	6	3
Ease of travel to Work	36	42	14	8	-
Management and Supervision by your Superiors	17	53	14	11	6
Relationships with Fellow workers	42	48	11	-	-
Opportunities for Advancement	11	56	17	17	-
Respect for the sort of work you do	39	47	14	-	-
Your own accomplishments	28	67	6	-	-
Developing your Skills	11	64	17	8	-
Having challenges to meet	28	70	3	-	-
The actual tasks you do	19	75	6	-	-
The variety of tasks	28	61	8	3	-
Opportunities to use your own initiative	58	36	3	3	-
The physical work conditions	33	56	-	8	3
Your work in general	42	58	-	-	-

(All rows may not add up to 100% due to rounding).

Just over two thirds of respondents were satisfied with their incomes, (72% of staff and 67% of managers were either quite or very satisfied with their income) although one third of the managers were dissatisfied with their income. At the time of the clinical grading review the pay awards given to staff were not extended to managers. Managers may, in effect, earn less than some of their senior staff who may also have the opportunity to claim payment for overtime and 'unsocial hours'.Such benefits are not payable to managers graded above Scale I in the new structure and did not apply to 60% of their managers in the sample. Whilst expressing concern for the level of income most staff did not imply that this had a major impact on their level of job satisfaction. This would appear to be typical of the profession who for many years had demonstrated their commitment to furthering professional issues before satisfying their need for monetary reward (an example of this is the profession's continuing stance on adopting a no-strike policy).

All but two staff were satisfied with their perception of **job security** compared with 58% of their managers. Some managers stated that they felt particularly vulnerable as their jobs took them further away from the 'shop-floor'. They felt that their clinical skills were in less demand and that they were in danger of becoming general managers and that in the longer term that they might be replaced by non-nurses. (These feelings were also reinforced by the introduction of a new 'General Management' pay spine in 1990 for nurse managers which removed them from the normal negotiating machinery for the nursing profession).

One other reason for the difference in perceptions of job security between staff and managers may reflect the concerns that many managers expressed regarding the impending White Paper on Community Care which they felt might transfer lead management responsibility to Local Authorities and thus reduce

their own opportunities for career advancement and security. Staff, working closer to their clients, expressed a greater sense of security since they believed that their skills would be needed in any setting as long as they remained with their residents. Benton and White (1972), in a study relating to general nurses, noted that of sixteen job factors, income and conditions of employment were the least important. The most important factors related to job security, safety and social aspects of their work.

Allen et al (1988) found in their study that community staff were slightly better off than their hospital counterparts in terms of income and were more satisfied with this aspect of their work. They also found that staff were concerned about the new grading structure and the possibility that a transfer of employment in the longer term to the local authority might result in unacceptable pay and conditions of service.

Linked to this factor was the question relating to opportunities for **career advancement**: two thirds of staff and over three quarters (83%) of managers felt satisfied with the opportunities that their new jobs in the community offered for promotion. Allen et al (1988) found that community staff felt slightly more secure than their hospital colleagues, but also that the majority of their sample felt that their careers were characterised by 'truncated job horizons' (p119).

It is interesting to note that staff in this present study were more confident about the prospects of promotion, as the comments received from one respondent indicate:

> ' I was one of the first to volunteer to work in the community. I could see the hospital was declining and felt sure that I would need to sort my career out. I always believed that we could do more for the residents in the community and felt if worth a try. It is better to

be able to choose where you work before they close the hospital, at least that way you have a choice. Now that i'm here I feel that I am in a secure position for the rest of my career. It was so unsettling in the hospital, almost devaluing when you did not know how to see your future. Now I feel I may be promoted in the future, it is like a new start with new opportunities.'

The managers were surprisingly content regarding opportunities for career advancement. Opportunities for career advancement for managers have been seriously curtailed in recent years as more and more resources have been allocated to client focussed positions. However, it could be that the managers in this sample regarded their positions as a secure base from which to develop new skills in a multi-agency service, thus confirming their confidence about promotion in the new services. These results appear similar to those found by Benton (1972) who found that nurses ranked 'opportunities for promotion as last overall and that they were regarded relatively low in order of importance for most nursing groups' (p57).

Flexibility of Hours

Staff were expected to work different shift patterns than they were used to in the hospital. In order to assess the impact that these new work patterns had on the workforce staff were asked to comment on their responses to flexible shift patterns. The results showed that staff were quite satisfied with the **flexibility of their hours of duty** (79%) compared to (64%) of managers; three quarters of staff were also satisfied with the number of hours worked compared to half of the managers. These figures correlate with the responses received during the informal interviews where the majority of staff were satisfied with the hours, but stated that they would prefer more notice of off duty rotas and time off. (The average notice given to staff was two weeks).

Although their was no relationship between flexibility of hours worked and their propensity to leave (Tables A8.23 & B8.23) there was some suggestion that a relationship existed for managers between their length of service and shift patterns (Table A8.35). [Having regard to the small nature of the present sample, there is some suggestion that respondents with less than ten years service were satisfied with their shifts compared to eighty per cent of their longer serving peers]. No relation existed between these variables for staff.

One of the major difficulties was the requirement for some staff to work long hours before and after **sleep-in duties.** Sleep-in duties are a new characteristic of the community services and usually require day staff to remain on duty for at least one night per week to supervise residents. This is known as 'sleeping-in' and an allowance is paid for doing so. (At the time of writing this allowance amounts to an average of eleven pounds per night). Six of the thirty six respondents made clear reference to their concerns about these additional duties and noted this as one of the disadvantages of working in the community.

These feelings were also noted by Allen et al (1988) who found that staff were less satisfied with the hours of work, which they felt was partially attributed to the need to work additional hours during the post-commissioning phase of the new projects. They also discovered that the sleep-in duties added to the 'workload' but that staff gained some satisfaction from the continuity of care that these shifts offered. They found that the latter also removed some of the old problems of separation between the formal day and night shift which was so evident in the hospitals. (Respondents in this study commented on the same problems of the 'old system').

The majority of shifts were of eight hours duration which allowed staff to concentrate their efforts into a relatively

short time span, rather than exposing themselves to pressures over longer periods of time. Todd (1989) noted that longer shifts (twelve hours or more) correlated with lower levels of job satisfaction. He found that nurses working twelve hour shifts lost motivation and tended to underachieve towards the end of their span of duty. He found their work less exciting and their working conditions less favourable. They found that younger nurses were more in favour of the longer hours than older people. In the conclusion Todd stated:

> 'Moreover, not only did the quality of care drop, but also nurses were more dissatisfied with their jobs under the twelve hour shift than they had been under the eight hour system' (p14).

Physical Conditions at Work

The physical features of the new houses in the community, were by far superior to those found in large hospitals. However, they provided little opportunity for staff to 'escape' from their clients and expected them to eat, work and sleep in the same areas as their clients. No facilities were provided for 'rest rooms' or for staff toilets and in some cases office facilities were integrated within the lounge areas of the houses. Despite this the majority of respondents were satisfied with the **physical conditions of their work,** (89% of staff and 67% of managers). This is hardly surprising since all the staff were working in newly commissioned environments in which they held a certain pride. The managers were less fortunate and often had to work in cramped conditions in open plan offices in health centres or in older hospital buildings.

One other measure of achievement and satisfaction was provided by asking respondents how they felt that the public perceived the value of their work. Bearing in mind that respondents were somewhat ambivalent about their new roles in the community it

was encouraging to note that they demonstrated high satisfaction ratings of 100% and 86% respectively. Similar ratings were received in respect of the challenges that their jobs provided with all but one staff member finding their work more than stimulating.

These sentiments were noted by one respondent:

> 'The community is never dull. It offers so many challenges and the number of problems that we encounter seem to test our skills to the fullest extent. Still, that is far better than spending time in the clinical room of the of old hospital wards trying to find something to occupy myself (like cleaning cupboards and instruments). The new job is far more to my liking.'

Finally consideration was given to the the dispersed nature of the new services and to the extent that they may have made the **journey to work** difficult for some employees. It was reassuring to note that over three quarters of the total sample were satisfied with this aspect of their work.

General Comments on Job Satisfaction

The results presented in the first section of this chapter referred to job satisfaction and were measured against a number of intrinsic and extrinsic factors. [Staff were also asked to identify the features of their work that they liked best and least. These results are of interest and are presented in the first two pages of Appendix Five].

In contrast to the present study, Allen et al found that community staff were less satisfied with the **'challenge factors'** related to their work. They did, however, find that the variety of tasks was similar to that experienced by nurses in hospital and that the community offered the highest results

for resident interaction. (In their study the opportunity to work and to engage in work with residents was also rated as a major indicator of job satisfaction).

Allen et al found that dissatisfaction was related to role ambiguity, and that the least satisfied 'perceived the least variety and the most role ambiguity' (p178). They also found that both hospital and community based services employed people who were highly motivated practitioners who may have had a lower perception of their own self-development needs.

The comparisons between Allen et al and the present study give useful insights into the factors which staff regard as important in their everyday work and which provide them maximum satisfaction at work. Respondents were asked to report the extent to which they felt satisfied with their work.The results are presented below in Table 10.5 and demonstrate that all but two staff members and five managers were satisfied with their work for at least sixty per cent of the time and of these approximately one half were satisfied for over eighty percent of the time (53% of staff and 42% of managers):

TABLE 10.3

For what proportion of your time do you feel satisfied with your work?

	%MANAGERS N=12	%STAFF N=36
< 50%	8	-
51-60%	17	6
61-80%	42	42
80%>	33	53

(All columns may not add up to 100% due to rounding).

(Clearly, therefore, a very high proportion of staff were satisfied for the majority of the time: the proportion of managers in this position was considerably lower).

Propensity to Leave the Service

One other measure of the degree to which respondents felt satisfied with their jobs was the extent to which they considered leaving their jobs. Consequently the final area to be explored in this section relates to the propensity that staff may have to leave the service. Allen et al (1988) found that community based staff were more likely to leave the service than hospital based staff (p134). They found that this conclusion turned out to be a 'chance variation according to statistical tests' but they did find that the community had a higher turnover rate than hospital.

The results of the present study also show that a significant number of staff and managers consider leaving their jobs or giving up work at least occasionally which indicates that, despite expressing relatively high levels of job satisfaction, some staff and managers may be unsettled in their new roles.

TABLE 10.4

How often do you think of leaving this job or stopping work?:

	%MANAGERS N=12	%STAFF N=36
Never	8	22
Very Rarely	41	42
Occasionally	50	31
Every day	-	6

(All columns may not add up to 100% due to rounding).

Several reasons for these findings were considered and they were presented below in respect of the relationship between a series of independent variables and the degree to which respondents consider leaving the services.

In the first instance the relationship with job clarity was tested and it was found that three quarters of those managers who never or rarely considered leaving the service were unclear about their role. This compares to seventy five percent of the sample who sometimes considered leaving who were clear! (There was no relationship between these variables for staff members - Table B8.29).

TABLE 10.5

The Relationship between Leaving and Job Clarity (managers).

Managers: Clarity and Role.

Leaving	Yes		No		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	1	16.7	5	83.3	6	50
Sometimes	5	83.3	1	16.7	6	50
Column Total	6	50	6	50	12	100

Fisher's Exact Test **P= 0.04004**

These results are somewhat puzzling and suggest that the clearer managers are about their roles, then the more likely they are to consider leaving their positions occasionally (one might have expected the reverse to be true since role ambiguity has been cited as a major determinant of poor job satisfaction and disenchantment [Allen et al 1988]). These findings may reflect the problems that some community managers in new service structures feel when confronted with a host of priorities and conflicting demands:

'We came into the community with an unclear vision of what was expected of us compared to the hospital structure. The reality was, however, daunting as you take stock of the enormity of the task and of the many facets that appear to exist to your job. To be quite honest if I stopped to think about the breadth of work and responsibility you would not sleep at night. Many is the time that I think about finding an easier way to earn a salary at 'house level' with the residents. Anything might be better than coping on a shoestring with poor resources and with the expectation from your managers that the success of your service will depend upon your own commitment and effort' (quote from one manager).

Closely associated with this variable is the extent to which respondents stated that they actually enjoyed their role in the community. In Table 10.6 the results arising from an analysis of the relationship between propensity to leave and **role enjoyment** are presented and suggest that of those staff who sometimes consider leaving the service approximately two thirds (62%) enjoy their roles very much compared to 87% of those who never consider leaving (absolutely no relationship was found between these variables for managers - Table A8.27).

These findings suggest that there is a relationship between the extent to which staff enjoy their jobs and the likelihood that they will seek alternative employment. (It is, however, interesting to note that the managers appear to avoid considerations about leaving their jobs even if they do not enjoy certain parts of their work).

TABLE 10.6

The Relationship between Leaving and Role Enjoyment

	The Extent to which Staff Enjoy their Roles					
Leaving	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Never	7	87.5	1	12.5	8	22.2
Very Rarely	5	33.3	10	66.7	15	41.7
Sometimes	8	61.5	5	38.5	13	36.1
Column Total	20	55.6	16	44.4	36	100

Significance **P= 0.0389**

Whilst managers appeared to be become less **satisfied** with their jobs as their total length of service increased (Table A8.1), it is interesting to note that length of service appears to reduce the possibility of **leaving** the service for managers since two thirds of the sample who stated that they never or very rarely considered leaving had over ten years service (Table A8.17).

It may therefore be that although job satisfaction may reduce with years of service that staff may not feel inclined to leave due to problems associated with seeking an alternative career,

concerns about losing a secure NHS pension or possibly for reasons due to apathy. These feelings were supported by one Manager:

> 'Many's the time I would like to leave the service. I have worked for fifteen years now and to be quite honest things are changing to such an extent that I would gladly leave and open a Post Office if I had the guts to do so. But what's the point even thinking about leaving now? I have my pension to consider and moaning only makes you more dissatisfied. I carry on regardless and hope that things will improve. I still have my loyalty to the profession and that helps!'

For staff the relationship between length of service and **propensity to leave** (Table B8.16) provided different results. It would appear that two thirds of staff who have worked for more than ten years in the service sometimes consider leaving their jobs compared to one third who have worked less than ten years. However there is no difference between length of service and those staff who never consider leaving the service. This suggests that length of service appears to have a slight influence on propensity to leave where staff members are concerned.

Summary of Key Issues Arising from Job Satisfaction Results

The study has demonstrated that nurses working in the community appear to place much emphasis on the outcomes that they are able to provide for their clients in terms of quality of life. Recognition of achievement appears to be highly correlated with job satisfaction which confirms the results of other studies, (Hertzberg 1959, Riordan 1988 & Benton 1972). Support and training, together with encouragement from employers and from the public, appear to be more important than extrinsic rewards such as income, ease of travel to work and conditions

of employment. Autonomy and the variety of work are important for staff but may cause some conflict in that they may make staff roles appear to be ambiguous and unclear. The good physical surroundings of the workplace for staff were identified as significant, while for managers the unsatisfactory environments within which they worked reduced job satisfaction. The present study confirms Benton's findings (1972) that prestige and job security have important implications for nurses working in the speciality.

Responsibility.

During the course of the informal interviews staff and managers expressed mixed reactions to the additional responsibility that they felt work in the community entailed. Allen et al (1988) noted additional responsibility was common to unqualified staff, nurses and to managers. They found that the nurses' roles appeared to be broader, with more variety of tasks, which in turn led to role ambiguity for some staff:

> 'The uncertainties of their work role, and their greater responsibilities, generate greater needs for support.' (p106).

In the hospital most wards were managed by two charge nurses who shared responsibility for the work of the ward. Defined hierarchies also ensured that managers 'could pass the buck' when they so wished to their nursing officers, or to more junior members of staff, depending upon the task. In the community houses are managed by one member of staff and responsibility for individual residents is allocated to named nurses and support staff who act as **accountable 'key-workers'.** Nurses also have responsibility for the twenty-four hour running of their houses and consequently account for the actions of their night staff.

In addition to care responsibilities, staff are also responsible for the management of the house budget, standards of household hygiene, building maintenance standards and for public relations. Each of these factors produces additional stress for staff and managers and requires the acquisition of new skills to meet the challenges that these tasks required.

The **geographical isolation** of the community houses from other neighbouring care facilities demanded immediate responses to problems in the house. In the absence of support services such as personnel, occupational health, administration and finance departments, staff had to meet demands for action from their own resources. (These support services are currently available to staff at the end of a telephone during office hours).

It has been acknowledged that work in the community present residents and staff with certain **'risks'**. Staff accompany residents into the community as part of their every day work and participate in a range of integrated activities with them. The use of leisure centres, restaurants and pubs are typical features of everyday work and compare dramatically with life in hospital where all of these activities were provided in segregated facilities on the campus.

One of the most commonly reported problems was the implied displeasure and **comments displayed by some members of the public** in the company of people with a mental handicap. Stares, non-verbal gestures and averted eye contact were amongst some of the comments presented by respondents. Others had been involved in isolated confrontations with members of the public:

> 'I remember one occasion when I took Joyce into a pub for a drink. Two young people moved away from the table where we were sitting and one of them said in a loud voice, 'why should we be bothered with spastics?', I turned immediately and told them what I thought about them. One person came to our assistance but the majority continued to look on with a dispassionate interest'.

Perceptions of responsibility

The following results were obtained from respondents in respect of their perception of job responsibility in the community.

TABLE 10.7

Responses by managers of their perception of job responsibility by percentage:

	Strongly agree 1	2	3	4	Strongly disagree 5
I am certain how much authority I have	25	50	25	-	-
Clear, planned goals and objectives exist for my job	8	58	17	17	-
I know that I have divided my time properly	-	33	58	8	-
I know what my responsibilities are	50	42	8	-	-
I Know exactly what is expected of me	-	67	25	8	-
I have to bend or ignore a rule or policy in order to carry out an assignment	8	42	25	25	-
I receive incompatible requests from two or more people	17	33	33	8	8
I do things which are apt to be accepted by one person and not accepted by others	17	33	33	17	-
I receive an assignment without adequate resources to carry it out	8	58	17	17	-
There can be little action taken here until someone in authority approves a decision	8	-	-	33	58
A person who wants to make his or her own decisions within his own area of responsibility would be quickly discouraged	-	8	-	25	67
Even small matters have to be referred to someone higher-up for a final answer	8	-	-	8	83
Participation in decisions is very limited	8	-	8	33	50
Consultation about changes is rare. I feel I have no say in the day-to-day running of this unit	-	-	17	25	581
My opinion does not count when a problem comes up	8	-	8	17	67

n=12

(All rows may not add up to 100% due to rounding requirements).

TABLE 10.8

Responses by staff in respect of their perceptions of job responsibility by percentage:

	Strongly agree 1	2	3	4	Strongly disagree 5
I am certain how much authority I have	23	50	23	3	3
Clear, planned goals and objectives exist for my job	6	50	31	6	8
I know that I have divided my time properly	17	25	36	20	3
I know what my responsibilities are	42	47	8	-	3
I Know exactly what is expected of me	19	45	19	11	6
I have to bend or ignore a rule or policy in order to carry out an assignment	17	30	17	25	11
I receive incompatible requests from two or more people	14	17	25	31	14
I do things which are apt to be accepted by one person and not accepted by others	22	20	33	8	17
I receive an assignment without adequate resources to carry it out	28	14	28	20	11
There can be little action taken here until someone in authority approves a decision	14	17	20	28	22
A person who wants to make his or her own decisions within his own area of responsibility would be quickly discouraged	3	17	8	22	50
Even small matters have to be referred to someone higher-up for a final answer	6	17	11	22	44
Participation in decisions is very limited	3	6	19	25	47
Consultation about changes is rare. I feel I have no say in the day-to-day running of this unit	3	-	19	22	561
My opinion does not count when a problem comes up	3	5	6	31	56

n=36

(All rows may not add up to 100% due to rounding requirements).

The first question in this series asked respondents to confirm their understanding of their responsibilities: 73% of staff and 75% of managers were clear about their responsibilities.

Between half and two thirds of the managers possessed **clear objectives for their work** which corresponded with the findings that two thirds of all respondents were clear about their managers expectations of their work.

The **management and allocation of time** also appeared to be significant (only 42% of staff and 33% of managers felt that they knew when they had divided their time properly). During the course of the informal interviews staff and managers were particularly concerned about the conflicting demands that they felt were placed on their time. [Comments were received about the amount of paperwork (20% of managers and staff) and inadequate clerical support to carry out these tasks (15% of all respondents)].

Several staff expressed their concern about the existence of an apparent **conflict between policy aims and practice** when implementing service philosophy (this refers to a question in Tables 10.7 & 10.8 relating to the need to 'bend or ignore rules to carry out assignments'). Some (11%) attributed this to the fact that inadequate resources encouraged the introduction of custodial care regimes and that inadequate staffing levels prevented integration in the local community. As a result some felt that their responsibility to ensure a high quality of life for their residents was compromised by bureaucratic procedures which 'took up much staff time' to fulfil the demands of the 'central office'.

In order to overcome some of these difficulties over one third of the sample (40% of managers and 47% of staff) felt that they had to 'bend the rules' in order to carry out procedures

in line with the philosophy of the service. Several reasons were given for this:

* inflexible financial procedures;
* lack of support for policy aims from managers;
* managers uniformed in respect of service aims and values;
* conflict between aims and practice;
* disagreements between staff on policy implementation;
* restrictive policies;
* conflict between professionals;
* absence of training to inform staff of policy aims and procedures.

(These results are taken from the second page of Appendix Five).

Two questions were asked in respect of **role ambiguity.** Respondents were asked to state if they received incompatible requests from different people and whether they were 'apt' to do things which are not accepted by all of their managers or colleagues. Both groups were consistent in their responses to both questions and half stated that they were occasionally placed in such positions. To add to their difficulties, four out of every ten staff and two thirds of their managers felt that they were often expected to carry out assignments without adequate resources.

Role Autonomy and Decision Making

A number of questions were asked in order to consider the importance of role autonomy and decision making (see Tables 10.7 & 10.8). The majority of respondents felt that they had a considerable degree of autonomy in respect of decision making. The study found that all but one manager and two thirds (66%) of staff were able to make most operational decisions relating

to their everyday life without referring to senior managers. Over three quarters of the sample stated that they were encouraged to participate in the decision making processes in their District.

The obvious opportunities for participation in decision making and autonomy in practice for local decisions, were welcomed by most staff and managers and demonstrated the confidence with which they approached their new found responsibilities. However the increase in autonomy and decision making required staff to engage in a number of new activities which were not required in the hospital. This provoked anxiety for one respondent:

> 'In the hospital we had to wait for all decisions to be made for us. In some ways we were like the people we cared for, passive recipients of instructions from our bosses. However, once you learnt the rules of the game you were left to get on with it. Routines and policies existed to determine how we worked and we had no difficulty in working out what to do. There was much responsibility within a restricted set of routines and so you always felt able to cope. In fact you were trained to cope and to improvise. You always knew that you had done well because with the resources they gave you there was little else that could be expected of you apart from keeping the patients happy and well fed. You knew just where you stood'.

These sentiments were shared by several respondents during the course of the interviews (13% of staff stated that they missed the 'satisfaction gained from the knowledge of having done a good job in hospital despite the poor resources). **Expectations** are increased in the community and staff and managers are encouraged to demonstrate that the investment made in their new services is worthwhile and 'value for money'. The measured outputs may be described as:

* the number of new skills acquired by residents;
* the number of inappropriate behaviours that have been reduced;
* the number of opportunities provided for community engagement;
* the way in which the status and image of the residents and property is perceived and accepted by neighbours;
* the number of relationships that residents build within their new community.

In addition to these requirements, staff and their managers are responsible for all aspects of the physical well-being and safety of their residents, and for ensuring that their services are provided in a cost efficient manner. In the present study there was also no doubt that the staff take most of the credit for the establishment and maintenance of good relationships with their neighbours (although many respondents commented that their residents 'were their own best advocates!).

Most of the respondents did, however, feel that their responsibilities were recognised and the majority felt that they were adequately consulted about the running of their service by senior managers. Similarly, 86% of all respondents felt that their opinion was respected and considered whenever difficulties arose in their houses.

The Relationship between Role Responsibility and Independent Variables

There appeared to be no relationship between the degree to which respondents understood their responsibilities at work and their perception of **job satisfaction** (Table A8.10 - managers & Table B8.9 - staff). [No relationship was found either between responsibility and propensity to leave (Tables A8.23 & B8.24).

As one might expect the more experience managers had in their jobs then the greater their understanding of their responsibilities. This was borne out by the results obtained from the correlation between **total length of service** and role responsibility (Table A8.37). Sixty per cent of managers who had more than ten years service strongly agreed that they knew what their responsibilities were. This compares to all to all of those managers with less service who appeared to be clearer about their scope of responsibility. For staff the opposite appeared to be true with sixty per cent of those with less than ten years service appearing to be in strong agreement that they know what their responsibilities were compared to one quarter of those with more experience (Table B8.37).

[It may be that managers are clearer about their responsibilities since they are more acquainted with general management tasks which are less ambiguous. Staff, however have diverse responsibilities ranging from client support to household management. The rules for these are often unclear in the untested area of community care which may account for some of the confusion that respondents feel about their new responsibilities and roles].

Staff members stated that the nature of community based services made a number of demands upon their time, some of which were client directed and others which were administrative and which may cause feelings of role conflict and confusion. When staff were asked if they were as clear as they would like to be about their role all respondents with less than ten years service confirmed that they understood their responsibilities compared with only 80% of those who had worked longer. One possible reason for this might be that less experienced staff had received qualifying training associated with community models of care; compared with longer serving members of staff who would have been trained under an older, and now outdated hospital-focussed syllabus of training. Consequently recently

qualified staff may have been more familiar about their new roles and responsibilities than longer serving staff who were more accustomed to task orientated routines in hospital.

TABLE 10.9

The Relationship Between Total Service and Responsibility (staff).

I Know What My Responsibilities Are?

Total	Strongly Agree		Agree		Neither Agree or Not		**Row Total**	
Up to and including 10 yrs	No	%	No	%	No	%	No	%
	9	64.3	4	28.3	1	7.1	14	38.9
Over 10 years	6	27.3	13	59.1	3	13.6	22	61.1
Column Total	15	41.7	17	47.2	4	11.1	36	100

Significance **P= .0896**

Role Expectations

The degree to which respondents understood what was expected of them was related to their experience of job satisfaction, their propensity to leave the service and with the number of years that they had worked for the NHS. Only two results were of interest, namely the relationship between total service and

role expectation for managers and the relationship between role expectation and propensity to leave for staff.

No relationship was identified with job satisfaction (Tables A8.12 & B8.11), with total service for staff (Table B8.39) or with propensity to leave for managers (A8.26).

Eleven out of the twelve managers interviewed stated that they knew what was expected of them at work:

TABLE 10.10

The Relationship Between Total Service and Role Expectation (managers).

I Know Exactly What is Expected of Me

Total	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	0	0	1	50	2	16.7
Over 10 years	7	70	3	30	0	0	10	83.3
Column Total	8	66.7	3	25	1	8.3	12	100

Significance **P= 0.0578**

From this table it can be seen that increased service appears to be associated with a clearer understanding of what is expected of managers in their everyday work (conversely half of those with less than ten years service were not sure of other people's expectations of them). These findings were further borne out when managers were asked to consider whether they were clear about their roles (Table A8.42). Here all managers with less than ten years service stated that they were not always clear about their roles compared to 60% of those with greater service.

Role clarity and expectation were not, however, necessarily indicative of role enjoyment and it is interesting to note that half of managers with less than ten years experience appeared to enjoy there work very much compared to one third of those longer service (Table A8.40).

One other point of interest relates to staff and their propensity to leave. The results suggest that the degree to which staff understand what is expected of them may be related to their feelings of staying with the service. In this study it appears that all staff who never consider leaving the service agree that they know what is expected of them (Table B8.26) whilst almost one fifth (18%) of those who sometimes consider leaving are unclear about what others expect of them at work.

Authority

Benton (1972) noted that nurses ranked responsibility and authority to carry out designated tasks as important factors in respect of the degree to which they experienced job satisfaction. He found that the amount of responsibility and authority that nurses had to carry out their tasks was generally adequate and these findings were borne out in the present study.

In order to carry out these responsibilities, nurses and their managers need confidence, knowledge and skills in general management. Hingley (1988) in a study of the effects of stress in the public sector noted that:

> 'Nurse managers, while confident in matters relating to patient care, admit lacking confidence in their management ability because of lack of training' (p17).

The present study found that respondents felt that in-service training should be provided in respect of the additional responsibilities that work in the community demanded. The topics raised by staff have already been discussed and related to advice on budget management, public relationships and risk-taking with residents in the community.

Hingley also noted the following bureaucratic influences which may influence the degree to which nurses and mangers might perceive they are supported in discharging their responsibilities:

> '- rigid hierarchies leading to a separation of policy and practice and excessive reliance on rules and regulations (especially nurses, and social workers);
>
> - centralisation of services and/or sites that is the merger of services into conglomerations.....Such reorganisations have many effects both positive and negative. Among the negative effects is the tendency of such large structures to fail to develop appropriate systems of communication and coordination. Attempts to deal with some of the problems thrown up by reorganisations, such as creating small semi-autonomous sections to retain local contact, are not always successful. Separate parts can be at large physical distances from each other thus exacerbating or causing

problems of communication and liaison. The net result can be that efficiency is impaired and workers come to feel isolated, uninvolved and unsure of their focus' (p17).

However, in the present study respondents appeared to welcome the additional responsibilities and autonomy in decision making that work in the community provided for them. They felt that rigid hierarchical structures did not unreasonably restrict opportunities for them to implement their policies in practice. However, they did report some problems in matching theory to practice due to inadequate resources and conflicting demands on their time and roles. They felt isolated from central support networks and believed that the newness of their services had not permitted alternative support structures to be introduced. Respondents were clear about their client focussed responsibilities but were often concerned with competing expectations from their managers in respect of 'management orientated priorities'.

When related to propensity to leave, two thirds of those managers who had never considered leaving the service agreed that they knew the extent of their delegated authority. Of those managers who sometimes considered leaving eighty three per cent agreed that they were aware of the scope of authority that had been delegated to them (Table A8.25).

For staff it would appear that the three quarters who never think about leaving are aware of the limits of their authority compared with Sixty per cent of those who sometimes consider leaving the service (Table B8.25).

The relationship between authority and the length of time respondents had spent in caring for people with mental handicaps was also considered. In respect of knowledge of their scope of **authority (Table B8.38) and expectations** (Table B8.39) staff with longer service appeared to less sure of what

what was expected of them and were unclear in respect of the scope of their delegated authority (for both variables over three quarters of staff with less years experience were clear about other people's expectations of them at work and the range of their delegated authority compared to just over one half of their colleagues with longer service records).

These results suggest that the clearer managers are about their responsibilities and scope of authority then the more likely it is that they will sometimes consider leaving their jobs (possibly because of the personal demands and responsibilities it places upon them to manage dispersed services). For staff such a relationship does not appear to exist and the clearer they are about their expectations then the less likely they are to think about moving on. The longer managers work in the service also appears to reduce their understanding of what people expect of them and of the scope of their delegated authority.

In order to consider the degree to which respondents felt that they were effective in discharging their responsibilities further analysis is provided in the next section.

Role Effectiveness

Staff and managers were asked to respond to a series of seven questions relating to their perception of the effectiveness of their roles in the community services. The first question related to the degree to which they felt that their role was considered to be 'important' by the organisation and it was found that all but three managers and seven staff felt that they had an important role and contribution to make to the organisation and this was recognised.

The majority of staff (83%) and managers (86%) felt that their previous experience and skills were valued in their new jobs

and that they had opportunity to use them. Nearly all of the respondents also considered that they were able to be creative in the way in which they employed their skills and felt that they were involved in new and stimulating tasks. Correspondingly nearly half of the present sample reported that their new roles contributed to the acquisition of new skills and learning and that they had new opportunities for professional growth in their roles.

Between half and two thirds of the sample considered that they had a great deal of freedom in their roles and 33% of managers and 44% of staff were satisfied that they had 'enough freedom' in their role. However, there were some differences in the degree to which they found their overall jobs satisfying: one third of managers and half of the staff stated that 'they enjoyed their role very much' whilst two thirds of managers and 44% of staff 'enjoyed some parts of their role and not others'.

Half of all respondents felt that they were not as clear as they would have liked to have been 'about the things they had to do in their jobs' confirming that there were difficulties in respect of **job clarity and ambiguity.**

Allen et al (1988) noted that qualified nurses reported greater ambiguity in their roles in the community compared to their work in hospital. They found that staff had a continual conflict between meeting the demands of client related matters and the operational management aspects of running their houses. The dependency of their residents also demanded more skill and attention. A number of people had 'challenging behaviours' which demanded much of the nurses' time if accurate observations and coping strategies were to be provided. They also found that whilst specialist staff, such as psychologists and psychiatrists, were valued, there was not enough of their time available to meet the often competing demands of clients in a range of houses in the community. The result was that

staff had to rely much more on their own resources in order to supervise staff and to maintain high quality services. The following quotation illustrates the problems faced by one staff member:

> 'In the hospital John's behaviour was manageable and we were able to ignore some of his problems. We accepted them as a matter of course but now we have to reduce them in order to, prevent the house being damaged, the neighbours complaining and other people getting hurt. When he becomes disturbed he throws things, screams incessantly for hours on end and bites. My manager is concerned that all of the money we put into developing this service will be wasted if he destroys the environment any more. (John had already broken the T.V., smashed a wall unit, broken the front door and pulled wall paper from the walls). We are in a double bind. Do we persevere with him (as the specialists and managers say we should) or do we move him elsewhere. I can only be here for a limited time and my phone rings continuously when I am off duty for support and advice. We cannot go on much longer like this.'

It is understandable that staff and managers do become concerned about the dilemma that this case illustrates. In some District's the policy is that <u>all</u> people will be cared for in these houses, irrespective of their needs. The service is expensive and alternatives may not be easy to find once the hospital is closed. The neighbours might complain and staff may become exhausted in dealing with one such client. Without the necessary support, staff will be 'stretched' in terms of their ability to cope, and during such times direct management takes priority and other tasks have to take second place.

Allen et al found that community staff were more likely to be stressed if they were experiencing high levels of role

ambiguity, combined with high levels of autonomy, in their jobs (p129). They found that:

> 'In summary, it is being left to confront the ambiguity of a new professional role that contributes most to stress in the community, but being obliged by circumstances to work differently from the preferred way that contributes most to stress in the hospital' (p132).

They illustrated this point by the use of the following quote from a nurse, who had previously worked in the hospital:

> '[speaking about the house] When you're on duty, you're there right - can't relax because you're there all the time. You need to be aware what's going on all the time - you have to keep your eye on them. If [a resident] wants to do something, then I've got to supervise, so the others have to sit around.
>
> [Compared to hospital?] More. More (stress) in this job than in the hospital. The targets (in the hospital) are impossible. On some wards maybe it's different, but on the one I was on, no. In the (community service) they are achievable but you've really got to work to it. [so in the hospital it's frustrations?] Yes, you can't win' (p133).

Relationships between Variables of Job Clarity and Role Enjoyment

Job Clarity

From informal discussions with respondents it would appear that there was some variation in the extent to which they were clear about their roles in the community. There are obvious overlaps in this area with their understanding of the expectations of

others about their performance but as this study found there was no simple relationship between these variables and the degree of role enjoyment that respondents experienced.

This is shown by the relationship that appears to exist between role enjoyment and length of service. Half of the managers with less than ten years service, despite being unclear about their roles for a significant amount of the time, appeared to enjoy their work very much compared to one third of those with longer service (Table A8.40).

When correlated with **job satisfaction** three quarters of managers who scored highest against this variable stated that they were unclear about their roles compared to two thirds of those with lower perceptions of job satisfaction who were clear about their contribution to the organisation (Table A8.15). For staff there was absolutely no relationship (Table B8.14 - P= 1.0000).

In respect of the relationship between their **propensity to leave** no relationship existed for staff (Table B8.29) but in the case of their managers a significant correlation exists (see Table 10.5).

The results are very similar to those reported by managers in respect of their perception of job satisfaction in that the clearer they appear to be about their roles then the more likely they are to sometimes consider leaving their jobs. (Conversely all but two managers who never think about leaving report that they are unclear about their role).

Role Enjoyment

The extent to which people enjoyed their roles was also considered to be important as a variable. When related to job satisfaction no relationship existed between the two variables for managers (Tables A8.13) whilst for staff there appeared to be some indication to suggest that job satisfaction was increased if staff enjoyed their role:

TABLE 10.11

The Relationship Between Job Satisfaction and Role Enjoyment (staff).

Role Enjoyment by Proportion

Job Satisfaction	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	8	42.1	11	57.9	19	52.8
% Satisfied for more than 80% of the time	12	70.6	5	29.4	17	47.2
Column Total	20	55.6	16	44.4	36	100

Significance **P= 0.1673**

The relationship between role enjoyment and **propensity to leave** provided some interesting results in respect of staff. Of those staff who never considered leaving the service (n=8) seven stated that they enjoyed their roles very much compared to sixty one per cent of those who sometimes considered leaving.

It is not therefore surprising to note that these results appear to support the findings identified above in respect of the relationship between propensity to leave and job satisfaction and confirm that the more one enjoys one's role at work, then the less likelihood there is that staff will consider leaving and the more they appear to feel satisfied with their jobs. [No relationship was found to exist between these variables for managers (Table A8.27 - P= 0.72727)].

TABLE 10.12

The Relationship between Propensity to Leave and Role Enjoyment (staff)

Role Enjoyment by Proportion

Leaving	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Never	7	87.5	1	12.5	8	22.2
Very Rarely	5	33.3	10	66.7	15	41.7
Sometimes	8	61.5	5	38.5	13	36.1
Column Total	20	55.6	16	44.4	36	100

Significance **P= 0.0389**

Characteristics of the Organisation

Firth and Myers (1985) in a study of nurses working in the mental handicap specialty, found that in order to encourage personal accomplishment, managers needed to identify the **personal contribution and outcomes** that staff should be striving to achieve. They found that if staff are to provide 'more than care', then they need goals, prompts and supports to experience 'a sense of personal success in their work'. Clear organisational goals are needed and staff must be encouraged to achieve them. A series of questions were presented to staff (not managers in this instance) to assess the degree to which they believed that the organisation was able to identify and to meet its goals and objectives (See Table 10.13).

The results from this exercise provide insight into a number of interesting features of community based services. In the first instance the majority of staff (93%) believe that the organisation has an explicit set of values upon which to base its objectives. All but 14% of respondents believe that these values are widely distributed throughout the organisation, whilst three quarters believe that their managers are accessible and 'in touch' with their objectives as they are translated in practice at 'house-level'.

When asked to state the extent to which their **managers were 'visible at all levels of the organisation'**, just over half of the sample responded positively whilst two thirds (65%) believed that they created an 'exciting' environment in which they could achieve these objectives 'through the personal attention and intervention' that their managers provided for them in the workplace. Ninety eight per cent of the total sample felt that the 'organisation' was in touch with the needs of the service and believed that it responded to the needs of the residents.

TABLE 10.13

Characteristics of the organisation - % responses by STAFF;

N=36	Never				Always
	1	2	3	4	5
Consistent high quality service emphasised within organisation	-	8	36	31	25
The Organisation responds to the needs of residents	-	8	39	36	17
The organisation is well in touch with its environment	-	8	50	31	11
The public sees the organisation as friendly	6	14	44	33	3
The organisation's leaders create an exciting working environment through personal attention/intervention	11	25	42	17	6
Managers are visible at all levels of organisation	14	31	28	22	6
Staff know their managers well and what they 'stand for'	3	25	22	36	14
The organisation has a well defined set of guiding beliefs stated in qualitative terms	-	8	36	45	14
General objectives and values are set forth and widely shared throughout the organis.	6	14	31	39	11
Information is widely shared/ managers are open with staff	11	19	31	33	6
Conflict is managed - not suppressed	6	22	36	33	3
The organisation will try out ideas without lengthy debate	3	25	39	28	6
People are encouraged to be creative and innovative	3	11	36	36	14
Failure is seen as an opportunity to learn	-	19	44	33	3
Managers assume that staff want to assume more responsibility and thus provide opportunities	6	14	42	33	6
An effort is made to inspire people at the bottom of org.	3	28	39	28	3
Management demonstrate respect for individuals	3	22	31	36	8
People work effectively in multi-professional teams	6	11	44	31	8
Casual meetings occur regularly	6	28	36	19	11

(All rows may not add up to 100% due to rounding requirements).

Two thirds of the sample believed that information was widely shared and that they were 'encouraged to be creative and innovative'. The organisation also appeared to encourage staff to 'take risks' and 63% felt that new ideas were well received and implemented. Such risks also implied additional responsibility for staff and over three quarters (81%) believed that their managers supported them in assuming additional responsibilities. A similar proportion also felt that 'failure' was regarded in their services as an 'opportunity' to learn from mistakes and that staff should be supported in their work.

Three quarters of staff felt that their managers demonstrated respect for them as employees and that people worked effectively to support each other in multi-professional teams. Only one quarter felt that conflict was not managed well and two thirds of staff stated that they appreciated the opportunity to meet together 'casually' to discuss their needs and problems as they required.

Perhaps the most important test for many respondents was the extent to which they felt that the organisation emphasised high quality services throughout the organisation; 92% supported this statement and a further 80% felt that the public viewed the organisation as 'friendly'.

Firth and Myers (1985) felt that the opportunity to engage in '**personal discussion**' about what was expected was more important than written job descriptions or written notes of guidance. They found that role clarity had a major influence on morale and suggested that conflicting demands should be discussed with staff in order to assist them in defining priorities;

'The system must involve a two way process, ensuring that all staff are kept in touch with what is possible within the organisation. The process consists of much more personal discussion, so that the organisational need to clarify priorities and objectives may also overlap with the provision of a degree of personal support for staff (p102).

They also felt that staff needed variety to avoid becoming 'emotionally drained' in respect of certain components of their jobs. They found that:

'Some time should be set aside each day in which they can contribute to care plans or to other tasks which do not involve direct contact with clients or other staff. This is very important for staff who work in homes where every task is undertaken (domestic, personal care, social) always involves teaching clients. This can be very demanding emotionally (P103).

Role Conflict and Role Ambiguity

In order to conclude the discussion on job satisfaction and job characteristics it is important to consider the extent to which respondents experienced conflict and ambiguity in their work.

Brief (1977) defined role conflict and role ambiguity as :

Role Conflict: 'a condition of incompatible sent roles to the focal person'.

Role Ambiguity: 'the existence of a lack of clarity in the sent roles' (p112)

Hingley (1985) found that problems of role ambiguity and conflict had effects upon confidence and role performance. Jamal (1984) found that professional and organisational commitment moderated the consequences of job stress. The present study supported both these sets of conclusions in that respondents were confident for the major part of their tasks and that three quarters (77%) of all respondents felt that they were effective in their role performance. Similarly the majority were positive about the support offered by the 'organisation' and by the nursing profession and many expressed pride in their profession during the course of the informal interviews:

> 'What was important for us here, was the reassurance offered by our managers that the role of mental handicap nurses was still valued in the new service. At a time of major organisational change, this has become more important. Our new roles have renewed confidence in our ability to function and to represent nursing in the new multi-agency service' (quote from one staff respondent).

One of the interesting findings was the general satisfaction by respondents in having fewer bosses to account to in the new service. Rizzo (1970) noted that multiple lines of authority are accompanied 'by role conflict and dissatisfaction for the members and loss of organizational efficiency and effectiveness' (p152). Lyons (1971) found that three general organizational conditions significantly contribute to role ambiguity:

* organizational complexity;
* rapid organizational change;
* managerial philosophies about communication (p101).

He found that role conflict and ambiguity may be reduced if staff are enabled to participate in negotiations about their job content and priorities. The permanency of their tasks, roles and functions also appeared to have some bearing upon the degree to which they felt stressed. Flexible job specifications were correlated with positive feelings of job satisfaction.

Brief (1977) found that high levels of conflict and ambiguity may prevent employees from perceiving their tasks as having high levels of identity, autonomy, or feedback. The relationships indicate that when higher levels of conflict and ambiguity exist there also exist lower levels of effort-performance and performance-reward probabilities (p125).

In the present study the rapid rate of organizational change and complexity do not appear to have adversely affected staff and managers. This is possibly due to the pace at which change has been introduced over the past two decades. Staff have the chance, in some areas, to accommodate the change in their roles over a period of time and appear to have accepted the reality of hospital closure. They have found the new community services to be less organisationally complex and clearer in respect of their philosophy, goals and aims. The six services were relatively new and consequently it was to be expected that some degree of ambiguity in respect of role expectation was to be anticipated. However, staff appear not to have been adversely affected by the pace of change and appear to have enjoyed the opportunity to assume greater autonomy in their roles. The novelty of their work and the apparently high levels of job satisfaction enjoyed by staff, suggest that the ambiguity of roles and tasks found in this sample, do not appear to have reduced the quality of their input or of their performance.

The Perceived Importance of Tasks and Responsibilities

The final section of this chapter considers the importance that managers place on their tasks and responsibilities:

TABLE 10.14

Percentage of managers naming tasks as important:

Motivating people to do things	100
Making decisions	100
Organising people and tasks	92
Persuading/influencing others	92
Leading a Group	92
Briefing People	92
Building a good team	91
Getting on with other people	83
Monitoring standards of quality	75
Counselling/developing staff	75
Delegating	75
Analysing problems	75
Setting targets/goals	75
Communicating well	69
Interviewing	67
Chairing meetings	59
Allocating work	58
Managing your time	58
Assessing yourself	50
Planning work	50
Developing own job skills	42
Making presentations	42
Disciplining subordinates	42
Designing/implementing systems	42
Assessing job performance	42
Handling grievances	33
Writing reports	24
Costing/financial matters	16
Writing job descriptions	8

*** The full Table of results associated with this Table is presented in APPENDIX SIX.**

The most important tasks related to decision making and motivating the staff team. Man-management, leadership, briefing and monitoring standards and quality followed closely. Staff counselling, problem-solving, staff selection and communication were also identified as being important.

The least important tasks related to the formulation of job descriptions, report writing, financial management and handling grievances.

Perhaps the most important conclusions from the analysis of tasks and responsibilities relate to the variety, nature and range of responsibilities that managers have to perform. This confirms the nature of the job and the resourcefulness that staff require if they are to manage their services effectively.

Summary and Key Issues Arising from this Chapter

This chapter has considered the many factors which influence the ways in which staff and their managers perceive their roles in the community. It may be concluded that they are generally very satisfied with the range and variety of their jobs, which demand increased responsibility and autonomy in decision making. They believe that they are effective in performing their roles, although they occasionally feel confused regarding the priorities that they should attach to their tasks.

Of primary importance to all respondents is the need for job security and guarantees of career progression. Apart from the many anxieties that face the mental handicap nursing profession the majority feel that the move to the community places them in good stead to face the future with greater certainty than they faced whilst working as part of an 'outdated' model of care within institutions. Managers, being closer to the decision-making level of the Health Authority feel rather less secure than their staff but still believe that their skills will be

needed following the publication of the National Health Service and Community Care Act (July 1990) [see Chapter Two].

Work in the community provides for greater flexibility of approach and deployment practice compared with the rigid shift patterns of the hospital. On the whole this study has illustrated that respondents welcome the change (however for those managers with longer service records there is a suggestion that too much flexibility in hours leads them to consider leaving the service rather more). Staff were less supportive of the need to work during the night in the form of 'sleep in' duties. The majority tolerated these but felt them to be intrusive into their home lives and spare time.

The importance of remaining involved with clients still appears to feature as an indicator of job satisfaction and proved to be the highest single factor of achievement for all respondents. Of almost equal importance is the degree to which respondents enjoyed comfortable and supportive working relationships with colleagues and their managers. The results from the current study suggest that on the whole they are satisfied with the support they receive.

The physical conditions offered by the new service were reported to be a major incentive for staff and the geographical dispersion involved in the relocation of staff did not appear to be too disruptive.

Although most staff reported high levels of job satisfaction a significant number still reported that they occasionally considered leaving their jobs. Whilst enjoying the additional responsibility, there were times when they said that they felt confused with their roles and as a result experienced a significant amount of ambiguity. A few also believed that they were often faced with a number of difficulties in their work for which they did not receive adequate support from their

managers or relevant training by way of preparation for their responsibilities.

Quite clearly those respondents who held optimistic or positive attitudes towards community care were the most likely to 'stay with the service' and to experience the highest feelings of job satisfaction. For staff, longer service increases their propensity to leave and makes no difference to their perception of job satisfaction. More experienced staff were also found to engage in a wider variety of tasks which were most likely to involve non-client activities. However, staff with less than ten years service are more likely to be clearer in respect of the nature of their responsibilities, of their scope of authority and of the expectations of others than their longer serving colleagues. Autonomy and greater involvement in decision making were appreciated by most respondents who seemed to rate prestige and the challenge of their new jobs very highly.

Respondents stated that they felt most comfortable when clear and specific objectives were set for them at work and when expectations were clarified. Those respondents with longer service appeared to be clearer about what was expected of them compared to more junior colleagues and there also appeared to some relationship between the number of times managers considered leaving their jobs and their understanding of what was expected of them at work (the greater the apparent level of understanding of their responsibilities then the more likely they are to think about leaving). For staff the opposite is true and the clearer they are about their roles then the more they tend to stay with their jobs.

The majority of respondents felt that their previous experience and skills were of value in the new service and apart from experiencing some confusion and conflict between client and

non-client aspects of their work, the majority considered that they were effective in their jobs.

In respect of the perceived importance that managers place on their many tasks and responsibilities managers prefer those tasks which facilitate and enable staff to perform their duties and dislike those tasks which remove them from 'man-management'.

The majority are committed to their profession and to the organisation and gain most satisfaction and enjoyment from their involvement with clients. The opportunity to practice their skills in appropriate settings in the community appears to enhance positive feelings about their work.

The next chapter concludes the presentation of results and considers the implications of workload for nurses in respect of their needs and responses within the context of their new roles in the community. Comparisons between work experiences in the community and in hospital are made.

Chapter Eleven

Implications for Staff

This chapter considers responses from staff and managers in respect of their experiences of the new service and considers the ways in which they adapted to their new role in the community. Their perception of personal support needs is considered and an account of the changes involved in their work provides insight into new practices and demands on their time and skills.

The chapter commences with a review of literature relating to stress and burnout in human services which provides the context within which service change and patterns of staff adjustment may be considered with specific reference to meeting the needs of people with mental handicaps in the community.

Literature Review on Stress, Burnout and Coping Capacity.

STRESS

An outstandingly complex and varied literature is available in respect of stress and burnout. In this section an overview of key concepts and issues arising from the literature is presented in so far as it forms the basis for discussion and understanding of the needs of staff experiencing new and challenging roles in what may be described for most staff 'as unfamiliar surroundings'.

Many people have attempted to define the concept of stress but according to Seyle, it suffers 'from the mixed blessing of being too well known and too little understood' (1950 p12). Because of its acceptance in everydaylife it often escapes precise definition:

> 'it is a concept which is familiar to both layman and professional alike; it is understood by all when used in a general context but by very few when a more precise account is required, and this seems to be a central problem' (Cassel 1976 p108).

A number of ways of classifying the different theoretical approaches to stress appear throughout the literature and have been discussed at some length by many authors (Lazarus 1966; Appley and Trumbell 1967; Levine and Scotch 1970; McGrath 1970). Cox (1978) following a review of the literature suggests that it is possible to identify three main approaches to assist definition. Stress, he concludes, can be seen:

a) **as a dependent variable** - stress is defined in terms of a person's response to the disturbing situation or environment;

b) **as an independent variable** - stress is usually described in terms of stimulus characteristics of those disturbing environments;

c) **as an intervening variable** - stress is seen as the lack of fit between the individual and his environment. In this model stress is seen in terms of causative behaviour and its effects (p46).

Stress is not a new concept as can be seen from the following quote from Hinkle (1973) who adopts an historical approach to the definition of stress:

'Stress is a word derived from the Latin stringere, to draw tight, and was used popularly in the seventeenth century to mean hardship or affliction. Only in the late eighteenth century did its use evolve to denote 'force, pressure, strain or strong effect' with reference primarily to a person or person's organs or mental powers' (p36).

As a result of earlier interpretations a **mechanistic approach** to understanding stress was derived by researchers based on the principle that external forces distorted the body and mind and adversely affected their capacity to cope and interact with the environment. The mechanistic approach considered that individuals were passive recipients of change and were unable to interact purposefully with their environment to minimise the effect of life events.

However, a more purposeful theory of man's association with stress might be to consider how he responds to external influences or stimuli. Cannon (1935) noted that human subjects react to stress by 'fighting or fleeing' and Hinkle (1973) suggests that this may have been conditioned by a desire to restore equilibrium when confronted by disturbing forces or external factors. Cannon supported his theory by noting the occurrence of physiological changes e.g. the emergency release of adrenalin, when humans were experiencing stress.

Seyle (1946) suggested that man experiences three stages in stressful situations. Together these make up the **General Adaptation Syndrome:**

1. **Alarm reaction** - in which an initial shock phase of lowered resistance is followed by counter-shock during which an individual's defence mechanisms are activated. If the perceived threat of stress is severe or prolonged, resistance may collapse and death may occur;

2. **Resistance** - this is the stage of maximum adaptation and successful return to a state of equilibrium for the person. If the stressor continues, or the defence is ineffective, the individual will move onto the next stage;

3. **Exhaustion** - this is the final stage in which the individual's adaptive mechanisms finally collapse. Individuals usually react with alarm, flight and often die.

This theory suggests that man reacts to stress in an active way with the purpose of restoring equilibrium in his life. It suggests that in order for this to occur, man also possesses a number of inbuilt coping mechanisms which come into play in times of stress. These may be activated by physiological cues (Cox 1978) or in response to psychological impact on the individual.

Bowers (1973) indicated that for any theory of stress to be considered account had to be taken both of external influences and how they interact and change a person's behaviour. Mischels (1973) argued that any theory of human behaviour had to take account of three perspectives of 'environmental determinants, person variables, and experiential factors, ie. the individual's subjective interpretation of events' (p257). Basowitz (1955) emphasised the **interactive nature and influence of stress:**

> 'We should not consider stress as imposed upon the organism, but as its response to internal or external processes which reach those threshold levels that strain the physical and psychological integrative capacities to, or beyond, their limits' (p78).

Individual perceptions of stress would therefore appear to be essential in respect of the degree to which each person interprets or anticipates that external influences or changes

will affect their state of equilibrium. This implies that people respond to stress when they believe that their coping strategies no longer protect them from external influences in their environment. Bannister and Fransella (1980) illustrate this well:

> 'It implies that you are not reacting to the past as much as reaching out to the future; it implies that you check how much sense you have made of the world by seeing how well that 'sense' enables you to anticipate it; it implies that your personality is the way you go about making sense of the world (p89).'

Stress may also be associated with a person's inability to predict the future and as such may have its origins in the way in which people interpret the world; this implies that individuals constantly test out their role in society against the expectations of others and against their own sense of reality and past experiences.

Lazarus (1976) presents one of the most popular theories of stress - the **interactionist theory.** He suggests that the person, with all his attributes, inherited and acquired, interacts with his environment. He states that it is the nature of this interaction which is crucial:

> 'Stress refers, then to a very broad class of problems differentiated from other problems because it deals with any demands which tax the system, whatever it is, a physiological system, a social system, or a psychological system, and the response of that system' (p57).

He stated that the way in which people respond to stress will be determined by the way in which they interpret the significance of change or threatening situations. He believes that people have access to a whole array of coping mechanisms

or constructs which are arranged in particular ways by individuals as 'constellations'. For him, stress is not simply 'out there in the environment' but it depends upon the perception that individuals place on whether or not they have the capacity to cope with threatening behaviour or circumstances. If the person has confidence in coping behaviours then the threat is perceived as minimal.

Bowers (1973) suggests that people also adapt to stress in respect of degree to which 'they fit' with their environment. He stated that:

> 'The degree to which a person's attitudes and abilities meet the demands of the job and the extent to which the job environment meets the workers' needs, and in particular the extent to which the individual is permitted and encouraged to use their knowledge and skills in the work setting will be important. Stress is likely to occur when the individual's well-being is adversely affected because of a mismatch in either or both of these factors (p32).

Bowers (1982) and French (1974) suggest that when stress arises from the lack of a 'good fit' between the individual and their environment a number of **coping behaviours** come into play. Individuals may attempt to master their environment and try to manipulate circumstances in order to reduce stress (in mental handicap hospitals this was most commonly seen in staff who adopted a task-orientated approach to care rather than a person centred one).

Lazarus (1976) suggests that the two main coping behaviours utilised during stress are problem solving and emotional processing. In the case of the former the individual will employ coping behaviours which he believes will lead to a positive outcome and in the latter the individual engages in

LIBRARY UNIVERSITY

the process of **'cognitive reshaping'** in an attempt to alter and lower his/her perception of stress or danger and thereafter cope more positively. Baley (1983) suggests that **defence mechanisms** are most important:

> 'Defence mechanisms are ways of coping....Short term denial to alleviate anxiety may help the nurse to carry on with nursing. Similarly, intellectualising the approach of surgery may be of some coping efficacy to surgeons and theatre nurses. Other defence mechanisms such as the employment of suppression, and detachment, may make 'space' for the health professional to mobilise more open forms of problem solving when emotional expression as a means of coping with stress is inappropriate' (p98).

It is apparent that people will deal with stress in different ways according to their previous experiences and according to their coping behaviours. Cooper (1987) measured reactions to stressful situations according to the personality types of his subjects. He focussed a variety of **personality attributes** measured on personality inventory scales and as a result found that persons admitting to higher stress levels correlated with neurotic personality traits and weaker ego defence systems. Khan (1964) found that introverted subjects reacted more negatively to role-conflict than did extroverts and they also reported higher levels of tension. He found that the traits of flexibility and rigidity were strong mediators in the relationship between role-conflict where rigid people reported virtually no role-conflict.

The concept of **perceived control** as an exponent of stress perception was studied by Rotter (1966), who found that some people believe that they are masters of their own destiny whilst others feel that they have little control and are under the influence of the decision making process of others. The

former appears to be more confident in adjusting to change whereas his counterpart might feel comparatively powerless to influence change.

In the workplace, stress is common and accounts for many days of lost productivity. Personal perceptions of stress may be influenced by a variety of factors such as:

- **workload** (overload and underload) [Margolis 1958];

- **physiological strain** (French et al 1965);

- **shift rotation** (Seyle 1976);

- **role ambiguity** (Khan et al 1964);

- **role conflict** (Caplan, 1970);

- **responsibility** (Wardwell 1964);

- **relationships at work** (Cooper 1983; Minzerg 1973);

- **career development** (Hingley and Cooper 1983; Morris 1975);

- **work-home interface** (Beattie 1974; Gowler and Legge 1975);

Fiorentino (1986) noted that in 1985 costs associated with stress amounted to $75-$100 billion due to diminished productivity, medical costs, and absenteeism. She concluded in her research on this subject that personality factors and coping abilities certainly mediated between the effects of stressful life events. She stated:

'with the acquisition of resources, the individual may develop a sense of meaningfulness of life. This persuasive feeling protects the individual from purposefulness, a dreaded social stressor which precipitates disease...If we can identify characteristics common to individuals (at one point in time) who do not fall ill (at another point in time) in spite of high levels of objective and subjective stress, we will be able to control our own fate and that of our clients and nation' (p220).

In 1988 The Health Education Authority published a report on stress in the public sector. They recognised that nurses work in one of the most stressful professions and quoted Marshall's description that:

'The nurse's role is.....implicitly and chiefly one of handling stress. She is a focus for the stress of the patient, relatives and doctor, as well as her own' (Marshall 1980).

They defined stress as '**an excess of demands on an individual beyond their ability to cope.**' (p v). In their chapter on stress in nursing the authors confirmed that the main variables involved in the perception of stress were leadership and management style of bosses, economic factors, conflict and ambiguity, public and social attitudes, client problems, training issues, interpersonal relationships and matters relating to the organisational context of their work. They found that nurses often deny their stress and often take their problems home with them (p4):

'It is difficult for nurses to completely separate their job and home life... it is practically impossible just to forget about everything at the end of the shift.... the problem is trying to balance the demands of a career and a home.... if too many of the difficulties of one area spill over into the other, there is a very real danger of losing both career and home' (Hingley & Cooper 1986).

Other studies on occupational stress by the Post Office (Allinson et al 1989; and The Association of Scientific and Technical, Managerial Staff [ASTMS] 1983) drew attention to the dangers of stress in the workplace. They both found that **job satisfaction** is essential if stress is to be perceived as tolerable. They found that many jobs could be made less stressful by a more realistic assessment of individual capabilities and by providing staff counselling services. The majority of people in their two studies who acknowledged high stress levels felt that they were forced to take on responsibilities for which they lacked experience, skills and knowledge. To control this ASTMS (1983) suggested that 'Tasks Should:

- 'Combine to form a coherent job either alone or with related jobs whose performance makes a significant and visible contribution.

- provide **variety** of pace, method, location and skill;

- provide **feedback on performance** in a number of dimensions both directly and through others;

- provide a **degree of discretion** in carrying out successive tasks;

- carry **responsibility** for outcomes and particularly **control of work' (p17).**

ASTMS also confirmed the importance of job security in mediating against stress. They found that constant job changes and feelings of insecurity were a constant cause of stress and may make workers actually 'sick with worry' (p23). **Social relationships** and **support** from family, friends and colleagues were noted to reduce perceptions of stress for workers (p25).

Llewelwyn (1984) noted that the cost of caring may restrict emotional growth and cause physical distress. She felt that nurses had to feel safe and secure in their work environment in order to practise their skills effectively. These skills compliment the basic need to form positive relationships with clients and can only be achieved if staff are motivated and maintain a **high morale** in their workplace. Conversely for demoralised staff there will be little time left to devote to the needs of clients who often require emotional and practical support in all aspects of daily living. She concludes:

> 'Because nurses deal with human beings in distress, it makes sense to treat them as human beings, rather than as a collection of symptoms...Facing another human being is bound to give rise to some emotional response. Both nurse and patient are in the business of making some sense out of their predicament, and to reduce anxiety to a manageable level... such a system allows greater freedom to predict and control events (p64).

Consequently the effects of stress may be potentially damaging as the following quote for Holland (1987) suggests:

> 'The effects of stress are damaging both to the individual nurse, her relationships with colleagues, and ultimately, to the quality of care she helps to provide for patients and clients. We owe it to ourselves and others to gain insight into our existing coping strategies, to adapt and to improve upon them, and so

develop a whole range of approaches to managing it more effectively (p47).

This section has considered a number of theories surrounding the concept of stress and has identified a number of intervening variables that may influence the degree of stress experienced by employees. The interactionist approach seems to lend itself to an appreciation of man's behaviour and adaptation when confronted with change and stressful situations. Rather that behaving mechanistically, man may regard stress as the product of his relationship with his environment. Consequently each person may adjust to change in different ways and may influence the course of action by calling upon past coping strategies and behaviours.

BURNOUT

Closely allied to the concept of stress is a large volume of literature on 'burnout' which has been defined by Cade (1983) as:

> 'Burnout is that state of disillusionment and apathy that can eventually affect any of us if our ideals and ambitions are constantly eroded by frustrations and obstacles. The various helping professions are particularly at risk concerned as they are with...(difficult client groups)...and working frequently with inadequate resources and insufficient acknowledgement of support. All of us under such circumstances will inevitably experience periods of emotional exhaustion from which we will sooner or later recover; but for many, a state of 'burnout' can become chronic. Sometimes with considerable effects on mental and physical health and on family life' (p9).

Burnout can affect people who are motivated to do well and to give the most of themselves in the caring professions. Maslach (1976) found that nurses cope with stress by distancing themselves from their clients which has the result of hurting themselves and those they care for (p16). Examples of **techniques employed to reduce tension** were:

- **ascription of labels** to clients in terms of their diagnosis;
- explicit **split between home and work** life;
- **depersonalisation** of situations;
- **rigid rules** associated with non involvement with clients as friends;
- **minimising physical encounters** with clients;
- **'working to the rule book'**;
- adoption of a **task orientated approach**;
- through the use of sanctioned **'time-outs'** from resident contact;
- **intellectualisation**;
- **over-reliance** on colleagues and managers.

The outcome appears to be a poor health care system and low worker morale which also appears to be a key influence in increasing workforce turnover and absenteeism and often causes family distress at home due spillover of unresolved problems after work.

The number of hours that a person works are also likely to be associated with their experience of fatigue, stress and boredom. Maslach found that whilst this was true for nurses, the **impact of long hours** only had a negative effect on their attitudes when it was associated with prolonged exposure to residents in direct contact situations. When the hours involved administrative work, burnout was less likely to occur (p20). She concluded that administrative work and attendance at meetings, no matter how unpopular, acted as a welcome relief for staff who had continuous contact with clients.

Staff in dispersed services may also experience greater levels of burnout due to the **isolated nature of their work.** Attendance at formal training and support groups appeared, for Maslach, to ameliorate the effects of burnout:

> 'I felt cut off, isolated-I didn't feel I had people whom I could turn to when problems arose, and whose opinions I could trust' (staff member Maslach ibid p20).

Closely associated with stress and burnout is the experience of **guilt** that many staff appear to experience as a result of their increasing **disengagement** from their clients. Walker (1987) argued that nurses tend to act on impulse when under stress and tend to work more and more hours in order to accomplish their tasks. In time this approach results in fatigue and mistakes in their practical tasks, which in turn add to their feelings of guilt (p11).

Walker found that nurses work under external pressure which is a combination of **public opinion and government policy** which are often in conflict with each other in respect of the availability of resources. In failing to cope with the sheer volume of work, the professionals' identities may be shattered as they strive to provide the quality of care that they believe should be provided and yet fail to meet their objectives due to manpower deficiencies. Rather than blame their failures on the organisation, many nurses appear to assume direct ownership of the problem themselves which in turn may lead to feelings of deep personal hurt.

When this is combined with a poor response from managers staff may acquire a feelings of helplessness as they accept that they have little influence on their predicament. Walker suggests that workers have two choices - 'burnout or opt-out' (p12).

Moores (1983) suggests that staff experience burnout in two distinct stages - '**First Degree**' & '**Second Degree**' burnout:

First Degree Burnout

New and enthusiastic workers may begin to experience vague and indefinable personal distress. They may find that more and more personal effort is required to achieve less and less. As a result nurses may experience somatic symptoms such as exhaustion, colds, gastric disturbances and sleepless nights. They may also become cynical and critical at home and at work. There may also be a tendency to rely heavily on overeating, tranquillisers or cigarettes.

Second Degree Burnout

This stage may occur in staff who have worked in the system for some considerable time and age appears to introduce a greater rigidity of perception. Staff may respond to prolonged stress by becoming obsessive and sticking to rules and procedures. New suggestions and changes may be suppressed as traditional work practices are challenged or eroded. Staff may withdraw from resident contact and may become detached from their previous characteristics of enthusiasm and commitment.

The result may be a progressive journey to burnout, characterised by the following stages:

- **Enthusiasm;**
- **Stagnation;**
- **Frustration;**
- **Apathy;**
- **Burn-out.**

Maher (1983) felt that **ambiguous demands** and **role conflict** are also correlated with the experience of burnout (p391). She suggested that staff who occupy multiple roles in changing services may find that their energy potential may become exhausted. She quotes Freud (1961):

> 'since a man does not have unlimited quantities of physical energy at his disposal, he has to accomplish tasks by making an expedient distribution of his libido (p50-51).

In other words **energy** appears to be limited and may be in danger of depletion. However, Marks (1977) suggests that some roles may be performed without any net loss of energy and some may even create energy for use in their role performance (p.926). This theory suggests that man has an abundance of energy rather than a scarcity which implies a commitment to activity if the person is so motivated. Marks proposes four conditions for encouraging **commitment**:

- Intrinsic enjoyment of the activities involved in performing the role in question;

- loyalty to all or some of one's role partners;

- expectation of extrinsic rewards for the performance;

- desire to avoid punishments that could result from non-performance.

Maher (ibid) expounded Marks theory of commitment as a 'fruitful' way of examining the phenomenon of burnout (p393) and suggested that when a combination of conditions (such as those listed above) was noted, then there is an increased likelihood that burnout will be witnessed in the workforce. Its presence may be influenced by difficult clients, poor

relationships at work, low regard for one's clients, isolation from colleagues and poor working conditions.

There are also **moral and ethical factors** to be considered in the burnout equation. Cameron (1986) found that the responsibilities faced by nurses in making ethical decisions on behalf of their clients often caused stress. She suggested that research has demonstrated a high correlation between moral stress and burnout (p42b). Caton (1988) found that staff members in mental handicap care spend much of their time in intense interaction with their clients (p300). She found that moral dilemmas contributed to burnout when accompanied by feelings of alienation from the organisation and from the peer group. If work is not perceived to be valuable or meaningful then burnout can result, thus leaving the nurses with a feeling of detachment and the perception that their needs are left unfulfilled.

The implications of stress and burnout for the caring professions are clear. There is a need to make sure that services care for their employees who provide direct care services to clients in demanding and continuous circumstances. According to Bailey (1988) it should be possible to ameliorate and prevent the effects of burnout for staff and some of his suggestions (and those of others) will be presented in the final chapter of this study. The literature review concludes with the following quotation from Bailey (1988) which summarises the main features and implications of stress and burnout theory:

> 'Underlying these premises is the fundamental assumption that to care more effectively for clients we must first of all begin to provide organisational initiatives which support the health and performance of those who deliver front-line health care services....Stress will not go away: Some degree of stress is always essential for human

health and performance. However, its potential lies in its promise to better manage, reduce and even avoid the exhaustion of personal resources consumed in the course of human helping' (p7).

Linking Theory and Practice - The Changing Context of Care

Spencer (1983) noted that nursing staff may become exposed to higher levels of stress as new models of care emerge away from the hospital, in the community:

> 'The significant points to emerge were: the nature of stress; the problems of uncertainty in roles; less structured hospital regimes; increasing expectations but inadequate resources; lack of esteem; difficulties with parents and relatives; interprofessional tensions; and dichotomies in attitudes and philosophies (p7).

Spencer wrote that 'no vocation is without its stresses' and he regarded the presence of stress as being an essential ingredient of life and work (p7). The general uncertainty presented to the mental handicap nursing profession during the last decade fuelled feelings of concern and encouraged staff to become insecure in respect of their work roles. Such feelings when combined with poor resources may result in feelings of stress and work fatigue.

Oswin (1976) noted that shortages of staff not only resulted in poor standards of care for mentally handicapped children, but that they also left many nurses feeling unsupported and devalued:

> 'It is feasible to suggest that because the nurses were unable to fulfil their work as they knew it should be fulfilled, and because they felt unsupported in their problems, many were suffering from the same sort of

depression that affects unsupported parents. In effect, they were suffering from what I term professional depression. This was especially obvious among qualified staff, and it poses the question of how fair it is to train nurses and then leave them unsupported in stressful situations which inevitably will destroy their professional enthusiasm' (p82).

Spencer (1983) felt that increasing demands and expectations were being placed on nurses in mental handicap. Conflicts also existed between the progressive ideas that new staff wished to introduce and those regimes that existing staff wished to perpetuate. Less structured regimes also appear to have been significant in reducing 'clear-cut' guidelines for staff:

> 'Longer serving staff feel that there has been a breakdown in discipline, and a concession to letting people do as they like. They dread an anarchial state, a collapse of the structured system to which they have been accustomed' (p7).

Dunham (1978) noted that insecurity and unpredictability are major causes of stress in human services (p18). Reorganisation, role ambiguity and communication difficulties were also regarded as significant. He found that staff who reported lack of liaison with managers, often had feelings 'of not being part of the system' (p19). This in turn might lead to a lack of commitment to the work of the organisation:

> 'The barriers of effective inter-professional communication and cooperation with workers who are based outside the institution are caused by differences in professional experience.....we suffer from 'professional blindness' (p19).

Dunham felt that in order to overcome feelings of stress staff should be encouraged to identify their own support systems and to develop a 'sense of belonging' by encouraging better inter-professional communications and supportive group networks.

Stress and Social Change

One of the most important features of the National Health Service has been its stability as an organisation. As such it has provided its employees with relatively stable work patterns. Cope (1984) acknowledges that this may be fine in an unchanging world but in the real world staff must adapt to organisational changes if they are to survive:

> 'Changes to organisations involve changing their working practices and procedures, and so require individuals to do things differently. 'change' comes down eventually to getting people to do things in a new way. Sometimes when this concerns matters central to people's conceptions of themselves as persons this is extremely difficult to do' (p165).

This latter point is particularly true when related to nurses working in the mental handicap service. Many have been forced to change their work patterns as a result of social change. The question of personal choice and control may have some bearing on the extent to which nurses 'own' or accept the changes imposed upon them. Mithaug et al (1978) make this point well in their mental handicap study:

> 'One should never assume that a choice has been made because the person has acted in a situation in which choice is permitted' (p155).

The shift in attitudes required to realise the philosophy of work in community services may combine with new working patterns and service conditions to create new challenges and career opportunities for nursing staff. However, these new challenges may be perceived as threats in the first instance as they strive to find the right balance between tolerance and firmness during the first few months of their new jobs. This is not always easy for staff working in the less structured setting of the community. For many there is also the problem of losing friends and colleagues, of having to adjust to new work patterns and of having to change shift patterns in order to become more flexible in meeting the needs of their clients.

Perceptions of Support

A number of questions were asked in this study about perceived support at work:

TABLE 11.1

Which of the following would help to relieve stress in the work environment?

	Percentage Naming Item	
	STAFF	MANAGERS
More Support and Understanding	75	67
More Staff	64	58
More Time off	33	50
More Training	50	67
A More Relaxed Atmosphere	39	58
A More Personal Approach	39	50
	n=36	n=12

It should be noted that the results presented in this and in subsequent tables in chapter eleven refer to responses from 'commentary' type questions. Totals refer to the number of times respondents mentioned the 'items' listed in tables and are shown as percentages from each sample.

Staff felt that more support and understanding, more staff and training would help to reduce stress at work. Managers felt that more support, staff, training and a more relaxed atmosphere at work would be beneficial. The results provided by both groups are fairly similar with the managers paying more attention to the interpersonal environment and social aspects of the workforce.

The implications of these results would suggest that staff value personal support from their managers as a priority. Unfortunately the nature of community based services reduces opportunities for regular contact with line managers and it would appear that little opportunity was given to staff in the sample to determine their own support requirements. Rather an indication was given during the informal interviews in the present study that managers preferred to visit staff meetings on a regular basis than to meet staff individually to discuss personal needs.

The question of additional staff also raises some interesting points. From my own experience I am aware that managers may respond during times of crisis by offering more staff to defuse problems (eg disturbed behaviour). However, simply offering additional staff is superficial and that underlying problems need to be tackled. These might include skill-mix, staff support needs and interpersonal aspects of team integration.

Two respondents referred to directive actions by managers which ignored these needs and whilst additional staff assisted in times of crisis to 'reduce the load' it also created tensions for staff who had the additional responsibility of inducting

unfamiliar personnel and consequently rarely solved the real problems associated with behavioural management. However, it can be safely assumed that there will always be a minimum staffing level required for small houses, but staff in the sample rarely had access to this 'ideal' number and perceived their staffing levels to be below the number required to meet the therapeutic needs of their residents.

Closely associated with staffing levels is the level of confidence and competence which staff feel that they possess to meet the demands of their everyday work. The need for individually designed training programmes was mentioned by a number of respondents who regarded training as an important feature of staff support. Sadly a significant number of staff reported that such programmes were sadly lacking in the majority of services included in the current study.

During the course of the informal meetings with respondents a number of people mentioned the lack of physical support systems for staff at work. A series of questions were included in the questionnaire to reflect the incidence of provision of support services in the six services:

TABLE 11.2

Provision of support services and facilities for staff in the six services included in the sample:

FACILITY	THE NUMBER OF SERVICES IN WHICH THE FOLLOWING WERE PRESENT
Creche	0
Subsidised transport	1
Sports clubs	1
Subsidised housing	1
Single staff accommodation	4
Qualifying training	4
In-service training	5
Flexible shift systems	5
Uniforms	1
Uniform allowances	4
Opportunities for promotion	4

As one might imagine many features of the old hospital support system were either present in reduced form or were absent in the community services. Some features still applied such as subsidised transport and social clubs in one service and single staff accommodation was available in four. Most of these support services were still available to other client services in the Health Districts visited and were accessible to mental handicap staff, the key difference being that they were provided on the site of general hospitals or within hospitals for the elderly or for people with a mental illness. The tradition of providing sports facilities is one example, and this continued to be offered in one service, but this clearly represented a major change from the older hospitals who had taken great pride in the competitive inter-hospital league sports!

More apparent was the provision of qualifying and in-service training in four and five services respectively. Flexible shift systems were also present in all but one service. This represented a major change from the rigid 'long day' or set pattern shift systems which were seen in the old hospitals.

There was also a major change in the extent to which staff wore uniform. (It is of interest to note that one service still gave staff the option to wear uniform. During the field visits no uniforms were seen at all!).

The provision of subsidised staff housing was witnessed in two of the services and just over half of the services were perceived by staff as providing 'opportunities for career advancement'. No creches were present in the six services.

Cope (1984) described the process by which nursing staff might adapt to major changes in their work routines. He believed that nurses respond more readily to changes when they perceive

actual 'pay offs' for their efforts. Work in the community, clearly goes some way towards providing nurses with certain pay offs; in the community, for example, staff report that they enjoy closer working relationships with their residents and regard their future employment status with some degree of security (both were highly rated as indicators of job satisfaction in the present study).

During the course of the questionnaire respondents were asked to state from where in the organisation that they gained the most support. Just over half of the staff felt that they received most support from their managers, little from their peers and a significant amount from their subordinates. Of the managers half felt that they received support from their peers, 25% from their subordinates and 17% from members of the multi-disciplinary team. The results show clear differences in opinion between the two groups and clearly managers feel the least supported by their bosses (this could be due to the fact that many line managers may be non-nurses employed as General Mangers).

Respondents were asked to state the form in which they had received support from people at work:

TABLE 11.3

	%MANAGERS N=12	%STAFF N=36
Doing jobs to help	33	42
Dealing with problems	41	39
Giving advice	83	78
Preserving confidentiality	50	58
Listening	67	50
Explaining procedures	33	42
Showing an interest	42	64
Encouragement/praise	58	56

(Percentages represent the total number of responses for each form of support).

The results demonstrate that there is a significant difference between the groups in respect of the support that they received. The staff group, for example, found less support in the form of having their needs listened to but significantly more than their managers when it came to having interest shown in their work. However, whilst managers may not spend enough time with their staff, listening to their needs or giving feedback on performance, managers, themselves may receive even less support from their bosses and peers. This may account for some of the problems staff found in the new service:

> 'Whilst my boss is supportive, I never feel that there is enough time to speak with her about my day to day problems. She is always busy and to be quite honest only has time to hear about the results of tasks that she has set for us' (Staff member in one service).

Extension into Homelife

One of the constant problems shared with respondents during the course of the field visits was the extent to which work problems extended into their home lives. There appeared to be unanimous agreement that the overlap was far greater in the community than in the hospital because of the personal aspects of responsibility that their new roles appeared to encourage and demand. Obviously the 'spill-over' will also place demands on members of the family and impinge on friendships. Staff would therefore appear to require support from their families even more than they did in the hospital where their work routines were more defined and their shift patterns predictable and regular. Staff and managers were asked to elaborate on the support that they received in their work from friends and family:

TABLE 11.4

How would you rate the support received from friends and family?

Percentage Rating Support Received As:

POOR	----------				**IDEAL**
STAFF	13	20	20	28	19
MANAGERS	0	25	33	42	0

Staff - (n=36)
Managers (n=12)

Overall there were few differences in the rating scores provided by both groups. Just under half of both groups felt the support received from non work colleagues to be ideal or almost ideal, whilst 33% of staff and 25% of managers regarded it as poor. Clearly the latter figures are uncomfortably high and may demonstrate the possible conflict that work demands may place on staff and managers, which may also be intrusive in home life. (The long hours worked, both paid and voluntary and the high scores on preoccupation with work shown by both groups lend support to these findings).

Support from Colleagues

Respondents were also asked to consider the degree to which their staff and colleagues worked to support each other as a team and to comment on their expectations of support from their line managers:

TABLE 11.5

* % Managers (N=12)

a)-Concerning your work group/fellow employees - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How well they work together and offer each other support	-	17	33	33	17
How willing are they to listen to your problems	-	8	25	58	8

b)-Concerning your subordinates - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How much work they expect of you	-	-	17	83	-
How friendly and easy to approach they are	-	8	17	67	8

(All rows may not add up to 100% due to rounding errors).

TABLE 11.6

* % Staff (N=36)

a)-Concerning your work group/fellow employees - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How well they work together and offer each other support	-	6	17	47	31
How willing are they to listen to your problems	3	8	22	31	36

b)-Concerning your subordinates - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How much work they expect of you	-	-	11	56	33
How friendly and easy to approach they are	-	3	6	44	47

(All rows may not add up to 100% due to rounding errors).

These results suggest that just over half of both groups believe that that their peers are willing to share and listen to their problems and both suggest that the majority of their subordinates are friendly and approachable. Clearly both were agreed that their junior staff expected a great deal from them which suggests that demands are placed on midline staff and their managers from the care staff element of the workforce.

This feature warrants some explanation. One of the principal roles that qualified nurses are expected to play in the new services is that of role model and supervisor. The grade mix and skill mix of staff teams in small houses in the community varies greatly but is significantly different to that found in large mental handicap hospitals. The average percentage of the workforce who hold a professional nursing qualification for community is 27% compared to 47% in the hospital which suggests that the bulk of the workforce is made up of unqualified care or support staff.

The more unqualified staff in each house, the greater will be the burden for staff in fulfilling their supervisory role and the greater will be the demands on their time for direct observation of care practice. It is this feature of community care that requires many managers and first line staff to compromise between administrative aspects of their work and client directed tasks.

To assist in this process it is heartening to note that the teams appear to work with some degree of harmony in the houses, although the managers report a less satisfactory situation than their peers which may be attributed to the diversity of their work and lack of a common administrative base. It would seem that the presence of positive team work assists in the reduction of stress and motivates staff to share their feelings, needs and achievements and therefore contributes to positive outcomes for their clients.

Comparing the Old Service with the New

Within this section responses from staff and managers in respect of their experiences of the new service are considered. A number of open questions were included in the last section of the questionnaire which were designed to seek staff opinions of their new jobs in comparison with work in hospital (these are presented in summary form in Appendix Five).

Respondents were offered the opportunity to mention as many points as they wished in response to each of the open-ended questions. Following analysis of the total responses to each question the answers were classified under a number of general headings which represented the main factors underpinning their comments.

Since there was no limit to the number of points a person could mention, the answers cannot be added to a total of 100%. However it is possible to provide a total figure of responses for each of the broader categories [this feature applies to all tables included in this section].

The first open question generated much interest amongst respondents and referred to the features of the hospital culture which staff were pleased to leave behind. Staff and managers appeared to be unanimous in respect of most of their feelings about the old system although the managers were slightly less favourable about the old environments within which they had worked and managed for varying lengths of time (this could be due to the fact that they had previously left the 'closeness' of the word team to work in the central nursing office and were therefore less concerned about loss of features associated with ward life).

TABLE 11.7

What features of the old hospital were you pleased to leave behind?

A number of staff and managers reported that they were pleased to leave behind certain features of hospital life:

	%STAFF	%MANAGERS
	N=36	N=12
* Large wards	11	25
* Lack of privacy for residents	14	16
* Impersonal bathrooms	5	-
* Overcrowding	17	17
* Never ending telephone	5	8
* Isolated from community	8	17
* Large, closed community	17	25

(See Appendix Five, Table 5 for full presentation of results)

Altogether just over half of each group mentioned at least one feature of the environment which they were pleased to leave behind (50% of staff and 60% of managers). It should be noted that no one feature was mentioned very often. (This may, of course, be due to the unstructured nature of these questions or due to the classification used by the author.)

Others reported their pleasure in leaving behind a number of service systems which appear to have influenced the quality of life for people in the institution. These results demonstrate considerable differences between the groups and suggest that managers seem to be more aware of the negative or damaging features of the hospital than their staff.

The following table illustrates some of the key areas that staff and managers appeared to be pleased to leave behind and represent some of the most irritating aspects of institutional life for the workforce which militated against the provision of high quality services:

TABLE 11.8

What features of the hospital culture which militated against high quality services for people were you pleased to leave behind?

	%STAFF N=36	%MANAGERS N=12
* Interruption from visitors	14	17
* Loud music/T.V.	14	42
* Delay in maintenance	14	25
* Laundry problems	5	8
* Overbearing management structure	8	-
* Financial procedures/rationing	8	17
* Union domination	17	42
* Wasted manpower allocation	14	16
* conflict between shifts	16	16
* Bland food	8	8

A number of these features can be categorised in terms of organisational constraints, environmental features of ward life, industrial relations and lack of resources. There was little doubt that staff respondents were far from unanimous in respect of their pleasure in leaving features of the old hospital culture behind and very few members of the sample chose the same categories to illustrate their feelings. Not surprisingly nearly half of the managers were pleased to see

the loss of trade union domination and most likely found this to be a pleasant relief from regular negotiations in respect of industrial relations in the hospital.

Other comments related to **staff attitudes** and to the **philosophy of care** practiced in the institution:

Table 11.9

Staff attitudes to the philosophy of care practiced in hospital

	%STAFF	%MANAGERS
	N=36	N=12
* Task orientated approach	25	42
* Rigid procedures and rules	14	25
* Negative attitudes to clients	25	59
* No Opportunity for normalisation	51	59
* No insight about poor care practice	31	42
* Lack of management insight	22	25
* Destructive grapevine	11	17

Staff and managers were more assertive in recording their views about the philosophy of care in hospital and amongst the results the following appear to be significant:

- organisational constraints such as rigid systems and task allocation procedures militated against the introduction of ordinary life models of normalisation; just over half of each group felt this (51% of staff and 59% of managers). It is most likely that this related directly to the process of task allocation and depersonalisation which were common in hospitals;

- the hospital presented some difficulties due to the lack of management insight which may well have influenced the persistence of negative attitudes to clients; (it is important to note that twice as many managers staff reported this which may indicate that staff also lacked insight into the effects of their care practice!);

In conclusion it is significant to note that the highest scores are attributed to those features of the old service which appear to provide negative experiences for residents and which militate against ordinary life practices for residents. This supports the statement in the last chapter that staff and managers appear to rate the quality of their work in the community in client-focussed terms, as a high priority.

The other comments relate to the restrictive practices and policies that seem to be part of the hospital culture and which provide staff and residents with little incentive to use their imagination, autonomy or skills in designing responsive services for their clients.

Having considered some of the less favourable conditions of the hospital, staff and managers were asked to identify those features of the hospital which they missed:

What features of the old hospital culture do you miss most?

A large majority of staff (83%) and two out of every three managers mentioned aspects of the old culture which they missed:

TABLE 11.10	%STAFF N=36	%MANAGERS N=12
* Contact with friends/peers	28	42
* Many residents to share with	11	17
* Social aspects	39	64
* Less isolation	11	33

(See Appendix Five, Table 6 for full presentation of results)

The majority of comments relate to the support networks which existed in long-stay hospitals and which provided opportunities for staff to meet their friends and to 'unwind or offload' some of their frustrations and difficulties. The social aspects of the hospital were often mentioned by staff with fond memories although some were quite pleased to leave the hospitals and the 'gossip' which they felt created a number of problems for them in respect of their ability to provide high quality services.

During the course of informal discussions with respondents many took the opportunity to reminisce about their previous life in the hospital and although some held fond memories, on balance most felt that their new lives were preferable (as one respondent put it):

> 'I really miss the chance to talk and meet all of my old friends but to tell you the truth I don't miss the gossip and the back-stabbing that seemed to be all around us. There were times when you were glad to go to the social club to unwind - not from the patients but from the staff!'

One statement of this nature does allow one to draw conclusions but there is little doubt that the support systems of the hospital were not really missed to any great extent by the respondents in this study. However, the chance to meet and to share with friends was important and should be regarded as an important feature of the support required by staff and their managers, (perhaps moreso by managers according to the results in Table 11.10).

It is interesting to note that 17% of staff and 42% of managers mentioned that they were pleased to move away from a **Trade Union** dominated culture and no respondents stated that they missed its presence in the community. (Whilst Unions are still available to staff in the community, very few staff took the

opportunity to mention active membership in their new jobs). This finding supports that of Allen et al (1988) who found that only 12.5% of community staff were members of Unions compared to 85% of nurses employed in hospitals (p112). They suggested a number of reasons for this change:

> 'This is a new service, there were uncertainties about the most suitable organisation to join, and there may be local factors involved if a particular union is weak. The community staff were less convinced of the value of unions than the hospital employees, but their average response, on the measure we employed, was still in favour of organised representation. We can only conclude that if circumstances elsewhere repeat this pattern, there is likely to be a real gap in staff representation in community projects of this sort' (p114).

The following quotation from one of the respondents in this study serves to illustrate one person's view of unions:

> 'One of the things I like best about the community is that our clients are now in greater control of what happens. This is a welcome break from the 'mafia' of the old hospital where the staff imposed more rules than the managers in respect of what could or could not be done. The Unions were so powerful and were run by the less successful nurses and ancillary staff. They were an intrusion into our working lives, but they did provide a focus to draw attention in those days when our working conditions were so bad.'

The question of Trade Unions raises a number of questions about work in the community. The more intimate nature of community work facilitates closer access between staff and their line managers and the dispersed nature of their work prevents collective meetings and associations between large groups of

staff. Smaller numbers of employees with less opportunity to communicate together (there are no internal telephone systems or linked corridors in the community) were less able to meet or to use 'collective' means of advising managers of their needs or grievances. In its place appears to have emerged a new communication process characterised by personal contact with managers and the provision of more personal and supportive working conditions and environments:

> 'What is so different is that we can say what we feel directly to the boss without having to negotiate time with 'unseen' managers. We can state our claim for improved conditions for our clients and more often than not we are listened to. We now appreciate that we may not always get what we want for them, but, at least we are involved in discussions about the reality of the situation and can make some decisions ourselves within the resources that are available'.

The results from the present study suggest that a significant number of managers were pleased to support these changes (42%) whereas just under one fifth of the staff members shared their positive attitudes about the diminished role that Unions appeared to play in the new services.

Not everything appears to have changed in the community and during the course of the interviews staff were able to share a number of features of their new workplaces which they felt were similar to those encountered and experienced in the hospitals. These centred around staff attitudes and bureaucratic procedures which prevented staff from realising the objectives of community care and which caused them frustrations in their everyday work.

Respondents were asked to state those features of the hospital culture that they felt still applied:

TABLE 11.11

What features of the old hospital culture still apply to the community service?

	%STAFF N=36	%MANAGERS N=12
* Entrenched staff attitudes	8	17
* Daily routines	27	38
* Paperwork	11	8
* Policies and procedures	30	13
* Low staff/resident ratios	19	33
* Rude members of the public	3	8
* Poor financial resources	8	17

(See Appendix Five, Table 7 for full presentation of results)

It appears from these results that a number of old practices, polices and procedures were still in evidence in the new service. One quarter of the managers believed that that old attitudes and work practices were still being used and witnessed in the community, (although these feelings were shared by less than one fifth of the staff). Inadequate resources and rigid polices were also blamed for restricting opportunities to realise the objectives of community care.

On the more positive side a number of respondents felt that they had been able to build on their professional training and to adapt their skills and knowledge to match the demands of their work.

Student nurses were seen to have adapted their training and work experiences to the community and they were seen by staff as friends and partners to their clients:

'The students have really assisted us in making the resident's lives more positive. They spend longer with us now and offer valuable insight into the needs and potential of the clients. They no longer seem unwilling to try out new ideas and spend much of their time in the community with the residents as partners and friends. They are training in a different world to us older staff, they only have three months in the hospital for experience now and the rest [nurse training is three years] is in the community; we had all of our three years in the hospital as pairs of hands!'

One respondent listed the following responses to this question:

- 'The camaraderie - strengthened house team;
- 'using my old experiences to reduce stress levels ie. if I did that for 30 residents I can do so much more for just 5!;
- 'creating new friendships';
- 'the "characters" are still there - only scattered - reminiscing about them to new staff and students.'

This last quote summarises the sentiments of many respondents who were involved in the study. They found that the old ties of the hospital were clearly severed in respect of the **geographical distribution and dispersal** that care in the community required of staff. However, new friendships were developing and opportunities still existed to meet old friends and residents. The years spent working in hospitals appeared to provide some staff with many happy memories which were still evident in their daily work. Reminiscing about their residents offered respite from some of the intensive demands of community work and continued to reinforce old ties and connections which were obviously important to them during the transition period. Students provided opportunities to stimulate the daily routines of the house and challenged the 'permanent work team' to be less introspective. Finally, nearly all of the respondents were

encouraged by the way in which their residents were developing and acquiring more skills and independence and this was considered to be a major feature of enhanced job satisfaction.

Professional Issues

Bratt (1987) in a study on staff attitudes following transfer to community mental handicap services found that some nurses were also concerned about the apparent 'de-professionalisation' that they felt was taking place in their new roles. Some stated that they had difficulty in perceiving that their roles were valued by managers when on one shift qualified nurses might work and on another unqualified staff (these feelings were not confirmed in the current study).

Frankel (1969) reported that issues relating to professionalism are important in public services which are undergoing change or which might appear to be compromising professional standards:

> 'The duty of all professionals is to ensure that, in the midst of social conflict, some people will be sufficiently disengaged - or sufficiently engaged by their professional consciences - to call the shots as they see them, without regard to party or person.....the professions are the repositories of ideas of competence, critical enquiry, and moral impartiality, without which the hope that man can create a society both free and disciplined is null and void' (p34).

Comments received from staff during informal interviews conclude that many staff expressed views similar to Frankel in that felt that they were the guardians of high standards as the service developed in the community. To staff, the continued presence of mental handicap nursing offered renewed optimism and job security. Frankel believed that professionals have a key role to play in new services;

'It is late in the game to give up the idea of professionalism. To give it up is to say that principles definitive of liberal civilisation have no meaning. Whatever else we professional people do, in any field in which we find ourselves, it is desirable, I think, that we remember what the professional ideal represents. Each day that it is eroded, our chances for reason, for knowledge in action, for compassion, for honesty, for fairness decline. As individuals we all fail in these respects. As members of a profession we are carriers of these ideals. We have the unusual responsibility to make our decisions, at this moment in history, bearing this in mind' (p35).

The concept of professionalism was well described by one respondent:

'I feel that we have managed to achieve the impossible here. Only a few years ago we were given a clear message that the skills of mental handicap nurses would be no longer needed since we appeared to have been associated with the worst scenario of the hospital. Now we have been given the chance to prove ourselves in a valued setting. The unqualified staff are great but they could not function without the leadership of the qualified nurses. They offer commonsense and good homemaking skills whilst we complement these with a sense of professionalism and provide the focus for the work of the service. It seems to be a good combination.'

All respondents were qualified nurses and as such their views are important in providing an understanding of their perception of their place in the new service. The profession had received very little encouragement during the years building up to the advent of community care and as such it can be concluded that the nurses' own perception of their new role has encouraged

positive attitudes about the future of the mental handicap nursing profession in the community.

Job Satisfaction and Related Issues

In the last chapter the concept of job satisfaction for staff and managers was discussed and whilst respondents appear to have been satisfied the majority of the factors involved in their new jobs, they reported concern in respect of role ambiguity and a number of practical aspects of their job. These ranged to low levels of management support, inadequate levels of staff training and some difficulties with shift systems, long hours and the intrusion of work into their personal lives. Allen (1988) found that staff were likely to experience work stress if they were experiencing high levels of role ambiguity, combined with high levels of autonomy in their jobs (p129).

In the present study staff reported high levels of autonomy in their jobs (100% of managers and 94% of staff) which was mainly due to the fact that nearly three quarters of the sample were left to work alone without their boss being on duty with them. Allen suggested that a combination of perceived autonomy and isolation would contribute to high levels of stress for staff compared to their previous work in hospitals which was characterised by the opposite features (ie. less autonomy and more staff to share shifts).

These results provide an interesting comparison with work conditions in the community. One very clear indicator of job satisfaction in this present study was the consequence of the high levels of resident contact that work in the community encouraged. Respondents were particularly pleased to be able to work with fewer clients and to witness the development of new skills, independence and their enjoyment of participation in the community (this supports Allen's findings [1988] that

reductions in resident contact were associated with increased stress [p130]).

Allen also found that staff working in the community were less likely to experience high levels of stress when the philosophy of their service enabled them to practise care in a valued way. In such cases the experience of role conflict was minimised but the new individualised, caring approach demands more from staff in terms of personal involvement, commitment and energy.

Marks (1977), in a study on energy and personal commitment quoted earlier in this chapter, found that workers who do not appear to be experiencing role conflict (as appears to be true of respondents in the present study) 'do not seem to be experiencing the effects of scarce personal resources' (p925). He noted that Durkheim (1953) believed that:

> 'Life is not simply a precise arrangement of the budget of the individual or social organism, the reduction of the least possible expense to the outside stimulus, the careful balance between debit and credit. To live is above all things to act without counting the cost and for the pleasure of acting' (p86).

Durkheim's thoughts that human beings 'come away far more enriched' when they are offered new challenges and when their personal energy reserves are stretched to the maximum (p926), may be applied to staff working in the community. They have certainly been encouraged to meet new work challenges which may not necessarily result in fatigue, burnout or energy loss:

> 'perform some roles without any net energy loss at all: they may even create energy for use in that role or in other role performance' (Durkheim p926).

This may be explained by Marks who argues that human resources and energy are flexible and may expand or contract, depending on the degree of commitment that staff show to the activity concerned. For people working in the community the degree of commitment may be associated with increased and renewed job security, closer associations with residents and greater job satisfaction. If this theory is true, then staff and managers working in the community may be experiencing a degree of 'energy expansion' rather than 'contraction' as they perceive greater rewards in their new work setting compared to the restrictions that they experienced in hospital. (This in turn, may reduce some of the potential causes of stress that their new multiple roles demand).

However, not all of the conditions associated with work in the community were positively received. Clear indications of stress were given by staff in respect of **'sleep in' duties**: 15% of staff mentioned their concern with these duties and reported disturbed nights due to noisy residents and difficulties of sleeping away from home. Staff were often expected to work a full morning shift following their sleep in and this could be 'stressful' if a disturbed night had been experienced:

> 'The main problem with the job is the sleep in duties. I have tried to adapt but I find it impossible to adjust to them. I can never sleep properly as I have one ear open for the residents. They are generally fine but they get up at intervals to use the bathroom and slam doors. I also worry if one of them has a fit at night and I might fail to hear. All of this makes me very grumpy at either end of the shift. You don't even get paid a decent allowance for it [approx £10.00 per ten hour night] The family are well prepared for me and avoid me if they can!' (Comment from one respondent).

Home and Work Overlap

One other major problem was the degree of preoccupation that staff and managers had with work when they left for home: (66% of staff thought about work sometimes when off duty, and two thirds of these did so every day. Managers, possible because of less direct contact with residents, did so to a lesser extent - 58% thought about work occasionally and one third of these did so everyday. These results indicate the degree of personal commitment that staff and managers had for their residents and for their work. This contrasted somewhat to work in hospital, where whilst staff had a degree of commitment to their residents, they were able to hand over to other staff and to leave work behind them when their shifts finished. In the community the development of personal 'key worker' relationships with clients encouraged some degree of ownership between staff member and client. This caring relationship appeared to extend well into the person's home life and family.

These findings suggest that staff accept more personal responsibility for their clients and for their work which may lead them to experience greater levels of preoccupation when when they go home. The costs to the individual of trying to balance these potentially competing demands can be serious. However, little research appears to have been done in this area and it is difficult to locate hard evidence.

The costs are particularly important when one considers that many of the respondents in this sample were females with homes to run and families to raise and as one respondent noted 'I sometimes believe that I have two full time jobs!'.

Hingley and Cooper (1986) found that the problems associated with work 'overspill' often result in difficulty in 'switching off' from work, especially when staff were emotionally involved (p153). Unsocial hours and irregular shift patterns may also

put additional demands on staff and these are certainly typical of work in the community. Hingley and Cooper use one particularly useful quote from a ward sister in their study:

> 'It is difficult for all nurses to completely separate their job and home life. The sort of work that nursing entails means that it is practically impossible to just forget about everything at the end of the shift. You often take your worries and problems home with you. This is fine if your partner understands and supports you. It can be a disaster if he doesn't...The problem of the working woman trying to balance the demands of a career and a home is that she is in double jeopardy. If too many of the difficulties of one area spill over into the other there is a very real danger of losing both home and career', (p153).

Alienation and Power

Pearlin (1962) noted that alienation or powerlessness over the decision making process which regulates their work, may enhance stress amongst employees. He noted:

> 'A mental hospital is established to meet community needs and to alleviate human suffering. It recruits to it individuals who possess the talents and training thought to be instrumental to these ends. The individuals recruited necessarily bring with them various motivations, values and aspirations. In order to retain its staff and to maintain itself as an ongoing institution, it must gear itself not only for the attainment of the ends for which it was established, but also for the satisfaction of the diverse aspirations and opportunities sought by its members' (p230-1).

He found that one of the most important reasons for feelings of powerlessness were related to problems of career advancement and job security. He also found that hospital wards failed to provide staff with appropriate environments within which to work and this in turn encouraged a situation 'that will not yield to their desires' (p321). The results of his study demonstrated that alienation is most likely to occur when:

- conditions minimise interaction between subordinates and superordinates and when opportunities to influence the latter are restricted;

- where authority is communicated in such a way as to prevent or encourage exchange of views or opinions;

- when the superordinate exercises authority 'in absentia'.

Although Pearlin was writing some time ago about working conditions in a mental hospital his work provides insight into some of the factors which influence stress and perceived value at work. Moores (1977) found similar results results in a study designed to measure the degree to which staff and their managers felt 'alienated' in a hospital for the 'mentally handicapped'. However the results from the present study indicate that staff felt particularly 'in touch' with the decision making process of their services and that whilst their bosses were absent for a significant period of time, they felt that they were accessible and 'listened to their opinions; for example, one respondent wrote:

> 'One thing about working here is that we are more in control of our work and we feel closer to the boss. We don't see as much of him as we would like but there is no doubt that the managers are not so distant as they were in the hospital. This makes us feel that we are sharing

more in the way we work and it is rare for the boss to interfere in our decisions.'

If one assumes that Pearlin's theory of alienation and powerlessness is correct then the present study illustrates that the management structures and processes provided in the community reduce the risk of high stress levels for staff and managers by encouraging staff involvement when decisions are made about their work.

Bratt (1987) in a study to determine the effects of transfer from a mental handicap hospital on staff and residents noted that the following influences make for stress for staff:

- fewer staff contacts for support;
- staff incompatabilities;
- financial procedures;
- financial rewards not commensurate with responsibility.

He found that the community environment brought staff and residents closer together to their mutual advantage and provided staff with greater job variety and overall satisfaction. His results were similar to those found in the present study in that staff appreciated having greater responsibility, more flexible work routines and the opportunity to 'get to know' their residents better as individuals.

It may be, therefore that staff and their managers appreciate the opportunity to assume responsibility for their work and to account for their successes and failures. They may also appreciate the opportunity to gain more control over their work and over the environment within which it is practised. The community offers every challenge to realise these objectives since the staff themselves are responsible for the total establishment within which they work as accountable managers for all aspects of the operation of the 'House' (this compares

with work in the hospital where nurses depended on administrators, domestic supervisors and other ancillary Heads of Department to ensure work was completed, and often below their expected standard!).

How do Nurses Cope with Stressful Situations?

Results from a series a questions relating to the way nurse's cope with stress at work are presented in **Appendix Seven.** They represent views of staff and managers expressed during the course of the formal or structured part of the interviews.

Perhaps the most popular coping methods employed by staff members of the sample to relieve stress were those associated with the adoption of problem solving techniques. Three quarters of the sample often stood back from their problems and employed an objective review of their predicament without engaging in undue pessimism. It would also appear that the majority of nurses (81%) make use of their past experiences during their deliberations and engage in an analysis of the problem before rushing in to solve their problems (94%).

When asked to comment with whom they shared their problems the majority reported that sharing occurred with friends, family and colleagues on approximately forty per cent of occasions which demonstrates some degree of reliance on their own coping abilities (or possibly their reluctance to share work issues outside of the job context).

Outlets for stress at work were mainly concerned with keeping busy in order to 'keep one's mind off the problem', (67%) and less than one fifth relied on alcohol, medicines, smoking or excessive eating to solve or to reduce their stress levels.

One interesting finding was that whilst many held positive attitudes for the most part of the time, one third stated that they sometimes 'took their anger out on others' whilst another third suggested that they 'hoped all would work out in the long run'.

The managers presented similar responses and over three quarters shared their staff's tendency to adopt a positive and preventative approach to the management of stress at work. A problem solving approach was shared by the majority (83%) and all respondents employed an analytical approach to their problems.

Rather more managers chose to share their problems with professionals and colleagues at some time (42%) but rather less chose to share with their friends (one reason for this may that managers have access to a wider circle of colleagues than their staff who tend to be restricted to their houses for the most part of their working week).

Similar results for physical aspects of coping behaviour were reported by the managers and again dependence on over eating, smoking, alcohol or reliance on medicines was less than sixteen per cent for the whole sample.

Just under three quarters (67%) admitted to keeping themselves busy to avoid too many worries and most felt it almost never necessary to 'take things out on others' (24%).

These results are encouraging, demonstrating that the chosen pattern of stress reduction for most staff and managers was to engage in problem solving techniques on the basis of past experience and insight. However, both groups had a tendency to prepare themselves for the worst and to keep their feelings and needs to themselves.

These findings are hardly surprising considering the degree of self-sufficiency that the mental handicap nursing profession has developed in the past when working in hospital based care. The culture of the hospital encouraged staff to look to their own resources to solve many of their day to day problems. This may be explained by the following quote from one community manager:

> 'in the hospital it was always preferable to keep your mouth shut and your eyes and ears open. You received no thanks from your bosses (who were supposedly supporting you) if you went to them with problems. The Nursing Officer's visit was typically a courtesy call to check that all was well and started with the words, 'any problems?'. Needless to say you gained respect if you reported that all was well and learnt to cope without bothering them'.

Nurses have also been encouraged to repress their emotions when working with clients. It was seen to be unacceptable to share work outside with family and friends and the profession's 'Code of Conduct' places great emphasis on maintaining confidentiality (UKCC 1986). Since most of the problems experienced at work are related to clients or colleagues the need to maintain confidentiality militated against open disclosure or sharing with others outside of work (or even outside the ward or house within which you worked). Consequently the attitudes conditioned by the profession and by the mental handicap hospital culture appear to be significant in assisting in the understanding of this phenomena.

Finally the use of problem solving skills and the adoption of objective approaches when faced with stressful situations or challenges might also be explained by the nursing profession's tendency to exercise these skills during the course of their

everyday practice (evidenced when faced with violent patients, emergency medical crises and feelings associated with death).

Hingley (1986), in a study on stress in nurse management, noted that his survey results provided 'a relatively optimistic picture with the large majority of nurse managers indicating high levels of job satisfaction'. He found that absence figures were low and that nurses, whilst admitting quite high stress levels at work at times, were less likely to succumb to mental health problems or somatic illnesses than the general average of people in the community. However he offered a warning in the conclusion of his discussion on coping techniques by noting:

> 'It seems that nurse managers are job satisfied, reasonably mentally healthy and report low levels of absence. Yet nurse managers themselves suggest they are under enormous pressures, which affect their daily well-being and health. .....it is more likely that the unremitting pressures take their toll on physical healthy by a slow process of attrition, eating away gradually at the physical resistance of the nurse. At the same time, commitment to the profession and high levels of job satisfaction may mask the more negative effects of occupational stress' (p140).

'Bridging the Gap'

During the course of informal discussion with respondents comments were received regarding their experiences of the change processes involved in preparing themselves and their residents for transfer to the community. Not surprisingly these experiences provided mixed responses and a number of recommendations to assist in relocation programmes for other hospitals were presented in hindsight.

For Staff:

Ideas for 'bridging the gap' between hospital and the community to assist in making the transfer as painless as possible for staff were provided under five main headings, (See Appendix Five, Table 8 for full presentation of results).

Training

Many staff and managers felt that training and adequate induction was essential to assist in the change process. Half of all managers and one quarter of staff mentioned the need for comprehensive induction programmes and individually tailored training packages. Training appeared to be particularly required in preparing the workforce to acquire personal planning skills for their clients and to provide staff with the opportunity to achieve competence in budget and household management with the aim of accepting the responsibility that a small house placed on them.

Attitudinal change also appeared to be significant and staff made reference to encouraging the introduction of workshops to explore staff feelings with the aim of encouraging and developing positive attitudes to community care based on the principle of forming a partnership with their clients rather than controlling their lives (which was a common feature of their work in hospital).

Getting to Know the New Service

Gaining insight and familiarity with the new service also appeared to be essential for staff anticipating transfer and many stated that it was the 'sense of the unknown' that caused them the most anxiety.

Suggestions for reducing anxiety in this respect ranged from having the opportunity to visit existing community services, to working on a relief basis in small houses for a short period of time before the move and working with community mental handicap teams as secondees.

In all one third of staff members and their managers mentioned the benefits of early preparation and familiarisation with the new model of care and those people who were not 'thrown into the deep end' considered that they were able to look forward to the move with less anxiety.

Information

The provision of accurate information about the move and the time scales involved in hospital closure programmes was particularly important to most respondents. There were many questions to be answered which ranged from concerns about pay and conditions of service (including whether their jobs were secure) to ensuring that the houses would be designed to meet the needs of their residents.

Ideas were presented for newsletters, discussion and journal groups and some suggested that video presentations would be helpful on the subject of 'what life is like in the community'. The provision of a 'jobs-forum' was also favoured by a minority.

To be in possession of relevant information and advice appears to reduce the 'fear of the unknown' and restricts opportunities for the infamous rumour network of the hospital to take over (this may occur in the absence of informed communication channels and systems and may increase staff anxieties about their future job security).

Involvement

The need to feel involved with the development of community projects was also important to staff. Some felt that the earlier that they were involved then the more that they felt committed and excited about the project.

Early involvement in the commissioning of houses was the most common statement from staff and managers and indicated their interest in assisting in the design of their new houses with their residents. In order to accomplish this, staff needed to be in post prior to the actual opening of the houses and to work with architects and design staff to ensure that the house was 'custom designed' for the needs of the future occupants. Unfortunately in two of the six schemes staff were not involved at an early stage and reported concerns about the degree of 'ownership' that they felt they had for the service.

Getting to know the people with whom they would be working as colleagues, and more importantly their residents, was clearly as essential part of the preparatory phase.

Staff Support

The final recommendations concern the need for staff support systems and working practices. Some mentioned the importance of building a strong team identity amongst the staff team (14% of staff and 33% of their managers) and to allow the opportunity for natural friendships to build as a means of encouraging support networks in the houses (these feelings appeared to be an attempt to recreate some of the friendship networks that they had experienced in the hospital).

For Residents:

Respondents were equally keen to provide the benefit of their experiences in respect of identifying ways of reducing the effects of hospital moves for their residents. Responses are presented under three main headings, (See Appendix Five, Table 9 for full presentation of results).

Preparation

Training and preparation were seen to be the most important areas within which to concentrate resources in order to assist in the transition for people with mental handicaps. Early exposure to their new homes and to their new neighbourhood was essential if the 'culture shock' was to be reduced.

Many staff felt that the majority of their residents only began to understand that they were moving by actually seeing and experiencing their new homes (the reasons were given as reduced cognitive reasoning and lower order comprehension skills). As such several staff felt that an experiential learning programmes was required to introduce new aspects of their life.

The actual moves themselves also required sensitive handling and were felt best to be phased over a short period of time on the basis of gradual introduction, ranging from tea in their new homes, weekend stays and then the move itself. Thus the need to reduce any potential damage by the experience of entering a new lifestyle in the community was emphasised and the use of individually designed relocation programmes recommended. Moves should therefore take place on the basis of 'gradualism' as new skills and coping adjustments take place for each group of people involved in the change process.

Questions relating to the concept of 'a caring community' were also received and it was unanimously thought that whilst it was unacceptable to 'ask permission' of neighbours to move to their locality, that some introduction was preferable. This was most often done by personal visits to neighbours and through the extension of invitations to visit existing houses and to meet the new tenants prior to moving in. Coffee mornings and good neighbourly acts were also suggested as a means to 'break the ice'.

It was also felt necessary to motivate clients by providing meaningful rewards for them in their homes in order to see the benefits of the move. This was particularly important for staff who were concerned that if their clients failed to settle that they would be regarded as 'failures' and thus have an experience of rejection to contend with in addition to their mental handicap.

Finally questions were raised about the need for the provision of adequate numbers of qualified staff and sympathetic support staff. Workforce planning was considered to be unrealistic in some houses. Where levels fell below those required by residents to enjoy integrated lives in the community, staff felt that the philosophy of care extolled by the 'ordinary life' model might also fail due to the provision of inadequate resources.

Choice

In order to understand the exact needs of people with mental handicaps staff and their managers reported that they were concerned that some senior managers and planners thought that all people required the same facilities. In order to avoid this misconception, they felt that carefully designed individual programme planning processes must be in place to assist in the identification of needs, wants and ambitions for their clients.

These processes was seen as an essential prerequisites to the design of successful services and provided service users with some choice in the determination of their new homes and support requirements.

Choice was regarded as particularly important when applied to the selection of neighbourhoods and house design. Location, close to local amenities, work and transport routes were amongst some of the more popular comments received from respondents. Similarly resident involvement in the choice of furnishings, fittings and decor was noted and of paramount importance was the right for people to choose with whom they wished to work (and in some cases the right to choose who they wished to support them as care staff).

In order for choice to be exercised people need support in making informed choices which may not be easy if the basic communication skills are absent as is found with a significant number of people with mental handicaps. The development of self-advocacy skills is therefore important and time will be needed to assist people in making choices from a range of options (bearing in mind that some people may have had very little choice or experience in the past during their hospital careers).

Maintaining Social Networks

The move to the community will undoubtedly widen opportunities to engage in a range of activities in the community if there are adequate numbers of staff to support them. This question was raised many times during the informal interviews in respect of a debate on whether community care would work or whether poor resources would result in the creation of isolated homes for people within which they would have little to do.

Respondents felt that the maintenance of clients' previous friendships and social networks was therefore very important. Contact with parents and family (often the only stable human contact in their lives) was essential and the degree to which access could be maintained and encouraged was considered to be a factor to be addressed during the relocation process.

Reducing Stress in the Environment - Discussion.

Much has been written about methods that might be employed to reduce the effects of stress in the workplace. Firth and Myers (1985) noted the importance of morale in community based mental handicap services and quoted:

> 'A high level of morale in staff of community based services is of critical importance. To maintain high morale services must supply a variety of organisational and personal supports'.
>
> 'Good organisational supports include: (1) adequate materials, a good and responsive communication system, and cooperation with other elements of the service; (2) sufficient staff with the right skills, which are maintained by relevant training; (3) a clear service philosophy within which to operate and in which individuals' priorities are carefully linked; (4) sufficient variety in the job to avoid staff becoming drained. Good personal supports include: (1) involvement in decisions about client plans; (2) staff awareness of their own part in obtaining service goals and an opportunity to share in evaluation and development of new policies; (3) knowledge of personal objectives; (4) clear and positive, as well as negative, feedback on performance; (5) respect, empathy, and a lack of defensiveness from colleagues and superiors' (p100).

Firth and Myers demonstrate in this quotation the importance of clear organisational goals and systems to provide staff with clear objectives and feedback against which their contribution to the service might be judged. The move to the community appears to require very different ways of working. A shift from meeting basic instrumental needs (feeding, dressing, bathing, etc) to more complex practices involving the development of social and interaction skills in the local community. In addition staff are required to demonstrate expressive needs and to become a 'friend' and personal support to their clients.

The move away from the traditional role of the nurse obviously requires that nurses recognise and question their own attitudes and understanding of their working world, with a view to improving understanding and so developing their practice. The move to the community accelerates a confrontation with old attitudes which may have been more relevant to a hospital based model of care.

Since the emergence of community based residential care is relatively new for this client group, very few things appear to be constant in the new service. Staff and their managers are continuously having to review and evaluate their work and to adapt their skills in unfamiliar settings. This calls for a regular evaluation of 'where we are going', which in turn, may be disconcerting for staff who were accustomed to rigid patterns of working, so characteristic of hospital life.

However staff and managers appear to be happier with their world in the community and found their jobs more satisfying. The concerns of community staff were, however, clearly demonstrated in terms of quantitative aspects of work overload, i.e. having too much to do within the time available. Shortage of staff was seen to be a major source of pressure but to a lesser extent than in the hospital setting. The greater potential for flexibility and control over aspects of resident

care within the community may be an important mitigating factor in coping with the problem of work overload.

Relationships with senior staff are important and appear to be characterised with a sense of concern about irregular contact and feedback on performance. This must, however, be balanced against their positive feelings about being involved in decision making and the development of operational policies for their houses.

Work in the community also appears to have provided staff with renewed confidence about the security of their careers and role. Confidence and competence appear to have increased for most staff although more in-service training was considered to be essential to enable them to keep abreast of continuing professional and organisational changes. Hingley (1986) demonstrated similar findings in his study on stress in nursing:

> 'Feelings of professional competence appeared to be closely identified with the need for on-going training by staff in the community. A variety of training needs were mentioned including the need for 'More training in communication and team-work skills. More emphasis on the need for an improvement in interpersonal relationships in general'. We need more training in administration and management from professional administrators and not just from other nurses' (p166).

Conflicting procedures within the community also caused concern for both staff and managers. They reported that their roles were often more ambiguous than there previous role in the hospital. More importantly, some respondents noted that there were insufficient resources or inflexible procedures to realise the objectives of community care (inadequate staff numbers and bureaucratic financial Standing Orders etc.).

Then effect of home and work pressures and overspill was evident and was not always appreciated by superiors and some stated that this lack of understanding was in itself a source of stress. Problems associated with the degree of emotional involvement required with clients sometimes resulted in staff being more likely to take work problems home with them. It would therefore seem that community staff may have more difficulty in switching off their work problems.

In order to relieve and prevent some of the problems that might be associated with stress at work respondents were asked to identify systems that might support them. The main conclusions and findings are presented below (see appendix Five, Table 10 for full presentation of results).

The provision of an independent counselling service has been noted by many authors to be significant in this respect (Allinson etal 1989, Gillespie 1987, Owen 1989) and was also mentioned by staff and mangers as an important source of support. Support groups (Vousden 1985, Howden 1987, Henson 1988) and social activities were also identified as ways of preventing stress at work.

Other strategies were the provision of a clear vision of the future, closer links, commitment and feedback from managers, personal training plans and effective communication networks.

Finally, and in some ways the most important of all, was the need for reassurance that the service would be continuously evaluated in respect of its need for resources and in respect of its success in meeting the needs of people with mental handicaps and of retaining a committed and motivated workforce.

Community care requires the provision of supportive structures which allow nurses to deal constructively with the emotional side of their work. This involves recognising that work stress

does not reside only in the job characteristics themselves but in the relationship between the demands of the situation and the support and discretion that the nurse has in meeting those demands. That change means that staff will need to evaluate the positive and negative features of their job and to recognise that work environments involve a complex perception of formal and informal structures, climates and expectations which should all be considered when considering intervention strategies.

Firth noted (1983) in his study on stress in mental handicap nursing, the importance of recognising stress at work and providing systems to reduce its incidence may have significant payoffs for the organisation:

> 'What may happen when personal and organisational support is not sufficient? Quite simply, staff may suffer from professional depression or burnout. And my own research suggests that staff who suffer from professional depression are poor at supporting others. So a vicious circle may be set up. Starting perhaps with lack of organisational or personal support from the top, managers' morale may suffer and their ability to support their own staff suffer in turn. And it is bound to affect the quality of life of the mentally handicapped people for whom we are concerned' (p46).

Chapter Twelve

Conclusion - The Challenge of Change

Introduction

This study has had two principal aims:

- to identify the support systems that would be required by mental handicap nurses who transfer from mental handicap hospitals to work in community based residential facilities;

- to examine the way in which nurses had adjusted to the transfer and to make recommendations to assist in the transfer of the remaining workforce from hospital based care provision.

Six hypotheses were postulated about the proceses involved in the move to the community and were discussed in detail in chapter six (and will be considered further at the end of this chapter).

Testing these hypotheses was hampered by the fact that, even by 1989, very few Districts had introduced comprehensive services in the community and the vast majority were engaged at the preliminary stages of their implementation. There was no one blueprint for the introduction and commissioning of such projects, although the majority followed the principles of 'normalisation' and ordinary living in supported neighbourhoods. A representative sample was selected from six Health Districts in England and Wales, all of whom were involved in the contraction and closure of large mental handicap hospitals and all of whom were developing community based services to replace them.

The study attempted to capture the views of nurses, the majority of whom had considerable experience of working in institutions. Data was collected in two stages; with the assistance of a structured interview schedule and from personal interviews with respondents. In addition to presenting statistical results from the study, anecdotal or descriptive material was also included in order to present an overall picture of life in the community. The experiences, hopes, fears and aspirations of staff were also recorded and used to substantiate the factual evidence obtained from the structured interviews.

A considerable quantity of basic, factual information about the survey sample and its perception of working life in the community was collected and processed for computer analysis. As a result of this exercise three independent variables were identified which were considered to have had a significant bearing on the subjects investigated in the study:

- Length of Service
- Job Satisfaction
- Propensity to Leave.

These were later related to a series of dependent variables (job characteristics) and the results were presented in Chapters Eight, Nine, Ten and Eleven of the study.

Because of the slow emergence of services in the community (that were directly related to large hospital closure programmes) at the time of the study it was impossible to validate the findings more extensively with other samples. However, the study does present the real views of mental handicap nurses, speaking about their real life experiences and as such contributed to a better understanding of how to assist the with the implementation of community based programmes for people with mental handicaps.

The person with a mental handicap in the community

People with mental handicaps in the six services were beginning to demonstrate that they had the opportunity to participate as individuals in the lives of their local communities. Each of the services was designed on the basis of integration with local houses and was characterised by small houses in local towns and villages.

The philosophy of care was based on the principle of 'normalisation' and opportunities were in the process of being provided to enable service users to enjoy ordinary lives. This aim required commitment from staff to enter into contracts with service users to provide specific services in respect of their individual needs. A partnership in care was emergent in the services based on a concern for the interests of the welfare of individuals. There was also some evidence that service users were becoming increasingly involved in decisions that affected their lives.

The rate of service change witnessed was truly remarkable for both residents and their staff. The dismantling of old service structures had to be undertaken at the same time as new ones were developed to take their place, and together staff and residents had to endure many difficult months of preparation and waiting for new homes to 'appear'. Despite the obvious concerns expressed and experienced during this time, the results appear to suggest that users enjoyed more valued lifestyles together in the community (than in hospital).

It also became clear that people with a mental handicap can and wanted to live in ordinary houses and that they were beginning to participate in deciding how to manage their lives and to choose the things that they wanted to do when they were given the necessary support and opportunities. Mental handicap nurses, like their clients, were showing visible signs of

adjustment to working in the community and were able to make a contribution to assisting people with mental handicaps to enjoy their lives in a more fulfilled way while still responding to their special needs when this was required.

The nurses were more than pleased with the progress that their clients were able to make in the community and made frequent reference during the interviews to this being a key indicator of their job satisfaction. However the long hours and flexible shift patterns were clearly a price that the nurses had to pay for working in their new locations (this will be returned to later on). The structured interviews also found that most nurses had positive and optimistic views about the ability of people with mental handicaps living in the community, and the vast majority were pleased to have left hospital and the restrictions that they felt were placed upon them in respect of their ability to make independent decisions. Operational managers appeared to be managing their services in accordance with the expressed needs of their consumers and local staff and within the resources available. Operational policies had been introduced and reviewed regularly, and operational guidelines provided for local managers specified the limits of local decision making, which in turn outlined the processes which determined the efficient management of services.

The way in which service changes were introduced and managed appear to have been significant in determining the success of these new services. They required the introduction of challenging and innovative management structures and support systems. In their turn staff were required to work longer hours and to assume additional responsibilities, the most important of which was to begin to account for their activities to their clients and to the local community.

The principles described in this chapter are sound and can be changed and developed to suit local need. What appears to be

clear is that what is required to realise a high quality service is initiative, interest and commitment, and of course, a management (and financial) system that reinforces the aims and objectives of the service in practice.

The mental handicap nurse

The subculture of the mental handicap hospital, while important to sustain the practices of nurses working within hospitals, does not appear to be present in the community and does not appear to be really missed by the majority of nurses. Most consider that the community offers a pleasant alternative to many years of working with restricted resources and under repressive management regimes. This phenomenon has been well recorded by Coxon (1990) who regards many senior nurse managers as being guardians of outdated models of practice which restrict the development of innovative practices which are required by good nurses to practise their art. He stresses the need for nurses to exercise 'discretionary responsibility' and believes that hospitals and rigid hierarchical structures militate against this. He acknowledges that these structures were once productive in protecting nurses from anxiety provoking situations but now considers them to be dysfunctional:

> 'However, I believe that the traditional nursing systems, which now produce such anxiety, were originally introduced to protect nurses and distance them from their patients....As the nursing profession has evolved, it has lost sight of the defence mechanism for anxiety. The inherited systems have been interpreted as a means of creating anxiety rather than as alleviating it' (p36).

Coxon notes that the old system was characterised by task allocation and the preservation of hierarchical management structures which required nurses to maintain an an acceptable

distance from their charges. The new services completely challenge these requirements and insist on the development of positive partnerships with residents and a sharing of daily routine. (However it should be noted that in the absence of an evaluation of user's views of service provider's claims to offer 'valued and responsive services', claims of success in the community should be viewed with circumspection).

The nurses in the present study appeared to welcome these changes but commented on the need for more support from their managers and more sensitive preparation for the transfer in the form of skilled counselling and relevant in-service training.

Failure to acknowledge these feelings and needs may influence the success of social care programmes [for example, insecure staff may rely on outdated task-orientated practices and 'power relationships' (once familiar in hospitals) may actually transfer to the community] and may challenge their rationale. Management systems need to be in place before the commissioning of community based projects if staff are to be effective in the performance of their roles. Staff, once familiar with their new roles, will require support to develop adaptive and mature coping mechanisms to replace the more destructive defences characteristic of the institution. Failure to address these issues may adversely affect the success of individual acceptance of the new service and may result in the rejection of the primary aim and goals of the organisation in respect of benefits for clients.

As a result of this survey it may be concluded that nursing staff appear to be in favour of the transfer to the community because of its advantages for service users. However, there were obviously a number of concerns that could be potentially transferred with them to the new service. Their main concerns may be summarised as the need for:

* clear information;
* guidance and support during the transition period;
* reassurance that their skills and competences will be valued in the new service (and a clear career pathway);
* a clear definition of their role and expectations;
* processes to be introduced to monitor and to evaluate the quality of the service;
* assurance that adequate financial resources will be made available to support care in the community initiatives;
* more training;
* better and more responsive managers;
* regular feedback on their performance;
* the introduction of coping strategies to reduce the potential incidence of stress following transfer to the community.

In Chapter Five it was suggested that:

> 'The assumption that community services for people with mental handicaps can be developed simply by transferring existing human and physical resources is both simplistic and inaccurate. Community care is a most complex business, requiring the redirection of previous allegiances, attitudes and commitments.' (p.233).

For many staff concern will not be restricted only to their own well being or future job security. The well-being of their client group will also be of primary interest and at times these two concerns of meeting personal needs and those of people with mental handicaps might create tension. However it seems that the nurses in the present study believe that they are beginning to demonstrate their ability to transfer some of their skills from the hospital to new services in the community.

Working Life

All respondents had worked in a long stay hospital within which specific work routines and practices were expected and where care regimes were carefully established over many years. These routines served to control working systems. Many of these old systems were no longer present in the community, and in their place were new practices and attitudes necessary to match the philosophy of 'ordinary living' which underpinned the philosophy of the service.

The pace of development of these new services had, in some places, been fast and as a result staff had sometimes been confused and concerned about their role and about the quality of care that had been provided for their residents during the transfer period. However, the majority of staff believed that they had been able to transfer a range of expertise and experience from the hospitals in which they trained to the community, and some managers believed that this was invaluable in supporting people with mental handicaps in their new homes.

A number of new skills were required by nurses as they prepared to work in the community. These skills related to budget management, risk taking and the implementation of 'normalisation' practices. The majority of staff in the present study were satisfied with the in-service training that they had received but a significant proportion of respondents had received less than five days training in the past year (more experienced managers and staff received marginally more training than did their junior colleagues).

The study has demonstrated that, generally mental handicap nurses are in favour of community care and the majority of respondents have indicated that they would be either quite likely or very likely to seek re-employment in community based services for people with a mental handicap. However the nature

of the job sometimes made them feel isolated in their work and many appeared to spend a significant amount of time working alone with their residents either in their houses or with them in the community.

The nature of the job was varied and there appeared to be considerable scope for variety at work; although this was welcomed to some extent, there was some suggestion that conflict between client and non-client directed aspects of the job could be a source of concern for some staff and managers and might occasionally increase the likelihood of them thinking about leaving the service.

The longer managers appeared to have been in the service then the less satisfied they appear to have been with their jobs (although this was unlikely to encourage them to leave the service). Longer experience also appeared to be associated with a wider variety of non-client associated tasks as practitioners (staff and managers) were more likely to be left alone to work unsupervised. Longer service also appeared to improve managers' understanding of their roles and of other people's expectations of their contribution to the service.

Many staff missed the interpersonal support that they found to be readily available to them when they worked in hospital. Most felt that a balance should be struck which allowed staff the flexibility to use their initiative at work but also to receive the support from colleagues that they required on a regular and consistent basis.

While many staff rated the support that they received from their managers highly, many also felt that it was not always sufficient to meet the needs of staff working in isolated settings, and that the quality of feedback about performance could be improved. (Many regarded staff development and appraisal reviews as an essential part of this feedback process

but found this to be lacking in their new services). Moreover, during the course of informal interviews respondents stated that it was important to provide staff and managers with regular feedback, encouragement and support during the transition period from hospital to the community.

Staff worked long hours and a significant proportion of these were unpaid additions to the official working day. They appeared to share with their managers a commitment to their work and to their clients which implies that they were proud of their service.

Overall respondents appeared to be very satisfied with the range and variety of their jobs, which demanded increased responsibility and autonomy in decision making. They believed that they were effective in performing their roles, although they occasionally felt confused regarding the priorities that they should attach to their tasks.

All respondents mentioned the need for job security and guarantees of career progression. Apart from the many anxieties that face the mental handicap nursing profession the majority felt that the move to the community placed them in a better position to face the future than they had whilst working as part of an 'outdated' model of care within institutions. Managers, being closer to the decision - making level of the Health Authority felt rather less secure than their staff but still believed that their skills would be needed in the new service.

The Nature of Stress at Work

The move to the community requires nurses to readjust their attitudes and work practices which had been based on a hospital based model of care. Many had to learn how to function in

multi-disciplinary teams and to acquire new skills in presenting themselves as alongside more 'experienced' colleagues such as Clinical Psychologists and Social Workers (many of whom were well used to public speaking and teamwork). Discretion, initiative and personal judgement were required which were not easily developed by some nurses who were more used to working in a repressed system where decisions were sanctioned by line managers.

The new system required nurses to exercise their own discretion and to work with constantly changing situations for which rules did not appear to exist to guide them. (Since the emergence of community based residential care is relatively new for this client group, very few things appear to be constant in the service). This calls for a constant evaluation of approach and for the calculation of risks.

Many found that the most worrying feature of the community service was the extent to which staff were expected to extend their traditional working hours and routines into home life. Some reported that they found it impossible to complete the tasks that they had set for themselves in the time allotted. Many, therefore, reported having too much to do within the time available. This factor is clearly related to the number of additional expectations that staff feel are placed upon them by their managers and by the general public.

While reporting that the new physical conditions of their work were a vast improvement on life in hospital, some staff believed that there was a price to pay for the new resources that they now received. More money, more staff and a more appropriate environment may all enhance the expectation that residents will improve in terms of adaptive behaviour (and in the extent to which they enjoy a high standard and quality of life). Operational policies and client teaching schedules determine the standards of performance that should be expected

and these in turn are transferred to the residential care staff to realise and to achieve. Consequently some staff expressed their concerns about the degree to which they felt personally responsible for the quality of life of their clients and the apparent failure of some managers to appreciate or acknowledge the additional stress that this placed on them and their families (in the past responsibility was more easily discharged in the form of corporate accountability as part of a larger ward team).

Many staff felt that these higher standards and expectations did not merely come from moving to the community but depended on close attention being paid to detail in areas of maintaining service quality, more intensive (and individually tailored) staff training, leadership and support.

The intensity of relationships between staff and residents was a similar problem and several respondents mentioned that they felt that there was little opportunity to escape from the intensity of an eight hour shift (or twenty four hours in the case of 'sleep-in' duties'). If this is accompanied by working alone with a client group who have little expressive language then the job can be exasperating and stressful.

From a positive point of view staff felt pleased to be involved in the determination of polices although many reported that they were the people who often set their goals too high! Work in the community also appears to have provided staff with renewed confidence about the security of their careers and role as they were given the opportunity to begin to demonstrate their skills and competences publicly and in response to the identified needs of their clients.

On some occasions staff experienced stress at work due to apparent conflicts in procedures within the community. Some reported that their roles were often more ambiguous than their

previous roles in the hospital. More importantly, some respondents noted that there were insufficient resources or too inflexible procedures to realise the objectives of community care (inadequate staff numbers and bureaucratic financial Standing Orders etc.).

The effect of home and work pressures (and the transfer of concerns about work to homelife) was evident and for some was an obvious source of stress. This has led me to conclude that it would seem that community staff may have more difficulty in switching off from their work problems.

A number of strategies were regarded as important for relieving stress at work:
- the provision of a clear vision of the future;
- closer links with managers;
- commitment and feedback from managers;
- personal training plans;
- effective communication networks.

Of these the most important support of all, was the need for the service to be constantly evaluated in respect of its need for resources to meet the needs of people with mental handicaps (and in respect of retaining a committed and motivated workforce).

Community care requires the provision of supportive structures which allow nurses to deal constructively with the emotional side of their work. This involves recognising that work stress resides not only in the job characteristics themselves but in the relationship between the demands of the situation and the support and discretion that the nurse has in meeting those demands. More work is required to work out what characteristics an effective support system should have and these will be considered later in this chapter.

Finally, one important conclusion can be drawn from the study. While many nurses missed the interpersonal support networks which existed in the hospital, few missed other features of the institution. In fact the majority appeared to be pleased to have left behind them the imposing management structures and rigid procedures. Few appeared to regard the task orientation of routine as helpful, and above all respondents appreciated the freedom to practise some degree of autonomy.

The features of the old hospital culture which had dominated life for so many years were therefore not seen to be helpful or conducive to supporting staff in their primary aim of providing high quality lives for their clients in their new homes. Trade Unions, social clubs, sports days and dining rooms, whilst occasionally mentioned, were things of the past for many. They appeared to have served their purpose but with the demise of the institution they now appeared to be irrelevant attributes of an outdated culture. What was required was a new approach to providing staff support if the positive practices enjoyed by mental handicap nurses in their new working environments were to be sustained to the benefit of their clients.

The Changing Context of Health Care

Quite clearly the next decade will provide many new challenges for mental handicap nurses. Unlike the last one, these challenges will be introduced within the context of legislation and will demand that mental handicap nurses reconsider the way in which they provide their skills and deploy their practice. At the time of writing the Government have announced that they are delaying the implementation of their proposals for community care and the date for transfer of services for people with a mental handicap to the lead status of the Local Authority has been postponed until 1992. In a letter from the Health Minister, Virginia Bottomley (EL(90)M/3) in July 1990 it was announced that:

'We are committed to implementing our Community Care policy. We will begin to phase it in over a three year period beginning on 1st april 1990. We have always recognised that it would take years rather than months to develop many of the proposals which are now available' (p1).

The delay therefore does not imply a change in policy and the next three years will present the mental handicap nursing profession with a major requirement to evaluate its practice. A new marketing strategy will also be needed to ensure that Directors of Social Services, (as major purchasers of care for this client group) are apprised of the valuable contribution that mental handicap nurses can make to the new patterns of emerging care for people with mental handicaps in the community. The value of this contribution has been affirmed to the Government in evidence provided by Mencap in its evidence to the Government's Social Services Select Committee report on 'Informal Carers':

'Brian McGinnis drew attention to the role of mental handicap nurses; ".....the fact is that the residue of expertise in mental handicap tends to lie with mental handicap nurses. In many cases, social workers have specialised in that field, but the bulk of social workers are actually generic social workers. So that the bulk of the expertise lies with the mental handicap nurse and one of the sadnesses of recent years has been the extent to which that role has actually been devalued.....there is absolutely no doubt about the importance of the role of the nurse in that context' (Department of Health May 9th 1990 p xvi).

Christine Hancock, General Secretary of the Royal College of Nursing, in an address to Community Nurses (General) also paid tribute to the resilience of the mental handicap nurse and of

their ability to adapt to meet the changing context of health care provision:

> 'I am confident that community nurses can rise to the challenge of change. I have seen an important branch of nursing do so before. I'm referring to the success of mental handicap nurses in adapting to and leading a major process of change which appeared at first to threaten their very existence. We should not forget that those people with a mental handicap who had been cared for in hospital only started to move into the community when their nurses went with them. Before then, despite an anti-institutional rhetoric which had severely dented nurses' self-confidence, the policy of care in the community was honoured more in the breach than the observance. I would like to pay tribute to the courage of many thousands of mental handicap nurse who made that change happen' (p28).

The value of mental handicap nursing was also being considered by the Association of Directors of Social Services who in a report on the provision of services for people with learning difficulties/mental handicaps (May 1990) noted that:

> 'If staff are bringing commitment to the new philosophies and principles they will need to be reassured that their implementation does not threaten their livelihood. With the lead responsibility for community care given to Social Service Departments, opportunities should be explored for members of the nursing profession to transfer through secondment either as primary care workers or as case managers, after a period of bridging training. Such moves will be welcomed by SSD's and flexibility will be required in dealing with matters affecting conditions of service' (p12).

One final set of findings were obtained from an interim report published by Lahiff (July 1990) in which he compared the attitudes of 387 mental handicap nurses with the attitude findings published by Jay in 1979. Ten years later Lahiff was able to report that an overwhelming majority (95.4%) [compared to 48% in the Jay sample) saw a future for mental handicap nurses in community based services and over 96% [compared to 58 % in the Jay sample] rejected claims of hospital models of care in favour of normalisation and care in the community.

In summary the pace of change continues to present the profession with many anxieties and whilst a significant number of mental handicap nurses believe that they possess the skills required to work in new services, these skills still need to be assessed in respect of the extent to which they meet the real needs of service users (and hence nurses may regard the future with some degree of uncertainty). It is during this period of transition from Health Service led responsibility to the Local Authority that mental handicap nurses will require firm leadership, encouragement and commitment from their managers and employers. The next section considers the broader implications of this change and the effect that it is likely to have on the mental handicap nursing profession.

Broader Implications Arising from the Study

Staff following their clients to new life experiences will be required to work in very different ways from those which were common place in hospital. Nurses will find themselves in close contact with the general public as they accompany their residents to adult education colleges, to the swimming pool and to local community events. Much flexibility will be demanded of them in these new roles and (it is hoped but not assured) that the division of power between nurse and service user will become increasingly equitable.

Similarly, under the new arrangements for community care, inter-service collaboration will be imperative across a broad range of activities. This will involve clarification of responsibility for health and social care and this in turn will require the mental handicap nurse to clarify his or her personal contribution to the care process.

These changes, may in the first instance, be seen in a reduced input into residential care services as more and more people with mental handicap have their residential care needs determined within the context of social care. Mental handicap nurses may find themselves providing services as peripatetic support staff to people in their own homes, and residential care to only a minority of people with very special needs who require nursing and medical supervision.

These changes are not new and have been postulated for many years, leaving the health services with more dependant members of the client group to care for. The Government in a series of implementation documents published to support the NHS and Community Care Act (1990) drew attention to the problems that the separation between health and social care might present for professionals:

> 'Much will clearly depend on whether that distinction between the statement somewhat quaintly terms 'health and non-health care' can be made in practice and this is an issue which local agencies will no doubt wish to address. However, the potentially conflicting pressures of professional imperialism or self interest, on the one hand, and of cost-shunting, on the other, suggest that it may not be a straightforward distinction to make or maintain in practice' (CC13-p42-43).

Some would argue that the majority of people currently resident in mental handicap hospitals are in fact predominantly

receiving social care from people called nurses. Whilst this may be partially true it is clear, however, that the Government is well aware that hospitals cannot be closed until all of the things that are carried out for people currently living in them are provided in the community and executed in a more appropriate manner.

For staff, caught up in this debate, many are left feeling ill at ease and unsure of the value that is attached to their personal contribution to the care process. Many of these nurses are now working in the community (as this study has demonstrated) and are providing a teaching and advisory resource to the local community and to other agencies. Working in dispersed settings some respondents felt that they have been able to overcome some of their prejudices and have managed to achieve more appropriate standards of care.

The adjustment to multi-agency teamwork has demanded much of each staff member, and in some cases this has resulted in stressful outcomes as people aim to adapt to new working patterns and practices. Much of this can be avoided if managers involve the workforce at the outset of all project developments and assist in negotiating specific roles for each employee to play in the new service. Early staff training, team development and continued support are essential (as determined by respondents in the current study), and when these are combined with a clear definition of responsibility for individual clients this has proved to be enormously helpful to both staff members and clients. Such systems imply systematic managerial review, the monitoring of staffing levels and of the appropriateness of staff training/development and above all the provision of support for the workforce.

Caring for the Carers Needs

It seems that many mental handicap nurses feel swept along on a tide of irreversible change. The anxiety and stress arising from this organisational upheaval may induce the workforce to adopt resilient attitudes and values. This study has demonstrated that the reverse may be happening, with the majority of staff adjusting reasonably well to the change and providing a valuable contribution to the care of their clients within the context of a mixed 'economy of care' in the community.

The challenge now facing the profession implies that there will be a need to create a new multi-disciplinary approach to leading and managing services. This will be undertaken within a climate characterised by increasing complexity, continual change, higher expectations for the consumer, and considerable political pressure. In order to meet such demands the skills of appropriately motivated mental handicap nurses should be used as a valued resource. The challenge is two fold;

- releasing the initiative, creativity and commitment latent in the workforce;
- integrating people's agreed contributions towards achieving negotiated goals.

Leadership in mental handicap care requires that the conditions are created to ensure that these challenges are faced and that the workforce is enabled to assume new (and in some cases discretionary) responsibility for personal practice in the community (thus leading to an enriched standard of life for clients).

Respondents felt that the following were needed to assist them in responding to the needs of their residents:

- Well defined leadership and accountability;
- Secure relationships between peers, peers and managers and members of the multi-disciplinary team;
- Opportunities to be listened to and to influence policy-makers;
- Acceptance of the skilled contribution that mental handicap nurses can make and will continue to make to new services;
- Access to new learning opportunities;
- Maintenance of a high level of self-esteem and appreciation for 'a job well done';
- Publication of operational policies for the service and clearly defined standards of expected practice and performance;
- Consistent feedback on performance from managers;
- Involvement in evaluation and monitoring of service accomplishments;
- Continuing resource provision for community care.

Developing such a climate of leadership in community mental handicap services provides staff with an effective and responsive support network; in turn this may ultimately lead to a major shift in the organisational culture within which local services are provided. For staff the realisation that managers are prepared to change and to respond to the needs of the workforce in a preventative way may lead to more positive feelings of security and support at work. This need is supported by a series of questions that respondents raised during one group discussion about their perception of support from their managers:

- What can we expect from our managers if we agree to go along with them and their ideas?
- What will managers give in return for good work?
- Will our managers take credit for the successful integration of our clients into the community or will our good work be made recognised for positive reinforcement?

- Will the rules keep on changing - will our approach to work change as managers change their goals and agendas?

Perhaps, what the staff were saying was that they have had a great need to develop trust in their managers and to develop a partnership with them based on mutual respect and honesty. They appeared to need to believe in each other and to acquire some degree of cohesion between their respective agendas in order to maintain the systems of care that both staff and managers were aiming to implement together. The early stages of such a 'coupling' of a joint vision in the community were evident in the present study, but it was interesting to note that the staff members of the sample (on the whole) appeared to be more content with their new lives in the community than their managers. This may have been due to the closer contact that staff had with their clients and hence were able to appreciate the progress of their residents. This in turn appeared to reward them for their efforts; unlike their managers who had less tangible indicators of success to work with.

Coping with the Effects of Stress

Respondents felt that the following could help to relieve some of the stress encountered in their jobs:

- inter-disciplinary social functions;
- inter-disciplinary training events;
- access to independent counsellors;
- the development of inter-personal support networks between carers in the same locality;
- the provision of supervision sessions and regular feedback on performance;
- access to formalised staff review systems;
- access to stress management sessions and workshops.

Reviewing the Hypotheses and Outcomes of the Study

The following hypotheses were postulated at the beginning of the study:

* that as nurses leave the institution, their motivation and job satisfaction will increase;
* that this increase is because they find they are able to assist people with mental handicaps to improve the quality of their lives;
* that as nurses move to the community they will leave behind them a number of personal support systems that were personally supportive to them in their work and that are incapable of replication outside of the institutions in which they worked;
* that it will be difficult to replicate or replace these support systems in the community, the absence of which increase job stress;
* that managers may not yet have identified or provided those components of the infrastructure that will be required to sustain community care and that as a result nurses may be frustrated and less content in their jobs;
* that the community may reduce opportunities for career advancement and expose nurses to working conditions associated more with Local Authority employment status than with the National Health Service, the result of which may contribute to feelings of job insecurity.

The results of the study suggest that only the first four hypotheses were proven:

As the nurses experienced 'working life' in the community their motivation and job satisfaction increased (as reported in Chapter Ten - 'job satisfaction' results'). This finding is further supported by the apparent satisfaction noted by staff in being able to engage in more meaningful activities with

service users and to witness positive changes in their lifestyle following their departure from hospital.

The nurses certainly left behind a number of support systems that were appropriate to their work in the institution and as has been seen in Chapter Eleven these were not only absent in the new service, they were also regarded as being inappropriate in this setting (the majority of nurses stated that they were pleased to leave many characteristics of the 'old' support system which were, in themselves, stressful).

The services were new and whilst staff experienced some frustration in the support they received from their managers most found the new service to be both challenging and more flexible. Managers did not always provide adequate feedback on performance and were not consistently responsive (in some cases) to staff needs and as such staff were occasionally frustrated. However, the results of the study do not suggest that these problems with the new service made them any more discontent in their work.

The final hypothesis considered opportunities for career advancement and job security. Respondents believed that their new work provided them with opportunities to demonstrate the relevance of their skills publicly. In this they tended to consider their careers more positively than they did in the hospital, although they still regarded a potential transfer to Local Authority employment with suspicion and concern (although several respondents believed that this was due more to 'fear of the unknown' than to any objective cause). Consequently it may be surmised from these results that the move to the community actually improved their perception of job security and career advancement but that the question of a potential change of employer precipitated feelings of concern in the longer term.

From a personal perspective I believe that the study has demonstrated the following:

* mental handicap nurses may not be as dependent on the support systems found in hospitals (which served a useful function within the life of the institution to assist its employees to cope with the demands of work routines);
* work in the community, whilst being preferred by the majority of nursing staff, does bring with it new sources of occupational stress;
* services in the community are in their infancy and are not (yet) built within the context of a firm infrastructure and as a result there may be an absence of appropriate (or acknowledged) support for staff; if these needs are ignored this may result in a return to inappropriate methods of work practice more akin to the institution;
* mental handicap nurses believe that they are beginning to demonstrate that they are able to make a valued and significant contribution to supporting (and working with) people with mental handicaps; consequently they do not believe that their practice is dependent on a hospital setting.

The Practical Implications of the Research Findings

In the results of this study the practical implications of mental handicap nurses failing to adjust to the demands placed upon them by community care have been alluded to implicitly. Not all nurses accepted the changes with eager anticipation and some have been faced with 'a no win situation', of either accepting the changes or facing redundancy. The major implication of this dilemma has been the frustration felt by many nurses who were powerless to halt the pace of change as hospitals close.

It is therefore of interest to note that only a few nurses in the current study expressed dissatisfaction with their new jobs

in the community; quite clearly if they had feelings of dissent about their new roles they did not allow them to interfere with the service that they offered to their clients.

It is important to note the resilience that many of these nurses demonstrated when confronted with the changes that hospital closure would present them with and the extent to which they were able to adapt their skills and care practices to more appropriate models of care in the community. The nurses appeared to adjust remarkably well and attrition rates (propensity to leave) were very low. For them, job satisfaction was clearly related to the extent to which they were able to work directly with their clients and to assist them towards a better and integrated future with their neighbours in local towns and villages.

The study showed that most were pleased and willing to continue to work as nurses, employed by the National Health Service, and although some voiced their concern about the lead responsibility that Social Service Departments will assume in the near future it is clear that many regard the Local Authority with suspicion and with a degree of pessimism. Some felt that Social Service Departments were convinced that mental handicap nurses were employed within the context of a medical model of care and that they would be unable to adopt the attitudes considered necessary for care in the community.

The Government and local service providers may have to grasp the nettle and convince mental handicap nurses that they will be employed as valued members of the care team if transfers are to take place following the implementation of the NHS and Community Care Act (1990). They will need to do so for several reasons:

- the number of skilled practitioners available to support people with mental handicaps is falling as demographic factors

reduce the number of people in the labour market;
- Social Service staff are not trained or experienced in caring for some people with severe mental handicaps and/or profound medical needs;
- consumers have repeatedly requested that they be given a positive choice in selecting their carers. As such there is every indication to suggest that mental handicap nurses will continue to be chosen by a significant number of people with mental handicaps and their families (although it is recognised that this statement requires validation by service users).

In order for a smooth transition to occur it will be necessary for local service providers to negotiate equitable status, pay and conditions of service for nurses in the envisaged 'mixed economy of care'. They will need to ensure that nurses have access to skilled supervision and that they are encouraged to practise as accountable professionals. The present study has demonstrated that these processes are not readily available and there is a need to ensure that they are implemented before the Local authority assumes lead responsibility for mental handicap services in 1992 (as proposed by the 1990 National Health Service and Community Care Act).

Nurses appear to value their new jobs in the community far more than they did in the hospital. They seem to have a sense of pride and ownership in their work and appear to receive satisfaction from the knowledge that their contribution enhances the quality of life for their clients. Many commented that their new roles provided them with a new sense of public accountability which has been denied to them in the hospital, and that this may encourage the dissolution of negative stereotypes more commonly associated with hospital based nursing roles.

In order to take full advantage of this degree of commitment the Social Services Departments will need to demonstrate their

willingness to develop a partnership with Health Authorities and their employees and above all to agree upon a new framework within which to prepare and train the workforce for the future. Discussions will need to continue between the statutory bodies responsible for the regulation of nursing and social work and a new joint curriculum will need to be agreed upon and published which will build upon the very best skills and competences to be found in both professions. This debate is far from complete and the statutory bodies are no where near agreeing common standards for practice and preparation; some local providers, impatient for a solution, are turning to local colleges and private companies to devise a common curriculum that will be ready for implementation in their new mixed services.

There will also be a challenge to determine the skill mix and manpower levels that will be required to staff these new services, and this will feature as a requirement to recruit suitably experienced (unqualified) people as informal carers who may, in time, compete with qualified nurses and social workers for positions in the labour market. The price of care is clearly a variable that must be considered in this equation and qualified staff may find themselves as a rather expensive commodity as new social care services emerge.

For those mental handicap nurses employed in the new services there will be a need to ensure that their skills are used for the benefit of consumers in the most effective way. This will need to be done in conjunction with consumer satisfaction surveys and in association with an analysis of the identified care needs of clients following the implementation of case management. These in turn will inform service providers and purchasers of the skills that will be needed to provide high quality and responsive services for people with mental handicaps.

Walton and Brown summarise the dilemma that such an approach may have for service users and for their carers (1989):

> 'Much has been achieved in mental handicap nursing since the 1982 syllabus was introduced-to the benefit of students, staff and residents. But in the present climate of cost cutting and constraint there is a very real danger that progress cannot be sustained and may even be reversed. Quality services for people with a mental handicap in the community or in the declining hospitals cannot be obtained 'on the cheap'. Nor can a relevant training for professional staff to man and manage those services. Mental handicap nurses in the past have, in many ways, been their own worst enemies by tolerating "the very worst conditions of building, facilities and staffing ratios" and allowing their dedication and commitment to be exploited". This is not likely to be the case in the future' (p163).

The assertion skills that Walton and Brown mention are certainly evident within the mental handicap population and were witnessed in the present sample. It may be that these very skills are responsible for the way in which mental handicap nurses have coped with the many exacting changes that they have met in recent years. Used to adverse conditions in hospitals they learnt to survive and it is this ability that many appear to have transferred to their new jobs and in turn this has provided continuity for their clients.

In return for these adjustments managers should consider ways of providing relevant and responsive support for their staff. The costs of caring are high but the costs of replacing the mental handicap nursing workforce (estimated at between 12,000-16,000) would be exceedingly high. If mental handicap nurses were able to access whatever support was appropriate for themselves the possibility of retaining (and in some cases retraining for work in the community) a motivated and skilled workforce is enormous.

Suggestions have been offered, based on the findings drawn from the research, on ways in which staff might be supported during

and after the transition to the community. Mental handicap nurses remain a minority group and this is not the most attractive position from which to seek additional resources for improved services. In the same way their client group has also had to fight (in conjunction with pressure groups and their many supporters) determinedly to be recognised as a 'deserving cause'. Together, I believe that both groups believe that they are able to leave hospital life behind them and to integrate positively into the community with mutual benefits.

By way of conclusion to this study I would add to this the advantages of maintaining a high standard of staff morale; a more contented staff means a lower turnover of staff, higher standards of care and an enhanced quality of life for the people they care for. It is my conclusion that in this health and cost conscious age the health and social care systems in Britain can no longer afford to ignore the issue of staff support for its many mental handicap nurses. The final test will be the extent to which mental handicap nurses are able to demonstrate that they are capable and willing to provide high quality services for their clients in the community in a cost-effective and efficient manner.

This study ends with a quotation from Eleanor Roosevelt which I believe summarises the partnership that may exist between service users and their carers and the beliefs that they jointly hold as they face a slightly uncertain future together:

> 'Where, after all, do universal rights begin? In small places - so close and so small that they cannot be seen on any map of the world. Yet they **are** the world of the individual person: the neighbourhood he lives in; the school or college he attends; the factory, farm or office where he works. Such are the places where every man, woman and child seeks equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning **there**, they have little meaning anywhere. Without concerted citizen action to uphold them close to home, we shall look in vain for progress in the larger world' (Speech to the United Nations 27.3.58 p1).

APPENDIX ONE

Summary of the Key findings Perceived by Nurses from a Review of District, Board and Regional Health Authority Plans Relating to the Implementation of Care in the Community for People with Mental Handicaps.

Most nurses want and feel that:

* people with mental handicaps should have access to a wider range of opportunities and that they should leave hospitals;

* opportunities to experience valued leisure and work experiences should be provided;

* service users should be consulted about changes in their lives and that they should have the opportunity to express their views and opinions;

* service users should be valued as equal participants in the care process and that they should receive support from skilled staff to do so;

* people with mental handicaps are often patronised and undervalued and that their potential for growth and development has been underestimated;

* there is insufficient finance within the current system to fund the programmes identified for care in the community;

* central government should confirm the position of its funding polices for care in the community and that a policy statement should be issued detailing the future role of the mental handicap nurse when hospitals close;

* they need better and more informed managers who understand participate in the assessment of client needs and who are aware of the practical problems and difficulties involved in the transition to the new service;

* they need more guidance, encouragement and support in their everyday work, particularly when risks needed to be calculated in respect of client programmes as the philosophy of 'normalisation' was being introduced;

Some nurses wanted and felt that:

* their managers were inaccessible and distant and that they were not involved in the day to day issues that warranted their attention;

* managers often failed to set clear performance targets for their staff and that performance reviews were not evident in many services;

* managers often failed to monitor the quality of service systems and that systems did not exist in a number of services to evaluate the quality of care and life afforded to service users;

* they had unrealistic workloads which militated against client focussed outcomes;

* they received little feedback from their managers in respect of their performance and that they were rarely praised for their efforts despite that fact that they were often personally responsible for the realisation of high quality services;

* poor communication systems existed in many services which augmented difficulties in respect of setting standards of performance and developing the service;

* centralised policies tended to be translated from hospital care to community developments and that these were often unsuitable for small services and consequently restricted opportunities for progress;

* the nature of their work demanded wide ranging skills and competences which were not obviously apparent in hospital and for which little additional training had been provided;

* qualifying training opportunities were often restricted in the community and that a skill mix review was often absent thus depriving services and their staff of an objective appraisal of the nature of the future workforce;

* opportunities for sharing training with social workers were restricted and that service managers failed to recognise the importance of developing and fostering close links with other agencies as new patterns of multi-agency cooperation emerge;

* resources within the community might be inadequate to meet the needs of the growing number of people leaving hospital and that this might result in a reduction of opportunities for service users who previously had access to a range of activities within the hospital campus;

* they on occasions lacked confidence in some areas of their work due to the new demands placed on them in unfamiliar settings;

* some staff missed the support networks that existed in the hospitals and were unsure of how to replace these in the community;

* the introduction of flexible working patterns and shifts caused some concern and often involved intrusion into personal lives and personal space;

* selection processes for staff were not always fair; some people felt that their previous history of working in institutions militated against opportunities for them to work in community based services;

* inadequate thought had been given to the selection process for untrained support staff and that demographic changes might reduce recruitment and therefore inflict problems on the realisation on client programmes;

* inadequate thought had been given to the provision of specialist support staff in the community to support the community care programmes eg. psychologists, speech therapists and physiotherapists;

* one of the evolving problems facing community staff was the fact that many were isolated from mainstream services and from management support. Some regarded this as becoming a potential risk factor in respect of stress and work overload;

* small housing projects would overstretch limited staff numbers, thus leaving less time to work with service users;

* some staff would have difficulty to adapting to new working conditions;

* some service users would fail to realise the expectations set for their transfer to the community and would be disappointed;

* some people with challenging or difficult behaviours might find that the community service would be unable to meet their specific needs.

[**Adapted from two main sources:** South East Thames Regional Health Authority Policy for People with Learning Difficulties (1989) & Royal College of Nursing Survey on the Implementation of Care in the Community Initiatives, (1989).]

APPENDIX TWO

Date of interview:_____

CODE NO:_____

INTERVIEW SCHEDULE - STAFF

Good morning/afternoon. I am writing a research study which forms part of my Doctorate with the University of Southampton. The study is designed to identify the support systems that staff require when working in community based services for people with mental handicaps/learning difficulties. I am interviewing staff and their managers from six community based services and should be grateful if you would help by taking part. The survey has been discussed with your manager who has given his/her approval. The interviews will be confidential and nothing that can identify any individual will be given to any of the authorities concerned. The schedules have a code number for your exclusive use. You are not obliged to help but I hope you will!

SECTION A JOB AND CAREER CHARACTERISTICS.

1-How long have you worked for your present employer without a break in service?

2-How long have you worked in your present post?

3-What is your present post?

4-Have you worked in a hospital for people with a mental handicap before?

5-If so for how long ?

6-How long have you had in jobs caring for people with mental handicaps in total?

7-What was the last post you held before this one?

8-If for some reason you were to lose your job tomorrow, how likely is it that you would seek employment in a community based service for people with a mental handicap?

Not very likely	Unsure	Quite likely	Very likely

9-Do you have a professional qualification relating to work with people with mental handicaps?.....yes
.....no

10-Have you had any in-service training during the last year?

11-If so how many hours..... or days.....

12- Overall how satisfied were you with the most part of that training?

Very Sat	Satisfied	Unsure	Not Very Sat	Very Disat

13- Is a Staff Development Performance Review/appraisal System in operation here for all staff?

yes....

no.....

14-If so how often do they take place?.....

15-When did you last have a staff performance review?.....

16-Do you ever regularly work longer than your set hours?

If so how many hours?..... or days per month.....?

SECTION B THE NATURE OF YOUR JOB AND YOUR CLIENTS

1- please tick the relevant box for each question.

	very little	A little	A moderate amount	Quite a lot	A great deal
How much variety is there in your job?					
How much are you left on your own to work?					
To what extent is dealing with people other than residents part of your job?					
What opportunities are there for you to do different things in each work session/shift					
How much opportunity is there to talk to other employees while at work?					
To what extent are you able to act independently of supervision in your job?					
How much information do you receive on your job performance?					
How much of your job is directly concerned with interpersonal contact with residents, rather than other care duties?					

2-Imagine a scale of one to five and tick the box that measures how much you think each statement applies to your job and to your feelings regarding involvement in decision making:

	Strongly agree 1	2	3	4	Strongly disagree 5
I am certain how much authority I have					
Clear, planned goals and objectives exist for my job					
I know that I have divided my time properly					
I know what my responsibilities are					
I Know exactly what is expected of me					
I have to bend or ignore a rule or policy in order to carry out an assignment					
I receive incompatible requests from two or more people					
I do things which are apt to be accepted by one person and not accepted by others					
I receive an assignment without adequate resources to carry it out					
There can be little action taken here until someone in authority approves a decision					
A person who wants to make his or her own decisions within his own area of responsibility would be quickly discouraged					
Even small matters have to be referred to someone higher-up for a final answer					
Participation in decisions is very limited					
Consultation about changes is rare. I feel I have no say in the day-to-day running of this unit					
My opinion does not count when a problem comes up					

3-Thinking about the people with whom you work:

a)-Concerning your work group/fellow employees - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How well they work together and offer each other support					
How willing are they to listen to your problems					

b)-Concerning your subordinates - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How much work they expect of you					
How friendly and easy to approach they are					

4- These questions refer to people with mental handicaps.

How likely do you think it is that the following things will happen within the next 5-10 years? Please tick the relevant box.

	Very unlikely	Not likely	Unsure	Quite likely	Very likely
It is inevitable that all MH people will be discharged into the community					
That the move to the community will produce a poor service					
That the public will accept MH people in the community					
Residents will be able to lead a life which is as valuable as any one elses					

5-Thinking about the type of service:

	Agree	Tend to agree	Uncer-tain	Tend to disagree	Disagree
It is inevitable that MH people will not be properly cared for in the community					
MH people are safer in hospital					
Only a community based service can provide the life that MH people should enjoy					
There will never be the right facilities for MH people in the community					
People will be able to respond more readily in a community home					
Community services will always be preferable to instit/hospital care					
Specialised hospitals are the best places for MH people					
Small community units are bound to run more effectively than large hospitals					
Clients will develop new skills when taught appropriately in the community.					
Clients will appreciate attractive surroundings when provided.					
Participation in the community will enhance opportunties and skills					
Experience of living in family groups will encourage independence					

6- Do you know of any other places where experience has shown that people with mental handicaps can be accepted in the community?

Yes.....No.....

If so where.....

SECTION C ROLE EFFECTIVENESS

These questions refer to your perception of role-effectiveness:

1-Chose one statement from the following sets and indicate by ringing the appropriate number:

a-My role is important in this organisation;.....1
I am doing useful work here;.....2
Very little importance is given to my role in this organisation; 3

b-My training and expertise are not fully utilised in my present role.....1
My training and experience are not used in my present role.2
.....
I am able to use my training and experience here.....3

c-I am doing routine work here.....1
In my role I am able to use my creativity and do something 2 new.....
I have no time for creative work in my role.....3

d-Some of what I do contributes to my learning.....1
I am slowly forgetting all that I learned (my professional 2 knowledge).....
I have tremendous opportunities for professional growth in 3 role.....

e-I do not enjoy my role.....1
I enjoy my role very much.....2
I enjoy some parts of my role and not others.....3

f-I have little freedom in my role.....1
I have a great deal of freedom in my role.....2
I have enough freedom in my role.....3

g-I learn a great deal in my role.....1
I learn a few things in my job.....2
I am involved in routine or unrelated activities and have learned nothing..... 3

2-When you are confronted with a stressful situation how do you typically cope? Please indicate your answer by ticking the relevant box for each of the following possibilities:

	never	almost never	some-times	often	almost always
Try to see the positive side of the situation					
Try to step back from the situation to be objective					
Take things one step at a time					
Consider several alternatives for handling the problem					
Remember that I was in a similar situation before and draw on my past experience					
Try to find out more about the situation					
Talk with a professional outside of work eg. a clergyman					
Take some positive action					
Talk with spouse or relative					
Talk with friend about problem					
Exercise more					
Prepare myself for the worst					
Take it out on other people when I feel angry or depressed					
Try to reduce tension by eating more					
Try to reduce tension by smoking more					
Keep my feelings to myself					
Get busy with other things in order to keep my mind off the problem					
Think that everything will probably work out all right and not worry about it.					
I like to relax over a few drinks at the end of the day					
An occasional drink is better than taking tranquillisers					

3-Which of the following would help to relieve stress in the work environment?;

More support and understanding.....

More staff.....

More time off.....

More training.....

The creation of a more relaxed atmosphere.....

A more personal approach.....

What else?.....
.....
.....

SECTION D JOB SATISFACTION.

THESE QUESTIONS RELATE TO ASPECTS OF YOUR JOB.
1-These questions for example, concern your feelings about your work:

How satisfied are you with the following aspects of your work?	very satisfied	quite satisfied	neither one or other	quite dissatisfied	very dissatisfied
Income					
Job security					
Number of Hours Worked					
Flexibility of Hours					
Ease of travel to Work					
Management and Supervision by your Superiors					
Relationships with Fellow workers					
Opportunities for Advancement					
Respect for the sort of work you do					
Your own accomplishments					
Developing your Skills					
Having challenges to meet					
The actual tasks you do					
The variety of tasks					
Opportunities to use your own initiative					
The physical work conditions					
Your work in general					

2-Please write in the one thing you like best about your job.....

3-Please write in the one thing you like least about your job.....

4-For what proportion of your time do you feel satisfied with your work?.....

5-What are the main problems in your job?.....

6-Is there anything you would like to see changed?.....

7-In the last three months how many out of house meetings have you attended and met other colleagues?
.....

8- In the last month how many out of house meetings have you attended and met other colleagues?

.....

9- In the last two months how many times have you participated in a client care review/IPP?

.....

10-In the last two months have you had some conversation with your immediate boss?

once a month or less .....
once every two to three weeks .....
about once a week .....
several times a week .....
at least three or four times a week.....

11-Is support there from your boss when you need it?

never	sometimes	usually	always

12-When you are on duty, how often is your immediate boss on duty with you?

less than half of the time.....
about half of the time.....
more than half of the time.....

13-How many people work with you on average each shift?

14-How often do you think of leaving this job or stopping work?

never	very rarely	occasionally	every day

15-I stay at work voluntarily when my hours are finished on average:

never	very rarely	occasionally	every day

16-How would you describe the support you get from people outside the service which helps with work eg. family friends etc? (please indicate on scale below):

1.....5
least ideal ideal

17-I think about work when I am off duty:

very rarely	occasionally	every day

18-Do you think that you might be promoted at work one day?

1.....2.....3.....4
very unlikely possibly fairly likely very likely

19-Who in your present job is the most supportive to you?

.....

20-How have they been most supportive?
e.g. (tick more than one if appropriate)

doing jobs to help, demonstrating procedures;

taking up a problem with someone else on your behalf;

giving advice or suggestions;

keeping things I say confidential;

listening, understanding, encouraging me to talk;

explanation of procedures, information;

showing an interest in me and my work;

encouragement, praise.

21-Do you usually find that you know when your boss is satisfied with your work?

always know	usually know	sometimes know	often in dark	usually dont know

22-Do you always feel as clear as you would like to be about what you have to do in this job?

yes.....No.....

SECTION E CHARACTERISTICS OF THE ORGANISATION

These questions refer to the characteristics of the organisation. Please tick the box which indicates your perception of the following:

	Never True 1	2	3	4	Always True 5
Consistent high quality service emphasised within organisation					
The Org responds to needs of residents					
The organisation is well in touch with its environment					
The public sees the organisation as friendly					
The organisation's leaders create an exciting working environment through personal attention/intervention					
Managers are visible at all levels of organisation					
Staff know their managers well and what they 'stand for'					
The organisation has a well defined set of guiding beliefs stated in qualitative terms					
General objectives and values are set forth and widely shared throughout the organis.					
Information is widely shared/ managers are open with staff					
Conflict is managed - not suppressed					
The organisation will try out ideas without lengthy debate					
People are encouraged to be creative and innovative					
Failure is seen as an opportunity to learn					
Managers assume that staff want to assume more responsibility and thus provide opportunities					
An effort is made to inspire people at the bottom of org.					
Management demonstrate respect for individuals					
People work effectively in multi-professional teams					
Casual meetings occur regularly					

SECTION F GENERAL QUESTIONS

1- What features of the old hospital culture do you miss most?

2-What features of the old hospital culture were you pleased to leave behind?

3-What features of the old hospital culture still apply to the community service and how have you adapted them?

4-Which of the following do you provide for staff?

-Creche facilities.....
-Subsidised transport facilities.....
-Staff sports facilities.....
-Social Club/recreational facilities.....
-Subsidised housing facilities.....
-Single staff accommodation.....
-Access to qualifying training schemes.....
-Access to in-service/post-basic training courses.....
-Flexible shift systems.....
-Staff uniforms.....
-Uniform allowances.....
-Identified opportunities for career advancement.....

5-How well do you believe that you were prepared for transfer from hospital to the community?

What ideas have you for bridging the gap between the old hospital culture and the community services for:

A) Staff;

B) Residents.

Thank you for assisting in the completion of this interview schedule!

APPENDIX THREE

Date of interview: _____

CODE NO: _____

INTERVIEW SCHEDULE - MANAGERS

Good morning/afternoon. I am writing a research study which forms part of my Doctorate with the University of Southampton. The study is designed to identify the support systems that staff require when working in community based services for people with mental handicaps/learning difficulties. I am interviewing staff and their managers from six community based services and should be grateful if you would help by taking part. The survey has been discussed with your manager who has given his/her approval. The interviews will be confidential and nothing that can identify any individual will be given to any of the authorities concerned. The schedules have a code number for your exclusive use. You are not obliged to help but I hope you will!

SECTION A JOB AND CAREER CHARACTERISTICS.

1-How long have you worked for your present employer without a break in service?

2-How long have you worked in your present post?

3-What is your present post?

4-Have you worked in a hospital for people with a mental handicap before?

5-If so for how long ?

6-How long have you had in jobs caring for people with mental handicaps in total?

7-What was the last post you held before this one?

8-If for some reason you were to lose your job tomorrow, how likely is it that you would seek employment in a community based service for people with a mental handicap?

Not very likely	Unsure	Quite likely	Very likely

9-Do you have a professional qualification relating to work with people with mental handicaps?.....yes
.....no

10-Have you had any in-service training during the last year?

11-If so how many hours..... or days.....

12- Overall how satisfied were you with the most part of that training?

Very Sat	Satisfied	Unsure	Not Very Sat	Very Disat

13- Do you operate a Staff Development Performance Review System for all staff?

yes....

no.....

14-If so how often do they take place?.....

15-When did you last have a staff performance review?.....

16-Do you ever regularly work longer than your set hours?

If so how many hours?..... or days per month.....?

SECTION B THE NATURE OF YOUR JOB AND YOUR CLIENTS

1- please tick the relevant box for each question.

	very little	A little	A moderate amount	Quite a lot	A great deal
How much variety is there in your job?					
How much are you left on your own to work?					
To what extent is dealing with people other than residents part of your job?					
What opportunities are there for you to do different things in each work session/shift					
How much opportunity is there to talk to other employees while at work?					
To what extent are you able to act independently of supervision in your job?					
How much information do you receive on your job performance?					
How much of your job is directly concerned with interpersonal contact with residents, rather than other care duties?					

2 Imagine a scale of one to five and tick the box that measures how much you think each statement applies to your job and to your feelings regarding involvement in decision making:

	Strongly agree 1	2	3	4	Strongly disagree 5
I am certain how much authority I have					
Clear, planned goals and objectives exist for my job					
I know that I have divided my time properly					
I know what my responsibilities are					
I Know exactly what is expected of me					
I have to bend or ignore a rule or policy in order to carry out an assignment					
I receive incompatible requests from two or more people					
I do things which are apt to be accepted by one person and not accepted by others					
I receive an assignment without adequate resources to carry it out					
There can be little action taken here until someone in authority approves a decision					
A person who wants to make his or her own decisions within his own area of responsibility would be quickly discouraged					
Even small matters have to be referred to someone higher-up for a final answer					
Participation in decisions is very limited					
Consultation about changes is rare. I feel I have no say in the day-to-day running of this unit					
My opinion does not count when a problem comes up					

3-Thinking about the people with whom you work:

a)-Concerning your work group/fellow employees - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How well they work together and offer each other support					
How willing are they to listen to your problems					

b)-Concerning your subordinates - please estimate:

	Very little	Little	A moderate amount	Quite a lot	A great deal
How much work they expect of you					
How friendly and easy to approach they are					

4- These questions refer to people with mental handicaps.

How likely do you think it is that the following things will happen within the next 5-10 years? Please tick the relevant box.

	Very unlikely	Not likely	Unsure	Quite likely	Very likely
It is inevitable that all MH people will be discharged into the community					
That the move to the community will produce a poor service					
That the public will accept MH people in the community					
Residents will be able to lead a life which is as valuable as any one elses					

5-Thinking about the type of service:

	Agree	Tend to agree	Uncer-tain	Tend to disagree	Disagree
It is inevitable that MH people will not be properly cared for in the community					
MH people are safer in hospital					
Only a community based service can provide the life that MH people should enjoy					
There will never be the right facilities for MH people in the community					
People will be able to respond more readily in a community home					
Community services will always be preferable to instit/hospital care					
Specialised hospitals are the best places for MH people					
Small community units are bound to run more effectively than large hospitals					
Clients will develop new skills when taught appropriately in the community.					
Clients will appreciate attractive surroundings when provided.					
Participation in the community will enhance opportunties and skills					
Experience of living in family groups will encourage independence					

6- Do you know of any other places where experience has shown that people with mental handicaps can be accepted in the community?

Yes.....No.....

If so where.....

SECTION C ROLE EFFECTIVENESS

These questions refer to your perception of role-effectiveness:

1-Chose one statement from the following sets and indicate by ringing the appropriate number:

a-My role is important in this organisation;.....1
I am doing useful work here;.....2
Very little importance is given to my role in this organisation; 3

b-My training and expertise are not fully utilised in my present role.....1
My training and experience are not used in my present role.2
.....
I am able to use my training and experience here.....3

c-I am doing routine work here.....1
In my role I am able to use my creativity and do something 2 new.....
I have no time for creative work in my role.....3

d-Some of what I do contributes to my learning.....1
I am slowly forgetting all that I learned (my professional 2 knowledge).....
I have tremendous opportunities for professional growth in 3 role.....

e-I do not enjoy my role.....1
I enjoy my role very much.....2
I enjoy some parts of my role and not others.....3

f-I have little freedom in my role.....1
I have a great deal of freedom in my role.....2
I have enough freedom in my role.....3

g-I learn a great deal in my role.....1
I learn a few things in my job.....2
I am involved in routine or unrelated activities and have learned nothing..... 3

2-When you are confronted with a stressful situation how do you typically cope? Please indicate your answer by ticking the relevant box for each of the following possibilities:

	never	almost never	some-times	often	almost always
Try to see the positive side of the situation					
Try to step back from the situation to be objective					
Take things one step at a time					
Consider several alternatives for handling the problem					
Remember that I was in a similar situation before and draw on my past experience					
Try to find out more about the situation					
Talk with a professional out-side of work eg. clergyman.					
Take some positive action					
Talk with spouse or relative					
Talk with friend about problem					
Exercise more					
Prepare myself for the worst					
Take it out on other people when I feel angry or depressed					
Try to reduce tension by eating more					
Try to reduce tension by smoking more					
Keep my feelings to myself					
Get busy with other things in order to keep my mind off the problem					
Think that everything will probably work out all right and not worry about it.					
I like to relax over a few drinks at the end of the day					
An occasional drink is better than taking tranquillisers					

3-Which of the following would help to relieve stress in the work environment?

More support and understanding.....

More staff.....

More time off.....

More training.....

The creation of a more relaxed atmosphere.....

A more personal approach.....

What else?.....
.....
.....

SECTION D **JOB SATISFACTION.**

THESE QUESTIONS RELATE TO ASPECTS OF YOUR JOB.
1-These questions for example, concern your feelings about your work:

How satisfied are you with the following aspects of your work?	very satisfied	quite satisfied	neither one or other	quite dissatisfied	very dissatisfied
Income					
Job security					
Number of Hours Worked					
Flexibility of Hours					
Ease of travel to Work					
Management and Supervision by your Superiors					
Relationships with Fellow workers					
Opportunities for Advancement					
Respect for the sort of work you do					
Your own accomplishments					
Developing your Skills					
Having challenges to meet					
The actual tasks you do					
The variety of tasks					
Opportunities to use your own initiative					
The physical work conditions					
Your work in general					

2-Please write in the one thing you like best about your job.....

3-Please write in the one thing you like least about your job.....

4-For what proportion of your time do you feel satisfied with your work?.....

5-What are the main problems in your job?.....

6-Is there anything you would like to see changed?.....

7-In the last three months how many non-mental handicap meetings have you attended and met other colleagues?
.....

8- Is support there from your boss when you need it?

never	sometimes	usually	always

9-How often do you think of leaving this job or stopping work?

never	very rarely	occasionally	every day

10-I stay at work voluntarily when my hours are finished on average:

never	very rarely	occasionally	every day

11-How would you describe the support you get from people outside the service which helps with work? eg. family friends etc. (please indicate on the scale below):

1.....5
least ideal ideal

12-I think about work when I am off duty:

very rarely	occasionally	every day

13-Do you think that you might be promoted at work one day?

1.....2.....3.....4
very unlikely possibly fairly likely very likely

14-What percentage of staff have left your service/area of management in the past year?

.....

15-Who in your present job is the most supportive to you?
.....

16-How have they been most supportive?
e.g. (tick more than one if appropriate)

doing jobs to help, demonstrating procedures;

taking up a problem with someone else on your behalf;

giving advice or suggestions;

keeping things I say confidential;

listening, understanding, encouraging me to talk;

explanation of procedures, information;

showing an interest in me and my work;

encouragement, praise.

17-Do you usually find that you know when your boss is satisfied with your work?

always know	usually know	sometimes know	often in dark	usually dont know

18-Do you always feel as clear as you would like to be about what you have to do in this job?

yes.....No.....

SECTION E MANAGEMENT SKILLS AND PERFORMANCE

1-There are many skills managers need to perform effectively in their jobs. How important are the following in your job and how well do you perform them? Please rate on a scale of 1-5 to illustrate your perception of their importance(you more score more than one for each statement). Score 5 for the most important and 1 for the least.

SKILL	Importance in job 1 - 5
Motivating people to do things	
Building a good team	
Communicating Well	
Handling grievances	
Disciplining subordinates	
Chairing/conducting meetings	
Briefing people	
Interviewing	
Getting on with other people	
Leading a group	
Persuading/influencing others	
Managing your time	
Assessing yourself	
Making presentations	
Writing reports	
Making decisions	
Planning work	
Setting targets/goals	
Organising people and tasks	
Analysing/diagnosing problems	
Designing/implementing systems	
Delegating	
Allocating work	
Assessing job performance of others	
Counselling/developing staff	
Writing job descriptions	
Costing/financial matters	
Developing own job skills	
Monitoring standards/quality of care	

2-How much importance do you give to receiving feedback from subordinate staff?.....

SECTION F GENERAL QUESTIONS

1- What features of the old hospital culture do you miss most?

2-What features of the old hospital culture were you pleased to leave behind?

3-What features of the old hospital culture still apply to the community service and how have you adapted them?

4-Which of the following do you provide for staff?

-Creche facilities.....
-Subsidised transport facilities.....
-Staff sports facilities.....
-Social Club/recreational facilities.....
-Subsidised housing facilities.....
-Single staff accommodation.....
-Access to qualifying training schemes.....
-Access to in-service/post-basic training courses.....
-Flexible shift systems.....
-Staff uniforms.....
-Uniform allowances.....
-Identified opportunities for career advancement.....

5-How well do you believe that you prepare staff for transfer from hospitals to the community?

What ideas have you for bridging the gap between the old hospital culture and the community services for:

A) Staff;

B) Residents.

Thank you for assisting in the completion of this interview schedule!

APPENDIX FOUR

CODE BOOK - ITEMS COMMON TO STAFF AND MANAGERS

SECTION A - JOB AND CAREER CHARACTERISTICS

NAME	VARIABLE	VALUES	VALUE LABEL
Service	service	1	< six months
		2	6 - 11 months
		3	1 - 2 years
		4	3 - 4 years
		5	>4 years
Present	present	1	< six months
		2	6 - 11 months
		3	1 - 2 years
		4	>4 years
Post	post	1	Director/Asst DNS
		2	Person in Charge
		3	Dep/Asst PIC
		4	Team Leader
		5	Senior Care Staff
		6	Other
Hospital	hospital	1	Yes
		2	No
Length	hospital experience	1	1 - 3 years
		2	4 - 5 years
		3	6 - 10 years
		4	>10 years
Total	total service	1	1 - 3 years
		2	4 - 5 years
		3	6 - 10 years
		4	>10 years
Tot posts	previous posts	1	Asst DNS
		2	Senior nurse
		3	Charge Nurse
		4	Communty Nurse
		5	Staff Nurse
		6	Other
Remploy	remploy	1	not very likely
		2	unsure
		3	quite likely
		4	very likely
Qual	prof qualification	1	Yes
		2	No

Inservic	in service training	1	Yes
		2	No
Trantime	hours training	1	< 1 day
		2	1 - 5 days
		3	6 - 10 days
		4	11 - 20 days
		5	21 - 30 days
		6	>30 days
Tran sat	training satisfaction	1	very sat
		2	satisfied
		3	unsure
		4	not very sat
		5	very disat
SDPR	sdpr	1	Yes
		2	No
SDPR freq	sdpr interval	1	<6 months ago
		2	in last 9 months
		3	in last year
		4	>year
Vol time	voluntary time	1	Yes
		2	No
Vol hours	voluntary hours	1	<5 per month
		2	6 -10 per month
		3	11 - 20 per month
		4	21 - 30 per month
		5	>30 per month

SECTION B - THE NATURE OF YOUR JOB AND YOUR CLIENTS

NAME	VARIABLE	VALUES	VALUE LABEL
Job var	job variety	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Solo	work alone	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Non Pts	non client activity	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Variety	job variety	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Discpeers	discuss peers	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Indsupt	ind of support	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Feedback	job per feedback	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Enagagement	interpersonal contact	1	Very little
		2	A little
		3	A moderate amount
		4	Quite a lot
		5	A great deal

Authority	authority	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Goals set	goals set	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Time Man	time allocation	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Responsty	role responsibility	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Expect	role expectation	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Rules	rules set	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Incomrul	incompatible rules	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Inconsis	inconsistent	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Noresorc	inadequate resources	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree

Topdown	top down decisions	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Inddecin	independent decisions	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Bureac	bureaucarcy	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Nonpart	limited part dec	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
noconcng	no consult change	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Novalue	no value decisions	1	Strongly agree
		2	**********
		3	**********
		4	**********
		5	Strongly disagree
Peer team	peer team	1	Very litle
		2	Little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Peerlist	peer listen	1	Very litle
		2	Little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Subexpet	subordinate expectations	1	Very litle
		2	Little
		3	A moderate amount
		4	Quite a lot
		5	A great deal

Subpeers	approaching subordinates	1	Very litle
		2	Little
		3	A moderate amount
		4	Quite a lot
		5	A great deal
Disch	community ineviteable	1	Very unlikely
		2	Not likely
		3	Unsure
		4	Quite likely
		5	Very likely
Commpoor	past service	1	Very unlikely
		2	Not likely
		3	Unsure
		4	Quite likely
		5	Very likely
Pubacc	community acceptance	1	Very unlikely
		2	Not likely
		3	Unsure
		4	Quite likely
		5	Very likely
Commint	valued comm lives	1	Very unlikely
		2	Not likely
		3	Unsure
		4	Quite likely
		5	Very likely
Poorcare	community poor	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Hospsafe	hospitals safer	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Commpos	community excellent	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Poores	never adequate resources	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree

Indcont	ind contact	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Combest	commbest	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Hospbest	hospbest	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Comman	effective comm management	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Newskills	new skills	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Envirmnt	appreciate environment	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Commpart	participation skills	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Indepenc	independence	1	Agree
		2	Tend to agree
		3	Uncertain
		4	Tend to disagree
		5	Disagree
Othercom	other community schemes	1	Yes
		2	No

SECTION C - ROLE EFFECTIVENESS

NAME	VARIABLE	VALUES	VALUE LABEL
Roleimp	role value	1	1
		2	2
		3	3
Valtrain	value previous training	1	1
		2	2
		3	3
Routine	routine variety	1	1
		2	2
		3	3
Oldskills	previous learning	1	1
		2	2
		3	3
Rolesat	role enjoyment	1	1
		2	2
		3	3
Roleauty	role autonomy	1	1
		2	2
		3	3
Learnopp	new learning	1	1
		2	2
		3	3
Strespos	stress positive	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresobj	stress objective	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Strestep	stress analysis	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always

Stresalt	stress alternative	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresexp	past experiences	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresknow	explore options	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Strestalk	explore lay persons	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresact	positive action	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresfam	family sharing	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresfrnd	friend sharing	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresexs	stress exercise	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Strespes	stress pessimism	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always

Stresproj	stress projection	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Streseat	stress food	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresmoke	stress smoke	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresint	stress introversion	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresavod	stress avoidance	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresopt	stress optimism	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresalc	stress alcohol	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Stresdrg	stress drugs	1	Never
		2	Almost never
		3	Sometimes
		4	Often
		5	Almost always
Support	support	1	Yes
		2	No
Morestaf	more staff	1	Yes
		2	No

Timeoff	time off	1	Yes
		2	No
Training	training	1	Yes
		2	No
Relaxamr	relaxed atmosphere	1	Yes
		2	No
Personst	personal approach	1	Yes
		2	No
Other	what else	1	Yes
		2	No

SECTION D - JOB SATISFACTION

NAME	VARIABLE	VALUES	VALUE LABEL
Income	income	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Jobsecty	job security	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Hourwork	hours worked	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Hourflex	flexibility of hours	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Travel	travel	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Mansuper	management supervision	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied

Peerel	peer relationships	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Promotion	opp for advancement	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Respect	respect	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Personac	personal accomplishment	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Skilldev	skill development	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Challenge	challenges	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Tasks	actual taks	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Taskvar	variety of tasks	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Initiatv	initiative	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied

Workphys	physical conditions	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Workgen	work in general	1	Very satisfied
		2	Quite satisfied
		3	Neither one/other
		4	Quite satisifed
		5	Very satisfied
Best like	best Items	POST CODE	
Lesslike	least liked items	POST CODE	
Jobsatpr	job satisfaction ratio	1	< 20% time
		2	21 - 40% time
		3	41 - 80%time
		4	>80% time
Jobprob	job problems	POST CODE	
Jobchange	changes in job	POST CODE	
Meetings	out of house meetings	1	None
		2	1 - 3
		3	4 - 6
		4	7 - 10
		5	>10
Meetmont	meetings monthly	1	None
		2	1 - 3
		3	4 - 5
		4	>5
IPP	ipp	1	None
		2	1 - 2
		3	3 - 4
		4	>4
Bosscon	conversation with boss	1	Once month
		2	Once 2 - 3 week
		3	Once week
		4	Several times/week
		5	3 - 4 times/week
Bossuprt	support from boss	1	Never
		2	Sometimes
		3	Usually
		4	Always

Dutyboss	boss on duty	1	<50%
		2	50%
		3	>50%
Shiftnos	shift numbers	1	Work alone
		2	1
		3	2
		4	3
		5	>4
Leaving	leaving	1	Never
		2	Very rarely
		3	Occasionally
		4	Every day
Volhrs	hours voluntary	1	Never
		2	Very rarely
		3	Occasionally
		4	Every day
Suppfam	family support	1	1 Least Ideal
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Ideal
Preoctpn	preoccupation work	1	Very rarely
		2	Occasionally
		3	Every day
Promotion	possibility of promotion	1	Very unlikely
		2	Possibly
		3	Fairly likely
Jobsuprt	job support	1	Line manager
		2	Peers
		3	Subordinates
		4	Members MDT
		5	Others
Suphelp	support help	1	Yes
		2	No
Supaction	support action	1	Yes
		2	No
Supadvce	support advice	1	Yes
		2	No
Supconfd	support confidence	1	Yes
		2	No
Suplistg	support listening	1	Yes
		2	No

Supexpln	support explanation	1	Yes
		2	No
Supinst	support interest	1	Yes
		2	No
Supencge	support encouragement	1	Yes
		2	No
Bossat	feedback from boss	1	Always know
		2	Usually know
		3	Sometimes know
		4	Often in dark
		5	Usually dont know
Jobclart	job clarity	1	Yes
		2	No

SECTION E - CHARACTERISTICS OF THE ORGANISATION

NAME	VARIABLE	VALUES	VALUE LABEL
Quality	quality	1	1 Never True
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Always True
Residents	residents	1	1 Never True
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Always True
Intouch	in touch	1	1 Never True
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Always True
Friendly	public image	1	1 Never True
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Always True
Innovate	innovation	1	1 Never True
		2	2 **********
		3	3 **********
		4	4 **********
		5	5 Always True

Visible	managers visible	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Mission	public missiom	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Mission	public mission	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Philosophy	public philosophy	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Values	public values	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Infoshare	information sharing	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Lowconft	open management	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Newideas	risk taking	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Creative	creativity	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True

Failsupt	learn from failures	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Respnsby	staff responsibility	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Bottup	bottom up	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
MDT	multidisciplinary teams	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True
Casmeet	casual meetings	1	1	Never True
		2	2	**********
		3	3	**********
		4	4	**********
		5	5	Always True

SECTION F - GENERAL QUESTIONS

NAME	VARIABLE	VALUES	VALUE LABEL
Creche	creche	1	Yes
		2	No
Transprt	transport	1	Yes
		2	No
Sports	sports	1	Yes
		2	No
Soclub	social club	1	Yes
		2	No
Housing	housing	1	Yes
		2	No
Singacc	single accommodation	1	Yes
		2	No

Qualtran	qualifying training	1	Yes
		2	No
Instrain	in service training	1	Yes
		2	No
Shifts	flexible shifts	1	Yes
		2	No
Uniform	uniforms	1	Yes
		2	No
Unifall	uniform allowances	1	Yes
		2	No
Promotion	career advancement	1	Yes
		2	No
Prepared	preparation for transfer	1	Well prepared
		2	Reasonably prep
		3	unreasonably prep
		4	unprepared

CODE BOOK - QUESTIONS SPECIFIC TO MANAGERS

SECTION D - JOB SATISFACTION

NAME	VARIABLE	VALUES	VALUE LABEL
Staffdep	staff departures	1	None
		2	1 - 5
		3	6 - 10
		4	11 - 15

SECTION E - MANAGEMENT SKILLS AND PERFORMANCE

NAME	VARIABLE	VALUES	VALUE LABEL
Motivating	motivating	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Teambld	team building	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Commcat	communicating	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Grivance	grievances	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Discplin	disciplinary	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Chairing	chairing meetings	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp

Briefing	briefing	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Intstaf	interviewing	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Networks	networking	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Leading	leadership	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Influenc	influencing others	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Timeman	time management	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Selfass	self assessment	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Presents	presentations	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Reports	report writing	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp

Decisions	decision making	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Planning	planning	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Targets	goal setting	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Orgtask	organising tasks	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Probsolv	problem solving	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Design	design	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Delegate	delegating	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Allocate	allocating work	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Jobass	job assessment	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp

Counsell	counselling staff	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Jobdesc	job descriptions	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Finance	finance	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Ownskill	developing own skills	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Monqual	monitoring quality	1	1 Least imp
		2	2 *********
		3	3 *********
		4	4 *********
		5	5 Most imp
Feedback	importance of feedback	1	None
		2	Some
		3	Quite a lot
		4	Much.

APPENDIX FIVE

RESPONSES TO COMMENTARY TYPE QUESTIONS

STAFF AND MANAGERS

TABLE ONE

The things best liked about your job -

	Percentage Mentioning Item	
	STAFF	MANAGERS
Direct involvement with clients -	33	25
Freedom to plan the working day -	5	-
Challenges -	11	8
Variety of activities -	11	8
Flexibility -	5	8
Developing new ideas/pioneering -	5	16
Fun -	5	-
Independence -	8	-
Ability to influence decisions -	8	16
Giving residents a positive future -	5	-
Make own decisions -	5	16
Creativity -	8	-
Meeting people -	5	-
Teamwork -	5	-
Staff support -	5	16
Taking people into community -	11	-
Family/warm atmosphere -	5	-
Security of work position -	-	8
	n=36	n=12

The results presented in this appendix reflect the responses provided by staff and managers to a series of 'open questions' in the questionnaire. They relate to a number of points raised by members of the sample and since there was no limit to the number of points a person could mention the answers cannot be totalled. The responses are therefore recorded as percentage frequencies for each of the main subject areas mentioned.

TABLE TWO

The things least liked about your job

	Percentage Mentioning Item	
	STAFF	MANAGERS
No trust in policy makers -	8	-
Too many bosses -	8	-
Paper work -	22	20
Bureaucratic organisation -	16	8
Financial procedures -	11	8
Absence of support from boss -	5	16
Inadequate numbers of staff -	8	8
Loneliness -	8	-
Uncertainty of the future -	5	8
Conflict between aims and practice -	11	-
Overlap with homelife -	5	-
Stress -	5	8
Inadequate clerical support -	11	16
Long hours -	8	8
No breaks -	5	-
Disagreements between staff -	11	-
Counselling staff -	5	16
Housework/domestic tasks -	11	-
Conflict between professionals -	-	8
Inadequate finances -	11	11
Restrictive policies -	11	8
	n=36	n=12

TABLE THREE — Percentage Mentioning Item

What are the main problems in your job?

		STAFF	MANAGERS
Bosses competing for position	-	5	-
Prolonged decision making	-	5	8
Not enough time	-	5	11
Poor relations with staff	-	19	8
Not enough time to supervise staff	-	5	11
Day care clients	-	8	8
Low DSS benefits	-	11	11
No day care	-	8	8
Defining responsibilities	-	5	-
Attitude between past and present	-	11	8
Staff shortages	-	19	11
Traditional support services	-	5	11
Balancing priorities and resources	-	5	8
Pace of developments	-	5	8
Breaking new ground/no ground rules	-	11	8
Difficult clients	-	5	-
Staff apathy	-	8	8
Acute illness of client	-	5	-
Multidisciplinary team conflicts	-	11	8
Staff turnover	-	11	8
Wrong mix of clients	-	5	-
Juggling resources	-	5	8
Communication problems	-	11	8
Problems with Social Services	-	-	8
Inflexible finances	-	11	8
Recruiting appropriate staff	-	11	8
Over-zealousness of some staff	-	5	-
Public attitudes	-	11	8
Paperwork	-	11	8
		n=36	n=12

TABLE FOUR

Is there anything that you would like to change at work?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Decision making machinery -	3	8
Fewer managers -	3	-
More money -	11	25
Improve relationships -	3	8
Improve accountability -	5	8
Knowledge of budget -	5	-
More contact with boss -	11	-
More team building -	11	25
Defining responsibilities -	3	-
Less links with hospitals -	11	8
More staff -	5	8
More training -	11	11
More support -	5	8
More day care -	11	8
No changes -	14	-
Less clients -	3	-
Less paperwork -	14	25
More independence for clients -	11	25
More bank staff -	3	-
Shorter working week -	11	-
More psychiatric input -	3	-
Less bureaucracy -	8	16
Staff appraisals -	5	16
More multidisciplinary meetings -	3	16
Educate the public more -	8	8
Decentralise administration -	3	16
Unite health and social services -	-	16
Improve location of service -	-	8
Ensure staff feel secure -	-	16
	n=36	n=12

TABLE FIVE

What features of the old hospital culture were you pleased to leave behind.

	Percentage Mentioning Item	
	STAFF	MANAGERS
Large wards -	11	25
Work conditions -	14	25
Administration -	14	17
Food trolleys -	5	-
Uniforms -	8	8
Task orientated approach -	14	25
Autocratic approach -	11	17
Lack of flexibility -	17	25
No individuality -	17	17
Rigid procedures/rules -	14	25
Negative client attitudes -	14	42
No client engagement -	14	25
Loud music/T.V. -	14	42
No consultation with clients -	17	17
Wasted manpower at man. level -	14	17
Inferior status -	5	-
Financial procedures/rationing -	8	17
Delay for maintenance -	14	25
High sickness levels -	8	17
No opportunity for normalisation -	17	25
Lack privacy for residents -	14	17
Laundry problems -	5	8
Destructive grapevine -	11	17
Infighting -	11	8
Overcrowding -	16	17
Poor staffing levels -	16	42
Block treatment/regimentation -	11	25
Rushing to finish tasks -	5	-
Overbearing management structure -	8	-

No autonomy	-	8	17
Impersonal bathrooms	-	5	-
Bland food	-	8	8
Degrading treatments	-	11	17
No insight to poor care practice	-	17	25
Selfish staff attitudes	-	11	25
Union domination	-	17	42
Ancillary staff difficulties	-	17	33
Interruptions from visitors	-	14	17
Long drug rounds	-	14	17
Fire alarm testing	-	5	-
Never ending telephone	-	5	8
Conflict day and night staff	-	17	-
Isolated from community	-	8	17
Mass activities for residents	-	11	17
Conflicts between two shifts	-	11	8
Abusive staff	-	14	17
Lack of management insight	-	14	8
Elitism between staff ranks	-	8	-
No creative work with clients	-	11	17
Poor resident skill development	-	11	8
Uniforms	-	14	25
Large closed community	-	17	25
None	-	11	5
		n=36	n=12

TABLE SIX

What features of the old hospital culture do you miss most?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Not being disturbed at home -	5	17
Contact with friends/peers -	17	25
Friendly atmosphere -	5	8
Many residents to share with -	17	17
The concept of a 'ward team' -	3	8
Support services -	5	8
Social aspects -	14	33
Less isolation -	11	33
Social Club -	11	8
Larger peer group -	3	-
Meeting many old friends -	3	17
Sports facilities -	5	8
Sharing experiences -	3	8
Comradeship-community spirit -	5	8
Reliability of organisation -	3	-
The 'characters' -	5	8
Idle gossip - escapism - fun -	11	25
Dining room -	14	8
Meal breaks -	5	-
Change of scenery -	3	8
Hospital grounds -	8	-
No sleep-in duties -	3	-
Staff at hand to help -	5	8
More able clients -	3	-
Administrative support -	5	8
Regular hospital routine -	3	-
Opportunity to meet non nurses- satisfaction - poor resources but a job well done! -	3	25 -
None -	17	33
	n=36	n=12

TABLE SEVEN

What features of the old hospital culture still apply to the community service?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Certain policies (drugs, fire) -	11	5
Residents attend trad day care -	3	8
Financial bureaucracy -	5	8
In-house procedures -	14	-
No local budgets -	5	-
Poor staff/resident ratios -	11	17
Restricted choice -	3	-
Medical domination -	3	-
High professional standards -	3	-
Resident's institutional behaviours-	5	-
Division between staff/residents -	5	8
Division between clients/community -	3	-
Entrenched staff attitudes -	8	17
Strong team work -	3	-
Use of medicines -	5	-
In service training -	3	-
Paperwork -	11	8
Rude members of the public -	3	8
Shift systems -	5	8
Locked doors in community houses -	5	-
Low staffing levels -	8	17
Poor resources -	8	17
Daily routines -	11	8
Adapted student nurse training -	8	17
Supplies network -	-	8
Management hierarchy -	8	8
'Old habits die hard' attitudes! -	8	17
None -	14	8
	n=36	n=12

TABLE EIGHT

What ideas have you for bridging the gap between hospital and community for staff?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Intensive induction courses -	25	50
In service training -	28	50
Placements with community teams -	8	-
Relief work in the community -	3	-
Secondment to houses prior move -	11	17
Information and resettlement days -	3	5
Newsletters -	3	5
Exchange schemes -	8	5
Early involvement in commissioning -	8	5
Early appointments -	3	5
Visits to community services -	3	5
Discussion groups -	11	-
Preparation for responsibility -	5	5
Working with clients early on -	3	-
More staff to avoid single working -	5	-
Avoid 'fear of the unknown' -	8	5
Workshops to explore staff feelings-	3	5
Pre-move staff attitude check -	5	5
Advice from parents and consumers -	-	17
Strong teamwork -	11	17
Individual counselling -	5	17
Mutual support groups pre-move -	-	5
Videos of future workplaces -	-	5
Job opportunities forum in hospital-	-	5
Use friend networks to support -	-	25
New educational strategy for staff -	-	5
New educational strategy for RNMH -	-	17
Introduction to Personal Planning -	-	17
	n=36	n=12

TABLE NINE

What ideas have you for bridging the gap between hospital and community for residents?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Training to prepare for choice -	3	5
Early exposure to new homes -	3	5
Meet residents already in community -	3	-
Invite residents to see commissioning-	3	-
Intensify IPP system -	8	17
More daily opportunities -	8	5
Trial periods in new home -	3	5
Staff to be employed early on -	8	17
More individual work with clients -	8	17
Phased visits to new homes over tea -	8	17
Choice in all aspects (furnishings) -	11	25
Choice of whom they will live with -	8	25
Experiential training preparation -	5	17
Involvement with relatives -	5	5
Keep close friends/peers together -	25	25
Maintain valued ties and connections -	25	25
Full participation in the house -	25	25
Use half way houses for adjustment -	8	5
Informed choice re new expectations -	25	17
Improve/prepare public relations -	11	17
Move at their own pace -	22	42
Adequate staffing & money -	11	50
Sympathetic and supportive staff -	11	17
Assess risks and responsibilities -	8	17
Stimulate interest in appearance -	8	-
Encourage self-advocacy -	8	17
Involve in staff selection -	11	17
	n=36	n=12

TABLE TEN

What else would help to reduce stress in the environment?

	Percentage Mentioning Item	
	STAFF	MANAGERS
Specialist counselling service -	5	16
Closer links with mangers -	11	8
Social gatherings - functions -	14	7
Phasing demands for work outputs -	8	-
A clearer plan for the future -	8	8
Research and appraisal of resources -	14	33
Management commitment for comm.care -	11	17
Valued day care for residents -	8	8
Maintaining respect for staff -	3	17
More contact with colleagues -	14	17
Stress workshops -	11	8
Group and Social Activities -	14	17
Effective performance reviews -	11	25
Personal training plan -	14	25
Rationalise management structure -	25	35
More trust between team members -	17	25
Service evaluation -	11	33
'Time out' to appraise the service -	14	58
Effective communication networks -	22	17
Publication of service goals/values -	28	42
	n=36	n=12

APPENDIX SIX

MANAGEMENT SKILLS AND PERFORMANCE: - % RESPONSES BY MANAGERS:

N=12

SKILL Importance in job	1	2	3	4	5
Motivating people to do things	-	-	-	25	75
Building a good team	-	-	8	17	75
Communicating Well	-	-	8	25	67
Handling grievances	-	25	42	33	-
Disciplining subordinates	-	25	33	42	-
Chairing/conducting meetings	-	17	25	42	17
Briefing people	-	-	10	58	33
Interviewing	-	-	23	50	27
Getting on with other people	-	8	8	42	42
Leading a group	-	8	-	25	67
Persuading/influencing others	-	-	8	33	58
Managing your time	8	-	33	25	33
Assessing yourself	-	25	25	33	17
Making presentations	8	16	33	42	-
Writing reports	8	8	58	16	8
Making decisions	-	-	-	25	75
Planning work	8	-	17	15	33
Setting targets/goals	8	-	17	58	17
Organising people and tasks	8	-	-	42	50
Analysing/diagnosing problems	-	-	25	50	25
Designing/implementing systems	-	-	58	33	8
Delegating	-	8	17	58	17
Allocating work	-	-	42	50	8
Assessing staff job performance	-	17	42	15	25
Counselling/developing staff	-	8	25	33	33
Writing job descriptions	25	33	33	8	-
Costing/financial matters	8	-	67	-	17
Developing own job skills	8	-	50	25	17
Monitoring quality of care	-	8	17	75	-

5 = most important ranking.
(All rows may not add up to 100% due to rounding).

APPENDIX SEVEN

TABLE ONE

RESPONSES TO STRESS - STAFF AND MANAGERS:

When you are confronted with a stressful situation how do you typically cope? Percentage of responses given by STAFF:

N=36	never	almost never	some-times	often	almost always
Try to see the positive side of the situation	-	-	28	50	22
Try to step back from the situation to be objective	-	3	25	57	17
Take things one step at a time	-	3	22	39	36
Consider several alternatives for handling the problem	-	-	22	39	39
Remember that I was in a similar situation before and draw on my past experience	-	3	17	42	39
Try to find out more about the situation	-	-	6	36	58
Talk with a professional outside of work eg. clergyman.	45	31	14	8	3
Take some positive action	-	-	20	28	53
Talk with spouse or relative	7	8	37	25	25
Talk with friend about problem	14	14	42	22	8
Exercise more	11	42	22	22	3
Prepare myself for the worst	8	19	50	22	-
Take it out on other people when I feel angry or depressed	36	25	33	6	-
Try to reduce tension by eating more	58	17	14	8	3
Try to reduce tension by smoking more	61	8	17	8	6
Keep my feelings to myself	6	22	47	25	-
Get busy with other things in order to keep my mind off the problem	14	19	42	25	-
Think that everything will probably work out all right and not worry about it.	14	33	36	17	-
I like to relax over a few drinks at the end of the day	33	22	28	8	8
An occasional drink is better than taking tranquillisers	25	6	14	6	50

(Rows may not add up to 100% due to rounding errors).

TABLE TWO

When you are confronted with a stressful situation how do you typically cope? Percentage of responses given by MANAGERS:

N=12	never	almost never	some-times	often	almost always
Try to see the positive side of the situation	-	-	25	42	33
Try to step back from the situation to be objective	-	-	25	50	25
Take things one step at a time	-	8	8	42	42
Consider several alternatives for handling the problem	-	-	17	58	25
Remember that I was in a similar situation before and draw on my past experience	-	-	25	50	25
Try to find out more about the situation	-	-	-	50	50
Talk with a professional outside of work eg. clergyman.	17	33	42	8	-
Take some positive action	-	-	17	50	33
Talk with spouse or relative	-	33	8	33	25
Talk with friend about problem	-	42	33	17	8
Exercise more	33	25	8	8	25
Prepare myself for the worst	17	25	50	8	-
Take it out on other people when I feel angry or depressed	25	50	8	8	8
Try to reduce tension by eating more	67	17	17	-	-
Try to reduce tension by smoking more	92	-	8	-	-
Keep my feelings to myself	-	33	42	8	17
Get busy with other things in order to keep my mind off the problem	8	8	67	8	8
Think that everything will probably work out all right and not worry about it.	8	33	50	-	8
I like to relax over a few drinks at the end of the day	33	33	17	17	-
An occasional drink is better than taking tranquillisers	42	-	25	17	17

(Rows may not add up to 100% due to rounding errors).

APPENDIX EIGHT

RELATIONSHIPS BETWEEN VARIABLES

STAFF

TABLE B8.1

The Relationship between Job Satisfaction and Total Service (staff).

Job Satisfaction	Length of Service up to and including 10 Years		More than 10 Years		Row Total	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	7	36.8	12	63.2	19	52.8
% Satisfied for more than 80% of the time	7	41.2	10	58.8	17	47.2
Column Total		38.9		61.2	36	100

Significance **P= 1.0000**

TABLE B8.2

The Relationship between Job Satisfaction and Days Training (staff).

Job Satisfaction	Days Training < 1		2 - 5		6 - 10		11 - 20		21>		Row Total	
	No	%	No	%	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	10.5	4	21.5	5	26.3	6	31.6	2	10.5	19	52.8
% Satisfied for more than 80% of the time	7	41.2	2	11.8	3	17.6	2	11.8	3	17.6	17	47.2
Column Total	25		16.7		22.2		22.2		13.9		36	100

Significance **P= .1953**

TABLE B8.3

The Relationship Between Job Satisfaction and Attitude to Community Care (staff).

How Likely is it that all M.H.People will Live in the Community?

Job Satisfaction	Not Likely		Likely		Very Likely		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	62	31.6	8	42.1	5	26.3	19	52.8
% Satisfied for more than 80% of the time	5	29.4	9	52.9	3	17.6	17	47.2
Column Total		30.6		47.2		22.2	36	100

Significance **P= .54029**

TABLE B8.4

The Relationship between Job Satisfaction and Job Variety (staff).

Length of Service

Job Satisfaction	Little		Some		Quite a Lot		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	3	15.8	5	26.3	11	57.9	19	52.8
% Satisfied for 80% or more of the time	4	23.5	4	23.5	9	52.9	17	47.2
Column Total		19.4		25		55.6	36	100

Significance **P= .8420**

TABLE B8.5

The Relationship between Job Satisfaction and Non-Client Contact (staff).

Non-Client Contact

Job Satisfaction	Little		Some		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	7	36.8	6	31.6	6	31.6	19	52.8
% Satisfied for more than 80% of the time	4	23.5	8	47.1	5	29.4	17	47.2
Column Total	30.6		38.9		30.6		36	100

Significance **P= .5807**

TABLE B8.6

The Relationship Between Job Satisfaction and Working Alone (staff).

How Often do you Work Alone?

Job Satisfaction	Little		Quite a Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	10.5	3	15.8	14	73.7	19	52.8
% Satisfied for more than 80% of the time	4	23.5	4	23.3	9	52.9	17	47.2
Column Total	16.7		19.4		23		36	100

Significance **P= .4084**

TABLE B8.7

The Relationship Between Job Satisfaction and Feedback From the Boss (staff).

Feedback From the Boss

Job Satisfaction	Usually		Sometimes		Little		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	14	73.7	2	10.5	3	15.8	19	52.8
% Satisfied for more than 80% of the time	9	52.9	3	17.6	5	29.4	17	47.2
Column Total	63.9		13.9		22.2		36	100

Significance **P= .4315**

TABLE B8.8

The Relationship between Job Satisfaction and Flexibility of Hours (staff).

Flexibility of Hours

Job Satisfaction	Very Sat		Satisfied		Very Sat		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	4	21.1	1	57.9	4	21.1	19	52.8
% Satisfied for more than 80% of the time	4	23.5	12	70.6	1	5.9	17	47.2
Column Total	22.2		63.9		13.9		36	100

Significance **P= .4194**

TABLE B8.9

The Relationship between Job Satisfaction and Responsibility (staff).

I Know What my Responsibilities Are

Job Satisfaction	Agree ++		Agree		Indifferent		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	9	47.4	7	36.8	3	15.8	19	52.8
% Satisfied for more than 80% of the time	6	35.3	10	58.8	1	5.9	17	47.2
Column Total	41.7		47.2		11.1		36	100

Significance **P= .3634**

TABLE B8.10

The Relationship Between Job Satisfaction and Authority (staff)

I am Certain How Much Authority I Have

Job Satisfaction	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	4	21.1	9	47.4	6	31.6	19	52.8
% Satisfied for more than 80% of the time	4	23.5	9	52.9	4	23.	17	47.2
Column Total	22.2		50		27.8		36	100

Significance **P= .8651**

TABLE B8.11

The Relationship Between Job Satisfaction and Role Expectation (staff).

I Know Exactly What is Expected of Me

Job Satisfaction	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	26.3	11	57.9	3	15.8	19	52.8
% Satisfied for more than 80% of the time	2	11.8	12	70.5	3	17.6	17	47.2
Column Total	19.4		63.8		16.7		36	100

Significance **P= .6657**

TABLE B8.12

The Relationship Between Job Satisfaction and Role Enjoyment (staff).

Role Enjoyment by Proportion

Job Satisfaction	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	8	42.1	11	57.9	19	52.8
% Satisfied for more than 80% of the time	12	70.6	5	29.4	17	47.2
Column Total	55.6		44.4		36	100

Significance **P= .1673**

TABLE B8.13

The Relationship between Job Satisfaction and Staff Development/Performance Review (staff).

Have you had a Development Review in the Last Year?

Job Satisfaction	Yes		No		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	9	52.6	10	52.6	19	52.9
% Satisfied for more than 80% of the time	10	58.8	7	41.2	17	47.2
Column Total		52.8		47.2	36	100

Significance **P= .7241**

TABLE B8.14

The Relationship between Job Satisfaction and Role Clarity (staff).

Are You Always as Clear as you Would Like to be About Work?

Job Satisfaction	Yes		No		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	9	50	10	52.6	8	22.2
% Satisfied for more than 80% of the time	8	47.1	9	52.9	17	47.2
Column Total		47.2		52.8	36	100

Significance **P= 1.0000**

TABLE B8.15

The Relationship between Job Satisfaction and Propensity to Leave (staff).

Propensity To Leave

Job Satisfaction	Never		Very Rarely		Sometimes		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	34	21.1	7	36.8	8	42.1	19	52.8
% Satisfied for more than 80% of the time	4	23.5	8	47.1	5	29.4	17	47.2
Column Total	22.2		15		13		36	100

Significance **P= .7226**

TABLE B8.16

The Relationship between Propensity to Leave and Total Service (staff).

Length of Service

Leaving	up to and including 10 Years		More than 10 Years		**Row Total**	
	No	%	No	%	No	%
Never	4	50	4	50	8	22.2
Very Rarely	5	33.3	10	66.7	15	41.7
Sometimes	5	38.5	8	61.5	13	36.1
Column Total	38.9		61.1		36	100

Significance **P= .7366**

TABLE B8.17

The Relationship Between Propensity to Leave and Training Time (staff).

Days Training

Leaving	< 1		2 - 5		6 - 10		11 - 20		21>		**Row Total**	
	No	%	No	%	No	%	No	%	No	%	No	%
Never	3	37.5	1	12.5	1	12.5	2	25	1	12.5	8	22.2
Very Rarely	4	26.7	3	20	4	26.7	0	0	4	26.7	15	41.7
Sometimes	2	15.4	2	15.4	3	23.1	6	46.2	0	0	13	36.1
Column Total	25		16.7		22.2		22.2		13.9		36	100

Significance **P= .1529**

TABLE B8.18

Relationship Between Propensity to Leave and Attitude to Community Care (staff).

How Likely is it that all M.H. People will Live in the Community?

Leaving	Not Likely		Likely		Very Likely		**Row Total**	
	No	%	No	%	No	%	No	%
Never	0	0	3	37.5	5	62.5	8	22.2
Very Rarely	8	53.3	7	46.7	0	0	15	41.7
Sometimes	3	23.1	7	53.8	3	23.1	13	36.1
Column Total	30.6		47.2		22.2		36	100

Significance **P= .0054.**

TABLE B8.19

Relationship Between Propensity to Leave and Job Variety (staff).

Job Variety

Leaving	Little		Moderate		Quite a Lot		**Row Total**	
	No	%	No	%	No	%	No	%
Never	2	25	1	12.5	5	62.5	8	22.2
Very Rarely	2	13.3	7	46.7	6	40	15	41.7
Sometimes	3	23.1	1	7.7	9	69.2	13	36.1
Column Total	19.4		25		55.6		36	100

Significance **P= .1624.**

TABLE B8.20

The Relationship between Propensity to Leave and Non-Client Contact (staff).

Non-Client Contact

Leaving	A Little		Quite A Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
Never	3	37.5	3	37.5	2	25	8	22.2
Very Rarely	3	20	7	46.7	5	33.3	15	41.7
Sometimes	5	38.5	4	30.8	4	30.8	13	36.1
Column Total	30.6		38.9		30.6		36	100

Significance **P= .8239**

TABLE B8.21

The Relationship Between Propensity to Leave and Working Alone (staff).

How Often Do You Work Alone?

Leaving	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	0	0	2	25	6	75	8	22.2
Very Rarely	4	26.7	4	26.7	7	46.7	15	41.7
Sometimes	2	15.4	1	7.7	10	76.9	13	36.1
Column Total	16.7		19.4		63.9		36	100

Significance **P= .2982**

TABLE B8.22

The Relationship between Propensity to Leave and Feedback From the Boss (staff).

Feedback From the Boss

Leaving	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	7	87.5	1	12.5	0	0	8	22.2
Very Rarely	8	53.3	2	13.3	5	33.3	15	41.7
Sometimes	8	61.5	2	15.4	3	23.1	13	36.1
Column Total	63.9		13.9		22.2		36	100

Significance **P= .4596**

TABLE B8.23

The Relationship between Propensity to Leave and Flexibility of Hours Worked (staff).

Flexibility of Hours

Leaving	Very Sat		Quite Sat		Not Very Sat 1		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	2	1.8	5	75	0	0	8	22.2
Very Rarely	4	26.7	7	46.7	4	26.7	15	41.7
Sometimes	2	15.4	10	76.9	1	7.7	13	36.1
Column Total	22.2		63.9		13.9		36	100

Significance **P= .3014**

TABLE B8.24

The Relationship Between Propensity to Leave and Role Responsibility (staff).

I Know What My Responsibilities Are

Leaving	Agree++		Agree		Indifferent		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	4	50	4	50	0	0	8	22.2
Very Rarely	3	20	10	66.7	2	13.3	15	41.7
Sometimes	8	61.5	3	23.1	2	15.4	13	36.1
Column Total	41.7		47.2		11.1		36	100

Significance **P= .1336**

TABLE B8.25

The Relationship Between Propensity to Leave and Authority (staff).

I am Certain How Much Authority I Have

Leaving	Agree++		Agree		Disagree		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	4	50	3	37.5	1	12.5	8	22.2
Very Rarely	2	13.30	9	60	4	26.7	15	41.7
Sometimes	2	15.4	6	46.2	5	38.5	13	36.1
Column Total	22.2		50		27.8		36	100

Significance **P= .2499**

TABLE B8.26

The Relationship Between Propensity to Leave and Role Expectation (staff).

I Know Exactly What is Expected of Me

Leaving	Agree++		Agree		Disagree		**Row**	**Total**
	No	%	No	%	No	%	No	%
Never	4	50	4	50	0	0	8	22.2
Very Rarely	0	0	9.6	73.3	4	26.7	15	41.7
Sometimes	3	23.1	8	61.6	2	15.4	13	36.1
Column Total	19.4		63.8		16.7		36	100

Significance **P= .0825**

TABLE B8.27

The Relationship between Propensity to Leave and Role Enjoyment (staff)

Role Enjoyment by Proportion

Leaving	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Never	7	87.5	1	12.5	8	22.2
Very Rarely	5	33.3	10	66.7	15	41.7
Sometimes	8	61.5	5	38.5	13	36.1
Column Total	55.6		44.4		36	100

Significance **P= .0389**

TABLE B8.28

The Relationship between Propensity to Leave and Staff Development/Performance Review (staff).

Have You Had a Staff Development Review in the Last Year?

Leaving	Yes		No		**Row Total**	
	No	%	No	%	No	%
Never	4	50	4	50	8	22.5
Very Rarely	7	46.7	8	53.3	15	41.7
Sometimes	8	61.5	5	38.5		
Column Total	52.8		47.2		36	100

Significance **P= .7226**

TABLE B8.29

The Relationship between Propensity to Leave and Job Clarity (staff).

Are You Always as Clear as You Would Like to Be About Work?

Leaving	Yes		No		**Row Total**	
	No	%	No	%	No	%
Never	4	50	4	50	8	22.2
Very Rarely	8	53.3	7	46.7	15	41.7
Sometimes	5	38.5	8	61.5	13	36.1
Column Total	47.2		52.8		36	100

Significance **P= .7226**

TABLE B8.30

The Relationship Between Total Service and Days Training (staff).

Days Training

Total	< 1		2 - 5		6 - 10		11 - 20		21>		**Row Total**	
	No	%	No	%	No	%	No	%	No	%	No	%
Up to and including 10 yrs.	6	42.9	1	7.1	2	14.3	4	28.6	1	7.1	14	38.9
Over 10 years	3	13.6	5	22.7	6	27.3	4	18.2	4	18.2	22	61.1
Column Total	25		16.7		22.2		22.2		13.9		36	100

Significance **P= .2003**

TABLE B8.31

The Relationship Between Total service and Attitude to Community Care (staff).

How Likely is it That all M.H. People will be Discharged into the Community?

Total	Not Likely		Likely		Very likely		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	4	28.6	7	50	3	21.4	14	38.9
Over 10 years	7	1.8	10	45.5	5	22.7	22	61.1
Column Total	30.6		47.2		22.2		36	100

Significance **P= .9639**

TABLE B8.32

The Relationship between Total Service and Job Variety (staff).

Job Variety

Total	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	5	35.5	2	14.3	7	50	14	38.9
Over 10 years	2	9.1	7	31.8	13	59.1	22	61.1
Column Total	19.4		25		55.6		36	100

Significance **P= .1166**

TABLE B8.33

The Relationship between Total Service and Non-Client Contact (staff).

Non-Client Contact

Total	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	7	50	3	21.4	5	28.6	14	38.9
Over 10 years	4	18.2	11	50	7	31.8	22	61.1
Column Total	30.6		38.9		30.6		36	100

Significance **P= .0973**

TABLE B8.34

The Relationship Between Total Service and Working Alone (staff).

How Often Do You Work Alone?

Total	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	12	14.3	3	21.4	9	64.3	14	38.9
Over 10 years	4	18.2	4	4.3	14	63.6	22	61.1
Column Total	16.7		19.4		63.9		36	100

Significance **P= .9395**

TABLE B8.35

The Relationship between Total Service and Feedback From the Boss (staff).

Feedback From The Boss

Total	Little		Quite A Lot		Great Deal		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	10	71.4	2	14.3	2	14.3	14	38.9
Over 10 years	13	59.1	3	13.6	6	27.3	22	61.1
Column Total	63.9		13.9		22.2		36	100

Significance **P= .6519**

TABLE B8.36

The Relationship between Total Service and Flexibility of Hours Worked (staff).

Flexibility of Hours

Total	V. Sat		Quite Sat		Very Sat		**Row**	**Total**
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	3	3.1	9	64.3	2	14.3	14	38.9
Over 10 years	5	22.7	14	63.6	3	13.6	22	61.1
Column Total	22.2		63.9		13.9		36	100

Significance **P= .9952**

TABLE B8.37

The Relationship Between Total Service and Responsibility (staff).

I Know What My Responsibilities Are?

Total	Strongly Agree		Agree		Neither Agree or Not		**Row Total**	
Up to and including 10 yrs	No	%	No	%	No	%	No	%
	9	64.3	4	28.3	1	7.1	14	38.9
Over 10 years	6	27.3	13	59.1	3	13.6	22	61.1
Column Total	41.7		47.2		11.1		36	100

Significance **P= .0896**

TABLE B8.38

The Relationship Between Total Service and Authority (staff).

I Am Certain How Much Authority I Have

Total	Strongly Agree		Agree		Disagree		**Row Total**	
Up to and including 10 yrs	No	%	No	%	No	%	No	%
	4	28.6	8	57.2	2	14.3	14	38.9
Over 10 years	3	13.6	15	68.2	4	18.2	22	61.1
Column Total	19.4		23		16.7		36	100

Significance **P= .7088**

TABLE B8.39

The Relationship Between Total Service and Role Expectation (staff).

I Know Exactly What is Expected of Me

Total	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	4	28.6	8	57.2	2	14.3	14	38.3
Over 10 years	3	13.6	15	68.2	4	18.2	22	61.1
Column Total	19.4		63.8		16.7		36	100

Significance **P= .7088**

TABLE B8.40

The Relationship between Total Service and Role Enjoyment (staff).

Role Enjoyment by Proportion

Total	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	7	50	7	50	14	38.9
Over 10 years	13	59.1	9	40.9	22	61.1
Column Total	55.6		44.4		36	100

Fisher's Exact Test **P= .8484**

TABLE B8.41

The Relationship Between Total Service and Staff Development/Performance Review (staff).

Have You Had A Staff Development Review in the Past Year?

Total	Yes		No		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	7	50	7	50	14	38.9
Over 10 years	12	54.5	10	45.5	22	61.1
Column Total		52.8		47.2	36	100

Fisher's Exact Test **P= 1.0000**

TABLE B8.42

The Relationship between Total Service and Role Clarity (staff).

Are You Always as Clear as you Would Like to be About Work?

Total	Yes		No		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	6	57.1	8	57.1	14	38.9
Over 10 years	11	50	11	50	22	61.1
Column Total		47.2		52.8	36	100

Fisher's Exact Test **P= .9393**

APPENDIX EIGHT

RELATIONSHIPS BETWEEN VARIABLES

MANAGERS

TABLE A8.1

The Relationship between Job Satisfaction and Total Service (managers).

Job Satisfaction	Length of Service up to and including 10 Years		Length of Service More than 10 Years		Row Total	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	1	12.5	7	87.5	8	66.7
% Satisfied for more than 80% of the time	1	25	3	75	4	33.3
Column Total		16.7		83.3	12	100

Fisher's Exact Test **P= .57576**

TABLE A8.2

The Relationship between Job Satisfaction and Days Training (managers).

Job Satisfaction	Days Training: One Day		2 - 5 Days		6 - 10 Days		Row Total	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	62.5	2	25	1	12.5	8	66.7
% Satisfied for more than 80% of the time	0	0	2	50	2	50	4	33.3
Column Total		41.7		33.3		3	12	100

Significance **P= .1054**

TABLE A8.3

The Relationship Between Job Satisfaction and Attitude to Community Care (managers).

How Likely is it that all M.H.People will Live in the Community?

Job Satisfaction	Not Likely		Likely		Very Likely		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	25	2	62.5	1	12.5	8	66.7
% Satisfied for more than 80% of the time	2	50	2	25	1	25	4	33.3
Column Total	33.3		50		16.7		12	100

Significance **P= .4724**

TABLE A8.4

The Relationship between Job Satisfaction and Job Variety (managers).

Job Variety

Job Satisfaction	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	25	6	75	8	66.7
% Satisfied for more than 80% of the time	1	25	3	75	4	33.3
Column Total	25		75		12	100

Fisher's Exact Test **P= .76364**

TABLE A8.5

The Relationship between Job Satisfaction and Non-Client Contact (managers).

Non-Client Contact

Job Satisfaction	Quite a Lot		A Great Deal		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	1	12.5	7	87.5	8	66.7
% Satisfied for more than 80% of the time	4	100	0	0	4	33.3
Column Total		41.7		58.3	12	100

Fisher's Exact Test **P= .01010**

TABLE A8.6

The Relationship Between Propensity to Leave and Staff Training Time (managers).

Days Training

Job Satisfaction	< 1 Day		2 - 5 Days		6-10 Days		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	33.3	2	33.3	2	33.3	6	50
% Satisfied for more than 80% of the time	3	50	2	33.3	1	16.7	6	50
Column Total		41.7		33.3		25	12	100

Significance **P= .7659**

TABLE A8.7

The Relationship Between Job Satisfaction and Working Alone (managers).

How Often Do you Work Alone?

Job Satisfaction	Little		Quite a Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	0	0	2	25	6	75	8	66.7
% Satisfied for more than 80% of the time	1	25	2	50	1	25	4	33.3
Column Total	8.3		33.3		58.3		12	100

Significance **P= .1618**

TABLE A8.8

The Relationship between Job Satisfaction and Feedback from the Boss (managers).

Feedback from the Boss

Job Satisfaction	Usually		Sometimes		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	6	75	2	25	8	66.7
% Satisfied for more than 80% of the time	3	75	1	25	4	33.3
Column Total	75		25		12	100

Fisher's Exact Test **P= .76364**

TABLE A8.9

The Relationship between Job Satisfaction and Flexibility of Hours Worked (managers).

Flexibility of Hours

Job Satisfaction	Satisfied		Dissatisfied		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	6	75	2	25	8	66.7
% Satisfied for more than 80% of the time	4	100	0	0	4	33.3
Column Total		83.3		16.7	12	100

Fisher's Exact Test **P= .42424**

TABLE A8.10

The Relationship Between Job Satisfaction and Role Responsibility (managers).

I Know What my Responsibilities Are

Job Satisfaction	Strongly Agree		Agree		Neither Agree or Not		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	24	50	3	37.5	1	12.5	8	66.7
% Satisfied for more than 80% of the time	3	50	2	50	0	0	4	33.3
Column Total		50		41.7		8.3	12	100

Significance **P= .7408**

TABLE A8.11

The Relationship Between Job Satisfaction and Authority (managers).

I am Certain How Much Authority I Have

Job Satisfaction	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	2	25	4	50	2	50	8	66.7
% Satisfied for more than 80% of the time	1	25	2	50	1	25	4	33.3
Column Total	25		50		25		12	100

Significance **P= 1.0000**

TABLE A8.12

The Relationship Between Job Satisfaction and Role Expectation (managers).

I Know Exactly What is Expected of Me

Job Satisfaction	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	62.5	3	37.5	0	0	8	66.7
% Satisfied for more than 80% of the time	3	75	0	0	1	25	4	33.3
Column Total	66.7		3		8.3		12	100

Significance **P= .1684**

TABLE A8.13

The Relationship between Job Satisfaction and Role Enjoyment (managers).

Role Enjoyment by Proportion

Job Satisfaction	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	3	37.5	5	62.5	8	66.7
% Satisfied for more than 80% of the time	1	25	3	75	4	33.3
Column Total		33.3		66.7	12	100

Fisher's Exact Test **P= .59394**

TABLE A8.14

The Relationship between Job Satisfaction and Staff Development/Performance Review (managers).

Have you had a Development Review in the Last Year?

Job Satisfaction	Yes		No		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	62.5	3	37.5	8	66.7
% Satisfied for more than 80% of the time	2	50	2	50	4	33.3
Column Total		58.3		41.7	12	100

Fisher's Exact Test **P= .57576**

TABLE A8.15

The Relationship between Job Satisfaction and Role Clarity (managers).

Are you Always as Clear as you Would Like to be About Work?

Job Satisfaction	Yes		No		**Row Total**	
	No	%	No	%	No	%
% Satisfied for 80% or less of the time	5	62.5	3	37.5	8	66.7
% Satisfied for more than 80% of the time	1	25	3	75	4	33.3
Column Total	50		50		12	100

Fisher's Exact Test **P= .27273**

TABLE A8.16

The Relationship Between Job Satisfaction and Propensity to Leave (managers).

Propensity to Leave

Job Satisfaction	Never		Very Rarely		Sometimes		**Row Total**	
	No	%	No	%	No	%	No	%
% Satisfied for 80% or less of the time	1	12.5	2	25	5	62.5	8	66.7
% Satisfied for more than 80% of the time	0	0	3	75	1	25	4	33.3
Column Total	8.3		41.7		50		12	100

Significance **P= .2405**

TABLE A8.17

The Relationship between Propensity to Leave and Total Service (managers).

Leaving	Length of Service: up to and including 10 Years		Length of Service: More than 10 Years		Row Total	
	No	%	No	%	No	%
Never/Very Rarely	2	33.3	4	66.7	6	50
Sometimes	0	0	6	100	6	50
Column Total		16.7		83.3	12	100

Fisher's Exact Test **P= .22727**

TABLE A8.18

The Relationship Between Propensity to Leave and Attitude to Community Care (managers).

Leaving	How Likely is it that all M.H.People will Live in the Community? Not Likely		Likely		Very Likely		Row Total	
	No	%	No	%	No	%	No	%
Never/Very Rarely	2	33.3	3	50	1	16.7	6	50
Sometimes	2	33.3	3	50	1	16.7	6	50
Column Total		33.3		50		16.7	12	100

Significance **P= 1.0000.**

TABLE A8.19

The Relationship between Propensity to Leave and Job Variety (managers).

Job Variety

Leaving	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	3	50	3	50	6	50
Sometimes	0	0	6	100	6	50
Column Total	25		75		12	100

Fisher's Exact Test **P= .09091**

TABLE A8.20

The Relationship between Propensity to Leave and Non-Client Contact (managers).

Non-Client Contact

Leaving	Quite a Lot		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	3	50	3	50	6	50
Sometimes	2	33.3	4	66.7	6	50
Column Total	41.7		8.3		12	100

Fisher's Exact Test **P= .50000**

TABLE A8.21

The Relationship Between Propensity to Leave and Working Alone (managers).

How Often Do You Work Alone?

Leaving	Not Likely		Likely		Very Likely		**Row Total**	
	No	%	No	%	No	%	No	%
Never/Very Rarely	1	16.7	2	33.3	3	50	6	50
Sometimes	0	0	2	33.3	6	66.7	6	50
Column Total	8.3		33.3		58.3		12	100

Significance **P= .5647.**

TABLE A8.22

The Relationship between Propensity to Leave and Feedback From the Boss (managers).

Feedback From the Boss

Leaving	Usually		Sometimes		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	5	83.3	1	16.7	6	50
Sometimes	4	66.7	2	33.3	6	50
Column Total	75		25		12	100

Fisher's Exact Test **P= .50000**

TABLE A8.23

The Relationship between Propensity to Leave and Flexibility of Hours Worked (managers).

Flexibility of Hours

Leaving	Satisfied		Dissatisfied		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	6	100	0	0	6	50
Sometimes	4	66.6	3	33.3	6	50
Column Total	83.3		16.7		12	100

Fisher's Exact Test **P= .22727**

TABLE A8.24

The Relationship Between Propensity to Leave and Role Responsibility (managers).

I Know What my Responsibilities Are

Leaving	Strongly Agree		Agree		Neither Agree or Not		**Row Total**	
	No	%	No	%	No	%	No	%
Never/Very Rarely	3	50	3	50	0	0	6	50
Sometimes	3	50	2	33.3	1	16.7	6	50
Column Total	50		41.7		8.3		12	100

Significance **P= .5488**

TABLE A8.25

The Relationship Between Propensity to Leave and Authority (managers).

I am Certain How Much Authority I Have

Leaving	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Never/Very Rarely	0	0	4	66.7	2	33.3	6	50
Sometimes	3	50	2	33.3	1	16.7	6	50
Column Total	25		50		25		12	100

Significance **P= .1353**

TABLE A8.26

The Relationship Between Propensity to Leave and Role Expectation (managers).

I Know Exactly What is Expected of Me

Leaving	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Never/Very Rarely	4	66.7	1	16.7	1	16.7	6	50
Sometimes	4	66.7	2	33.3	0	0	6	50
Column Total	66.7		25		8.3		12	100

Significance **P= .5134**

TABLE A8.27

The Relationship between Propensity to Leave and Role Enjoyment (managers).

Role Enjoyment by Proportion

Leaving	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	2	33.3	4	66.7	6	50
Sometimes	2	33.3	4	66.7	6	50
Column Total	33.3		66.7		12	100

Fisher's Exact Test **P= .72727**

TABLE A8.28

The Relationship between Propensity to Leave and Staff Development/Performance Review (managers).

Have You Had a Staff Development Review in the Last Year?

Leaving	Yes		No		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	4	66.7	2	33.3	6	50
Sometimes	3	50	3	50	6	50
Column Total	58.3		41.7		12	100

Fisher's Exact Test **P= .50000**

TABLE A8.29

The Relationship between Propensity to Leave and Job Clarity (managers).

Are You Always as Clear as You Would Like to Be About Work?

Leaving	Yes		No		**Row Total**	
	No	%	No	%	No	%
Never/Very Rarely	1	16.7	5	83.3	6	50
Sometimes	5	83.3	1	16.7	6	50
Column Total	50		50		12	100

Fisher's Exact Test **P= .04004**

TABLE A8.30

The Relationship Between Total Service and Days Training (managers).

Days Training

Total	<1 Day		2-5 Days		6-10 Days		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	0	0	1	50	2	16.7
Over 10 years	4	40	4	40	2	20	10	83.3
Column Total	41.7		33.3		25		12	100

Significance **P= .4868**

TABLE A8.31

The Relationship Between Total service and Attitude to Community Care (managers).

How Likely is it That all M.H. People will be Discharged into the Community?

Total	Not Likely		Likely		Very likely		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	1	50	0	0	2	16.7
Over 10 years	3	30	5	50	2	20	10	83.3
Column Total	33.3		50		16.7		12	100

Significance **P= .7408**

TABLE A8.32

The Relationship between Total Service and Job Variety (managers).

Job Variety

Total	Not a Great Deal		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	2	100	0	0	2	16.7
Over 10 years	1	10	9	90	10	83.3
Column Total	25		75		12	100

Fisher's Exact Test **P= .04545**

TABLE A8.33

The Relationship between Total Service and Non-Client Contact (managers).

Non-Client Contact

Total	Quite A Lot		A Great Deal		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	1	50	1	5	2	16.7
Over 10 years	4	40	6	60	10	83.3
Column Total	41.7		58.3		12	100

Fisher's Exact Test **P= .68182**

TABLE A8.34

The Relationship Between Total Service and Working Alone (managers).

How Often Do You Work Alone?

Total	Little		Quite A Lot		Great Deal		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	0	0	1	50	2	16.7
Over 10 years	0	0	4	40	6	60	10	83.3
Column Total	8.3		33.3		58.3		12	100

Significance **P= .0542**

TABLE A8.35

The Relationship between Total Service and Feedback From the Boss (managers).

Feedback From The Boss

Total	Usually		Sometimes		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	1	50	1	5	2	16.7
Over 10 years	8	80	2	20	10	83.3
Column Total	75		25		12	100

Fisher's Exact Test **P= .45455**

TABLE A8.36

The Relationship between Total Service and Flexibility of Hours Worked (managers).

Flexibility of Hours

Total	Satisfied		Dissatisfied		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	2	100	0	0	2	16.7
Over 10 years	8	80	2	20	10	83.3
Column Total	83.3		16.7		12	100

Fisher's Exact Test **P= .68182**

TABLE A8.37

The Relationship Between Total Service and Responsibility (managers).

I Know What My Responsibilities Are

Total	Strongly Agree		Agree		Neither Agree or Not		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	0	0	2	100	0	0	2	16.7
Over 10 years	6	60	3	30	1	10	10	83.3
Column Total	50		41.7		8.3		12	100

Significance **P= .1864**

TABLE A8.38

The Relationship Between Total Service and Authority (managers).

I Am Certain How Much Authority I Have

Total	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	0	0	1	50	1	50	2	16.7
Over 10 years	3	30	5	50	2	20	10	83.3
Column Total	25		50		25		12	100

Significance **P= .5488**

TABLE A8.39

The Relationship Between Total Service and Role Expectation (managers).

I Know Exactly What is Expected of Me

Total	Strongly Agree		Agree		Disagree		**Row Total**	
	No	%	No	%	No	%	No	%
Up to and including 10 yrs	1	50	0	0	1	50	2	16.7
Over 10 years	7	70	3	30	0	0	10	83.3
Column Total	66.7		25		8.3		12	100

Significance **P= .0578**

TABLE A8.40

The Relationship between Total Service and Role Enjoyment (managers).

Role Enjoyment by Proportion

Total	Very Much		Sometimes		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	1	50	1	50	2	16.7
Over 10 years	3	30	7	70	10	83.3
Column Total	33.3		66.7		12	100

Fisher's Exact Test **P= .57576**

TABLE A8.41

The Relationship Between Total Service and Staff Development/Performance Review (managers).

Have You Had A Staff Development Review in the Past Year?

Total	Yes		No		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	2	100	0	0	2	16.7
Over 10 years	5	50	5	50	10	83.3
Column Total	58.3		41.7		12	100

Fisher's Exact Test **P= .31818**

TABLE A8.42

The Relationship between Total Service and Role Clarity (managers).

Are You Always as Clear as you Would Like to be About Work?

Total	Yes		No		**Row Total**	
	No	%	No	%	No	%
Up to and including 10 yrs	0	0	1	100	2	16.7
Over 10 years	6	60	4	40	10	83.3
Column Total	50		50		12	100

Fisher's Exact Test **P= .22727**

Bibliography

Statutes

8 & 9 Vict., C.100. County Lunatic Asylum Regulation Act, (1845).

16 & 17 Vict., C.97. The Lunatic Asylums Act, (1853) .

23 & 24 Vict., C.97. Criminal Lunatics Asylums Act ,, (1858).

47 & 48 Vict., C.64. The Criminal Lunatics Act, (1884).

49 & 50. Vict., C.25. The Idiots Act, (1886)

49 & 50. Vict., C.34. The Local Government Act, (1886).

3 & 4 Geo. V., C.28. Mental Deficiency Act ,(1913).

9 & 10 Geo. V., C.94. Registration of Nurses Act, (1919).

7 & 18 Geo. V., C.33. Mental Deficiency Act, (1927).

19 & 20 Geo. V., C.17. The Local Government Act, (1929).

7 & 8 Geo. VI., C.31. The Education Act, (1944).

9 & 10 Geo.VI., C.81. National Health Service Act, (1946) .

11 & 12 Geo. VI., C.29. The National Assistance Act,(1948)

5 & 6 Eliz. II., C.15. The Nurses Act, (1957).

7 & 8 Eliz. II., C.7. Mental Health Act, (1959).

17 & 18 Eliz. II., C.20, The Chronically Sick and Disabled Persons Act (1970).

18 & 19 Eliz.II., C.52. The Education (Handicapped Children) Act, (1970), Cmnd. 5603.

19 & 20 Eliz. II., C.15. The Education (Handicapped Childrens) Act, (1971).

23 & 24 Eliz. II., C.81. The Education Act , (1976).

27 & 28 Eliz. II., C.36. Nurses, Midwives and Health Visitors Act.

29 & 30 Eliz. II., C.60. The Education Act:An Act to make Provision in Respect to Children with Special Needs, (1981).

31 & 32 Eliz. II., C.20. Mental Health Act, (1983) .

32 & 33 Eliz. II., C.23. Registered Homes Act, (1984), Part One, Para. One, P.379.

35 & 36 Eliz. II., C.33. The Disabled Persons(Services,Consultation and Representation) Act., (1986).

43 & 44 Eliz. II., C.19. The National Health Service and Community Care Act.

Official Reports

Annual Report of the Local Government Board Report on the Education of Girls in Pauper Schools,, (1873-4), Appendix, London.

Report of the Royal Commission on the Care and Control of the Feeble Minded, (1908), Cd. 4202, London, HMSO.

Royal Commission on the Poor-Laws and the Relief of Distress, (1909), Appendix, Vol. xxviii, Cd. 4499, London, HMSO.

Report of the Royal Commission on Lunacy and Mental Disorder , (1926), Cd.2700, London, HMSO.

Report of the Mental Deficiency Committee, Parts i-iv, (1929), London,HMSO.

Report of the Working Party on the Recruitment and Training of Nurses, (1947), (Chairman, Sir Robert Wood). HMSO, London.

Report of The Royal Commission on the Law relating to Mental Illness and Mental Deficiency, (1954-57), Cmd. 169, London, London.

Report of the Working Party on Social Workers in the Local Authority Health and Welfare Services, (1959), (Chairman, E.L. Younghusband), Ministry of Health, and Department of Health for Scotland, London, HMSO.

Report of the Committee on Senior Nursing Staff Structure, (1966), (Chairman B.Salmon), Ministry of Health, London.

Report of the Committee on Local Allied Personal Services, (1968) Cmnd. 3707, (Chairman F. Seebohm), London, HMSO.

Report of the Committee of Enquiry into Allegations of Ill-Treatment of Patients and other Irregularities at the Ely Hospital, Cardiff, (1969), National Health Service. Cmnd. 3975, London, HMSO.

Better Services for the Mentally Handicapped- 1970, Department of Health and Social Security/Welsh Office, Cmnd.4683, London, HMSO.

Report of the Farleigh Hospital Committee of Enquiry, (1971), National Health Service, Cmnd.4557, London, HMSO.

Report of the Committee on Nursing, (1972), (Chairman, Asa Briggs). Department of Health and Social Security, Cmnd. 5115, London.

Report of the Committee of Enquiry into South Ockenden Hospital (1974), National Health Service,HC124, London, HMSO.

Mentally Handicapped Children in Residential Care, The Report of a Study Group Appointed by the Secretary of State for Social Services, (1974) London, HMSO.

The Education of Mentally Handicapped Children and Young People in Hospital, (1974), Department of Education and Science 5/74, London, HMSO.

St Ebbas Hospital Inquiry Report, (1975), Merton, Sutton and Wandsworth Area Health Authority.

Better Services for the Mentally Ill, (1975), Department of Health and Social Security, Cmnd. 6233, London, HMSO.

The Report of the Committee on Child Health Services- 'Fit For The Future' (1976), (Chairman Professor S.D.M.Court), Cmnd. 6684, London, HMSO.

Special Educational Needs: Report of the Committee of Enquiry into the Education of Handicapped Children and Young People, (1978), (Chairman M.Warnock), Cmnd.7212, London. HMSO.

Report of the Committee of Enquiry into Normansfield Hospital , (1978), National Health Service, Cmnd. 7357, London, HMSO.

Report of the Committee of Enquiry into Mental Handicap Nursing and Care, Vol 1, (1979), (Chairman Jay, Peggy), Department of Health and Social Security, Cmnd. 7468-1, London, HMSO.

Second Report of the Social Services Select Committee on Community Care with Special Reference to the Adult Mentally Ill and Mentally Handicapped People, (1985) Dept. Health and Social Security, London. (Chairman Short, Renee).

Government's Response to the Social Service Select Committee Report on "Community Care with Special Reference to the Adult Mentally Ill and Mentally Handicapped People", 1985, Cmnd.9674, HMSO, London.

Community Care: Agenda for Action. - A Report to the Secretary of State for Social Services By Sir Roy Griffiths. 1988, Department of Health and Social Security, London, HMSO.

Residential Care: A Positive Choice and the Research Reviewed - Report of the Independent Review of Residential Care. Department of Health and Social Security, (1988) Vols. 1&2, (Chairman Lady Wagner), London, HMSO.

Working for Patients: The Health Services - Caring for the 1990s. Cm. 555, Department of Health, 1989, London.

Caring for People: Community Care in the Next Decade and Beyond - Department of Health, London, Cm. 849, 1989, HMSO.

People First: Community Care in Northern Ireland in the 1990s, - 1990, Department of Health and Social Services, Northern Ireland Office, Belfast, HMSO.

Fifth Report of the Social Services Select Committee - 'Community Care - Carers', Session 1989-90, 9th May 1990, London, HMSO.

Other Sources.

Abdellah, F, & Levine, E. (1987) Better Patient Care Through Nursing Research, 3rd Edition, Macmillan, London.

Abel-Smith, B. (1964) The Hospitals 1800 - 1948,, Heineman, London.

Abel-Smith, B. (1970) A History of the Nursing Profession., Heineman, London.

Adams, J.D, Hayes,J. & Hopkins, B. (1976) Transition: Understanding and Managing Personal Change, Martin Robertson, London.

Allen, P., Pahl, J., Quine, L. (1988) Staff in the Mental Handicap Services: A study of Change, Health Services Research Unit, University of Canterbury. Kent.

Allen, P., Pahl, J., Quine, L. (1988) Staff Opinion Survey in Staff in the Mental Handicap Services: A Study of Change, Health Services Research Unit, University of Kent, Canterbury. Kent.

Allinson, T. et al (1988) Stress Counselling in the Workplace - The Post Office Experience, The Psychologist, September 1989, p. 384-389).

Allison, G. (1971) Decision Analysis, Litle Brown, Boston, USA.

Appley,M.H., & Trumbell, H. (1967) Psychological Stress, Appleton-Century-Crofts, New York.

Anderson, M. (1971) Family Structure in Nineteenth Century Lancashire, Cambridge University Press, Cambridge.

Angrist, S.S. (1963) The Mental Hospital: Its History and Destiny, Perspectives in Psychiatric Care, 1:20-26.

Anstruther, I. (1963) The Scandal of the Andover Workhouse, London, Bliss.

Association of Directors of Social Services. (1990) Community Care for People with a Mental Handicap/Learning Difficulty - Philosophy & Principles, London.

Association of Professionals for People with Mental Handicaps, 1982, Mental Handicap: Care in the Community , Report of the ninth annual conference, APMH, London.

ASTMS. (1983) Occupational Stress - an ASTMS Policy Document, Association of Scientific, Technical and Managerial Staff, London.

Audit Commission. (1986) Making a Reality of Community Care- A Report by the Audit Commission, Department of Health and Social Security, London.

Audit Commission. (1987) Community Care: developing services for people with a mental handicap, in Audit Commission Occasional Papers, No. 4. (Nov. 1987), Department of Health and Social Security, London.

Bannister, D & Fransella, F. (1980) Inquiring Man, Penguin, Harmondsworth.

Bank-Mikkelsen, N.E.(1969) Modern Service Models, Changing Patterns of Residential Care for the Mentally Retarded. Washington D.C., President's Committee on Mental Retardation.

Basowitz, H. et al. (1955) Anxiety and Stress, McGraw-Hill, New York.

Bayley, M. (1973) Mental Handicap and Community Care. A Study of Mentally Handicapped People in Sheffield, Routledge & Kegan Paul, London.

Baley, M. (1973) Nursing and Social Change, Heinemann, London.

Baley, M. (1977) Nursing, Batsford Educational, London.

Bailey, R. (1988) 'Burnt-Out - Counselling and the Health Care Professions, in J. Health Care Management, 3,1, pp. 5-8.

Beardshaw, V. (1981) Conscientious Objectors at Work. Mental Hospital Nurses - A Case Study, Social Audit, London.

Beattie, R.T, Darlington, T.G. (1974) The Management Threshold, British Institute of Management Paper, OPN, 11.

Belson, W., Duncan, J.(1962) A Comparison of the Check-List and the Open Response Questioning Systems, Applied Statistics, 11, 120-132.

Bendix, R. (1956) Work and Authority in Industry: A Study of Changing Managerial Ideologies in the USA, Britain and in the USSR, Harper, United States of America.

Benton, D. & White, H. (1972) Satisfaction of Job Factors for Registered Nurses, Journal of Nursing Administration, Vol,2, Part 6, p.55-63. November/December.

Billings, A,G. & Moos, R,H. (1981) The Role of Coping Responses and Social Resources in Attenuating the Stress of Life Events in Journal of Behavioural Medicine, 4, p.139-157, London.

Bingley, W. (1987) The Disabled Persons Act - Will it Deliver? in Community Living, November/December 1987, p.20, London.

Binet,A. et Simon, Th. (1906) Misere Physiologique et Sociale. Anne. Psychol.,xii, 1, p. 369-382.

Blunden, R. (1980) Individual Plans for People with Mental Handicaps: A Draft Prodedural Guide, Cardiff: Mental Handicap in Wales - Applied Research Unit.

'Borough Health Authority', (1988) A Strategy for Mental Handicap Services, London.

'Borough Health Authority', (1989) Operational Policy for Neighbourhood Houses, London.

Boswell,D & Jaehnig, D. (1975) The Social Integration of Mentally Handicapped People in the Community, published in the course material for course no. P853, Block 2, Social Interaction, Milton Keynes, The Open University.

Bowers, K.S. (1973) Situationalism in Psychology: an Analysis and Critique, Psychological Review, 80, 307-335.

Bowlby, J. (1951) Maternal Care and Mental Health, Monograph Series, No. 2, World Health Organisation.

Bowlby, J. (1953) Child Care and the Growth of Love, 2nd. Edition, Penguin, (1965), Harmondsworth.

Bowman, J. (1967) 'The Lamp and the Book', Royal College of Nursing, London.

Bratt, A. (1987) From Franklyn to Longcombe: An Attempt to measure the Effects of the Move on the Young People Concerned, and their Carers, Draft Report, Exeter Health Authority.

Brief, A., Schuler, R., Aldag, R. (1977) Role Conflict and Ambiguity: A Scale Analysis, in Journal of Organisational Behaviour and Human Performance, Vol.20, p.111-128.

Bronston, W. (1980) The Shape of a Marathon. In Apolloni, T. et al, (eds),(1970), Achievements in Residential Services For Persons with Disabilities: Toward Excellence, Baltimore, University Park Press.

Brown, G. (1973) The Mental Hospital as an Institution. Journal of Social Science and Medicine, Vol. 7, pp. 407-424.

Brown, J., & Shaw, I (1987) Mental Handicap Training Profile:- A Review of Training for Staff in the Northern Region of CCETSW, Department of Sociology and Social Policy, University of York.

Brundage, A. (1978) The Making of the New Poor Law, 1832 - 39, Hutchinson, London.

Cameron, M. (1986) The Moral and Ethical Component of Nurse Burnout, Nursing Management, Critical Care Management Edition, Vol.17, No 4, p. 42b-42e.

Campaign for The Mentally Handicapped. (1982) Care in the Community - When?, Newsletter 30, Autumn 1982, CMH, London.

Cannon, W.B. (1935) Stresses and the Strains of Homeostasis, American Journal of Science, 189, p.1.

Caplan, R.D,. & Jones, K.W. (1975) Organisational Stress and Individual Strain: A Social-Psychological Study of Risk Factors in Administrators, Unpublished PhD. Thesis, University of Michigan.

Cassel, J.C. (1976) The Contribution of the Social Environment to Host Resistance, American Journal of Epidimiology, 104, p. 107-123.

Castle, B. (1975). 'News from Westminster' , Nursing Mirror March, 6th, 1975, Vol. 45, p.39, London.

Caton, D.J. etal (1988) Burnout and Stress Among Employees at a State Institution for Mentally Retarded Persons, American Journal of Mental Retardation, Vol. 93, No.3, pp.300-304.

Caudill, J. (1958) The Psychiatric Hospital as a Small Society, Harvard University Press, USA.

Central Council for Education and Training in Social Work. 'CCETSW Examines Implications for Training of Griffiths and Wagner', Press Release, 22nd. March 1988, No. 08/88, CCETSW, London.

Central Council for Education and Training in Social Work. Internal Paper - C/87 - 3/7/87, p.4/5, CCETSW, London.

Chambers (1987) Concise English Dictionary, London.

Church, O.M. (1987) 'The Emergence of Training Programmes for Asylum Nursing at the Turn of the Century', in, Nursing History: The State of the Art, Ed. Christopher Maggs, Croom Helm, London.

Cicourel, A.V. (1964) Method and Measurement in Sociology, The Free Press, New York.

Cohen,S., & Scull, A.T. (1980) Social Control and the State, Robertson, London.

Collins, W.H. (1988) Concise English Dictionary, London.

Confederation of Health Service Employees. (1988) Future Services for People with Learning Difficulties, COHSE, London.

Conservative Party (1950) This is the Road, Conservative Central Office, London.

Conservative Party (1979) The Conservative Manifesto 1979, Conservative Central Office, London.

Cooper, C.L., & Marshall, J. (1987) Understanding Executive Stress, Macmillan, London.

Cope, D. (1984) Changing Health Care Organisations, in Understanding Nurses, Edited by, S. Skevington, J. Wiley and Sons Ltd, New York.

'Cornavon Health Authority' (1987a) 'Community Mental Handicap Team Operational Policy, Devon.

'Cornavon Health Authority' (1987b) General Philosophy, Devon.

'Cornavon Health Authority' (1988) 'Services for People with Special Needs - 1988-1989, Devon.

'Cornavon Health Authority' (1988-9) Parent Newsletters 1988-1989, Devon.

Cowles, E. (1906) Proceedings of the American Medico-Psychological Association (Nursing Reforms for the Insane, Trans. American Medico-Psychological Association, 13, p.206.

Cox, T. (1978) Stress, Macmillan, London.

Coxon, T. (1990) Ritualised Repression, in, Nursing Times, August 1, Vol.,86, No.31, London.

Craft, M. (1979) Tredgold's Mental Retardation'. 12th Edition, Bailliere Tindall, Ch.1, p.3, London.

Crossman, R.H.S, (1977), The Diaries of a Cabinet Minister, Vol.III, London, Hamish Hamilton & Jonathon Cope.

Crozier, M. (1965) The Bureaucratic Phenomenon, Tavistock, London.

Cullen, C., & Woods, P. (1983) Determinants of Staff Behaviour in Long Term Care, in Journal of Behavioural Psychotherapy, Vol 11, p.4-17.

Dalgleish, M. (1979) Childrens Residential Accommodation: Policies and User Reaction, Sheffield Development Project, Mental Health Buildings Evaluation, DHSS.

Davis,A. (1981) The Residential Solution, Tavistock Publications, London.

Department of Education and Science. (1975), Educating Mentally Handicapped Children, Education Pamphlet 60, London, HMSO.

Development Group for the Mentally Handicapped. (1976), Mental Handicap: Planning Together. Pamphlet No 1, London, HMSO.

Development Group for the Mentally Handicapped. (1976), Bulletin No. 2, London, HMSO.

Development Team for the Mentally Handicapped. (1978) First Report 1976-1977, London, HMSO.

Development Group for the Mentally Handicapped. (1980), Services for Mentally Handicapped People: 'Unfinished Business', London. HMSO.

Development Group for the Mentally Handicapped. (May 1980), Services for Mentally Handicapped People: Unfinished Business, unpublished summary paper submitted to Mr Patrick Jenkin, Secretary of State for Social Services, following the final meeting of the National Development Group, Ref- RD7, DHSS, London.

Dept. Health & Social Security. Speech by the Secretary of State for Social Services to the Mencap National Conference, July 1975, London.

Dept. Health & Social Security. Mental Handicap Policy: Speech by the Secretary of State for Social Services to Mencap, (Feb 1975), DS.76/75, London, HMSO.

Dept. Health & Social Security. Priorities for Health and Personal Social Services in England, 1976, HMSO, London.

Dept. Health & Social Security. Government's Response to the Jay Report, CNO(80)6, (24th July 1980), HMSO, London.

Dept. Health & Social Security. Mental Handicap: Progress, Problems and Priorities-A Review of Mental Handicap Services in England since the 1971 White Paper "Better Services for the Mentally Handicapped",(1980 & 1987- reissued), London, HMSO.

Dept. Health & Social Security. Care in the Community: a Consultative Document on Moving Resources for Care in England, (July 1981) London.

Dept. Health & Social Security. Care in the Community: New Drive on Transfer of Patients and Resources, (July 1982), Circ. 82/235, London.

Dept. Health & Social Security. Care in the Community and Joint Finance, (February 1983), Circ. HC(83)6, London.

Dept. Health & Social Security. New Initiatives in Care in the Community, (March 1983), Circ. 83/56, London.

Dept. Health & Social Security. Community Care with Special Reference to Adult Mentally Ill and Mentally Handicapped People. Minutes of Evidence - MENCAP- Session 1983-84, (2nd May 1984), London.

Dept. Health & Social Security. Helping Mentally Handicapped People with Special Problems- Report of a DHSS Study Team, (1984), HMSO, London.

Dept. Health & Social Security. Statistical Bulletin, Bulletin 2/85, (1985), London, HMSO.

Dept. Health & Social Security. Government's Response to the Social Service Select Committee Report on "Community Care with Special Reference to the Adult Mentally Ill and Mentally Handicapped People", December 1985, Cmnd 9674, HMSO, London.

Dept. Health & Social Security. The Role of the Nurse in Caring for People with Mental Handicap, [CNO(85)5], HMSO, London.

Dept. Health & Social Security. Neighbourhood Nursing - A Focus for Care, (Chairman, Julia Cumberlege), HMSO, London.

Dept. Health & Social Security. Press Release, 'Lady Trumpington Affirms Government Commitment to Good Quality Services for Mentally Handicapped People', (19th November 1986), 86/362, HMSO, London.

Dept. Health & Social Security. New Director for National Development Team for Mentally Handicapped People, (31st March 1987), 7/144, HMSO, London.

Dept. Health & Social Security. Health Service Development - Resource Assumptions and Planning Guidelines, (July 1988), HC(88)43, HMSO, London.

Dept. of Health. Personal Social Services: Provision for Mentally Handicapped People in England,- 1976 - 86, Statistical Bulletin, 3/10/88. London.

Dept. of Health. Departmental Working Group - Mental Handicap Nursing in a Community Based and Mental Handicap Service, CNO. Letter, 11.6.90, Dept. of Health, London.

Dept. of Health. Statement on Community Care, Letter from the Health Minister, Virginia Bottomley, July 1990, EL(90)M/3, London.

Dept. of Health. Caring for People - Community Care Planning: A Review of Past Experience and Future Imperatives, Implementation Document - CC13, March 1990, London.

Dick, D. (1986) 'Why Change?', Nursing Times, Jan 15th ,Vol 82, No 3, p. 55-56, London, Macmillan.

Dunham, J. (1978) Staff Stress in Residential Work, in Social Work Today, Vol.9, No.45, 25.7.78, p.18-20.

Durkheim, E. (1953) Sociology and Philosophy, Free Press, New York.

'Eastern Health Authority'. (1988) Operational Policy for Residential Services, East Anglia.

'Eastern Health Authority'. (1989) Relocation Programme, (1989), East Anglia.

Edwards, A. (1961) Mental Health Services, (Third Edition), Shaw and Sons, London.

Edwards, G. (1989) 'The Rise and Fall of the Male Nurse Movement', The Nursing Times, Vol.85, No.3, pp.51-53.

Edgerton, R,B. (1967) The Cloak of Competence, Berkley, University of California, Press.

Elliott-Cannon, C. (1981), Do the Mentally Handicapped Require Specialist Nursing Care?, Nursing Times, July 1st., p. 77-80.

English National Board for Nursing, Midwifery and Health Visiting. Education and Training of Nurses Caring for People with Mental Handicap, 85/55/ERDP, 1985 London.

English National Board for Nursing, Midwifery and Health Visiting. Nursing and Social Work Group to Facilitate Cooperation in Training, Circ.1986/5/IMS, January, 1986, ENB, London.

English National Board for Nursing, Midwifery and Health Visiting/ CCETSW. Cooperation in Qualifying and Post-Qualifying Training: Mental Handicap, Joint Working Group, 1986, ENB/CCETSW, London.

English National Board for Nursing, Midwifery and Health Visiting/ CCETSW. First Fruits of the ENB/CCETSW Joint Training Initiatives, Press Release, 28.10.88, ENB/CCETSW, London.

English National Board for Nursing, Midwifery and Health Visiting. The ENB Reaffirms Commitment to Mental Handicap Nursing, Press Release, 16.11.88, ENB., London.

English National Board for Nursing, Midwifery and Health Visiting/ CCETSW. Post-Basic Syllabus of Training in Community, and Residential Care, Course No. 740, 1988, ENB/CCETSW., London.

Erikson, K. (1957) Patient Role and Social Uncertainty: a Dilemma of the Mentally Ill, Psychiatry, 20, pp.263-274.

Esquiriol (1794) in Clarke, A.M. & Clarke, A.D. (1985) Mental Deficiency- The Changing Outlook, 4th Edition, Methuen & Co., London. p. 49.

Felce, D., Kushlick., A, Smith, J. (1983) Planning and Evaluation of Community Based Residences for Severely and Profoundly Mentally Handicapped People in the United Kingdom, Advances in Mental Retardation and Developmental Disabilities, 1, pp. 237-271.

Fiorentino, L. (1986) Stress - The High Cost to Industry, in American Association of Occupational Health Nursing, Vol. 34, May, No.5, p.217-220.

Firth, H. (1983) Training Support Staff, in An Ordinary Life Issues and Strategies for Training Staff for Community Mental Handicap Services, Kings Fund Project Paper No 42, London.

Firth, H., & Myers, M. (1985) Supporting Staff in Community Services, Mental Handicap, Vol.13, September 1985, p.100-103.

Firth, H., McIntee, J. (1985) Maslach Burnout Inventory: Factor Structure and Norms for British Nursing Staff, Psychological Reports, 57, pp. 147-150.

Firth, H., McIntee, J.,(1986) McKeown, P., & Britton, P. Interpersonal Support Amongst Nurses at Work, Journal of Advanced Nursing, 11, p.273-288, London.

Firth, H., McIntee, J.,(1986) McKeown, P., & Britton, P. Background Information Questionnaire in Interpersonal Support Amongst Nurses at Work, Journal of Advanced Nursing, 11, p.273-288, London.

Frankel, C. (1969) Social Values and Professional Values, Journal of Education for Social Work, Spring 1969, p.29-35.

French, J.P.R. et al (1965) Workload of University Professors, Unpublished Research Report, University of Michigan.

French, J.R.P., Rogers, W., Cobb, S. (1974) A Model of Person-Environment Fit, in Coping and Adaptation, Hamburgh, D.A, & Adams, G.E. (eds) Basic Books, New York.

Freud, S. (1961) Civilisation and its Discontents, Norton, New York.

General Nursing Council/ CCETSW. (1982a) Co-operation in Training - Part I- Qualifying Training, (Chairman, Edward Sidebottom), London.

General Nursing Council. (1982b) Syllabus of Training for Registered Nurses for People with a Mental Handicap, London.

General Nursing Councils/ CCETSW. (1983) Co-operation in Training - Part II- In-Service Training, (Chairman, Edward Sidebottom), London.

Gerth, H.H., & Mills, C.W. eds. (1948) From, Max Weber: Essays in Sociology, p.214. London, Routledge & Kegan Paul.

Gillespie, C. (1987) Stress-Reducing Strategies, Nursing Times, September 30th, Vol 83, No 39.

Godin, P. (1990) The Fencepiece Project, Mental Handicap, Vol. 10, No.3, March.

Goffman, E. (1958) Characteristics of Total Institutions: Introduction, Symposium on Preventive and Social Psychiatry, USA, Government Printing Office, pp. 43-49.

Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates, Washington, Anchor Books, Doubleday & Co.

Government Reports. (1982) Written Answer by the Rt. Hon. Mr Norman Fowler, Secretary of State for Social Services, 28th July, Hansard, Vol.28, Col. 559/560, Session 1981/82, London.

Gowler, D., & Legge, K. (1975) Managerial Stress, Gower Press, Epping.

Grunewald, K. (1977) Community Living for Mentally Handicapped Adults in Sweden. Current Sweden, 159, Stockholm, Swedish Institute.

Guys Health District. (1981) Development Group for Services for Mentally Handicapped People: Report to the District Management Team', Guys Hospital, London

Hall, V,. & Russell, O. (1985), Community Mental Handicap Nurses: The Birth, Growth and Development of an Idea, In, Sines, D, & Bicknell, J. (1985), Caring for Mentally Handicapped People in the Community, Harper and Row, London.

Hall, V. (1979) Community Nursing for the Mentally Handicapped: Threat or Challenge? Description of a Service in Action. Mental Handicap Studies Research Report No.3, University of Bristol, Dept. of Mental Health.

Hansard. (1986) Government Response to a Question Raised in the House of Lords in Response to a Question by The Baroness Trumpington, 21st April 1986, London.

Hansard. (January 1987) Government Answer by The Minister of Health Mrs Edwina Currie in Response to a Question Raised in the House of Commons by Sir Fergus Montgomery on 20th January 1987, House of Commons, Hansard, Part Answer, Session 1986-7, Vol. 108, Column 530.

Hartman, J. (1969) The Key Jingler, Journal of Community Mental Health, 5, p.199.

Health Care Evaluation Research Team (1977) Evaluation of Locally Based Hospital Units for the Mentally Handicapped in Wessex, Research Report, No. 124, (Director Albert Kushlick). Wessex RHA., Winchester.

Health Education Authority (1988) Stress in the Public Sector - Nurses Police, Social workers and Teachers, March. HEA., London.

Henson, C. (1988) Support Groups for Nurses, Nursing Standard, June 25th.

Hegarty, J.R. (1987) Staff Burnout: A Single Case Study, Mental Handicap, Vol 15, September, pp.93-95.

Heron, A. (1982) Better Services for the Mentally Handicapped? Lessons from the Shefield Evaluation Studies, Kings Fund Centre, London.

Hertzberg, F., Maunser, J. (1959) The Motivation to Work, 2nd Edition, Snyderman, B. John Wiley & Sons, New York.

Hingley, P., & Cooper, C. L. (1983) The Others at the Top: the Personality Characteristics of Key Change Agents, New Society, October.

Hingley, P., & Harris P. (1985) Stress in Nurse Managers, Unpublished Paper, Dept. Of Nursing Studies, Bristol Polytechnic, Bristol.

Hingley, P., & Harris, P. (1986) Lowering the Tension, Nursing Times, Vol 81, No.12, p.52-53, London.

Hingley, P., & Cooper, C.L. (1986) Stress in Nurse Managers, King's Fund Project Paper no 60, London.

Hingley, P., Baker, R., (1988) Stress in the Public Sector - Nurses, Dunham, J., Harrison, E., Police, Social Workers, & Teachers, Health Manolias, M. Education Authority, London.

Hinkle, L.E. (1973) The Concept of Stress in the Biological and Social Sciences, in Sci. Med. Man, 1, 31-48.

Holland, S. (1987) Stress in Nursing - What Does Stress Do To You? Nursing Times, July 29th, Vol.83, No. 30, p. 44-47.

Howden, C., & Levinson, A. (1987) Coping with Stress - Sharing and Learning, in Mental Handicap, Vol. 7, No. 2, August.

Independent Development Council for People with a Mental Handicap, (1981), Response to Care in the Community - A DHSS Consultative Document on Moving Resources for Care in England, IDC, London.

Jamal, M. (1984) Job Stress and Job Performance Controversy: An Empirical Assessment, Journal of Organizational Behaviour and Human Performance, Vol.33, p.1-21.

Jenkin, P. (1979) Speech to the Social Services Conference, Bournemouth, 21st November.

John, A. (1961) A Study of the Psychiatric Nurse, Livingstone, Edinburgh.

Jones, K. (1972) A Study of the Mental Health Services, Routledge & Kegan Paul, London.

Jones, K. (1974) Violence and the Mentally Handicapped, New Society, 31, Jan., p.247-9.

Kent County Council, (1987), Contract for the Provision of Services in the Private Sector, (Feb. 1987), unpublished.

Khan, R.L. et al (1964) Organisational Stress, Wiley, New York.

King, R., Raynes, N., Tizard,J. (1971) Patterns of Residential Care. Social Studies in Institutions for Handicapped Children, London, Routledge & Kegan Paul.

Kings Fund Centre. (1973) Perspectives of the Briggs Report-A Discussion Paper on the Future Role and Training of Subnormality Nurses, and their Relationship with Residential Care Staff, Mental Handicap Papers 4, No. 837, London.

Kings Fund Centre. (1980) An Ordinary Life. Comprehensive Locally-Based Services for Mentally Handicapped People, Project Paper No. 24, King's Fund Centre, London.

Kings Fund Institute (1987) Promoting Innovation in Community Care - From Small Scale Developments to Mainstream Provision. Briefing Paper No.3, (Sept. 1987), Kings Fund Institute, London.

Knapp, M., & Renshaw, J. (1986) Criteria in Planning Social Services For Mentally Retarded Adults, Discussion Paper 429/2, Personal Social Services Research Unit, University of Kent, Canterbury.

Korman, N., & Glennerster, H. (1986) Closing a Hospital - The Darenth Park Project, Occasional Papers on Social Administration 78, Bedford Square Press/NCVO, London.

Kotter, J., & Lawrence, P,R. (1974) The Management Skills Checklist, in Mayors in Action, J. Wiley, New York.

Lahiff, J. (1990) Profile of a Profession - A Survey of RNMH's in the U.K.' , Interim Report, July 1990, London.

Lancashire Health Authority'. (1984) A Comprehensive Local Service, Lancashire.

'Lancashire Health Authority' (1986) Operational Policy for Home Support Team Services, Lancashire.

'Lancashire Health Authority' (1988) A Plan for Resettlement, Lancashire.

Laslett,P. (1971) The World We Have Lost, London, Methuen and Co.

Lazarus, R.S. (1966) Psychological Stress and the Coping Process, McGraw-Hill, New York.

Lazarus, R.S. (1976) Patterns of Adjustment, McGraw-Hill, New York.

Leonard, A. (1988) Out of Hospital - A study of Thirty Centrally, Funded Initiatives of Moving Children from Hospital, University of York.

Levine, S, & Scotch, N.A. (1970) Social Stress, Aldine, Chicago.

Limbrick, P. (1976) One to One: An experiment in community participation in long-stay Hospitals, The Spastics Society, London.

Loeb, M.B. (1956) Some Dominant Cultural Themes in a Psychiatric Hospital, Social Problems, 4: 17-20.

Llewelyn, S.P. (1984) The Cost of Giving: Emotional Growth and Emotional Stress, in Understanding Nurses, S. Skevington, (ed), J. Wiley, London.

Lyon, T. (1971) Role Clarity, Need for Clarity, Satisfaction, Tension, and Withdrawal, Journal of Organizational Behaviour and Performance, Vol.6, p.99-110.

Maggs, C. (1984) Sources for the History of Nursing in Great Britain, Kings Fund College, London, Project Paper No. 46.

Maher, E. (1983) Burnout and Commitment: A Theoretical Alternative, The Personnel and Guidance Journal, 62, pp. 390-394).

Macmillan, H. (1938) The Middle Way , Macmillan, London.

Malin, N., Race, D., Jones, G. (1980) Services for the Mentally Handicapped in Britain, London, Croom-Helm.

Mansell, J, et al. (1979), The Bereweeke Skill-Teaching System: Programme Writers Handbook, Health Care Evaluation Research Team, Winchester.

Mansell, J., Felce, D., (1987) Developing Staffed Housing for People
Jenkins, J., DeKock, U., With Mental Handicaps, Costello,
Toogood, S. Tunbridge Wells, England.

Margolis, B.L. et al (1974) Work and the Health of Man in O'Toole Work and the Quality of Life, MIT Press, Mass, Cambridge.

Marks, S. (1977) Multiple Roles and Role Strain: Some Notes on Human Energy, Time and Commitment, American Sociological Review, Vol. 42, December 1977, p.921-936.

Marshall, R. (1989) 'Blood and Gore', The Psychologist, Vol 2 , No.3, March 1989, p.115-117. BPS. London.

Martin, F.M. (1984) Between the Acts: Community Mental Health Services 1959-1983, Nuffield Provincial Hospitals Trust, London.

Martin, J.P. (1984) Hospitals in Trouble, Blackwell, Oxford.

Maslach, C. (1976) Burned-Out, Human Behaviour, Vol. 5, pp. 16-22.

McCarthy, M, Ed. (1989) The New Politics of Welfare - An Agenda for the 1990s?, Macmillan, London.

McGrath, M., Humphries, S. (1988) The All Wales Community Mental Handicap Team Survey, University College of North Wales, Bangor.

McGrath, J.E, Ed. (1970). Social and Psychological Factors in Stress, Holt-Rinehart-Winston, New York.

Mencap. (1983) The Mencap Homes Foundation - A Plan for Development of Residential Services for Mentally Handicapped People, Mencap, London.

Mencap. (1986) Care in the Community for People who are Mentally Handicapped, Stamina Paper No. 7, Mencap., London.

Menzies, I.E.P. (1970) The Function of Social Systems as a Defence Against Anxiety - A Report of a Study on the Nursing Service of a General Hospital, Tavistock Institute, London.

Menzies, I.E.P. (1986) Containing Anxieties in Institutions - Selected Essays, Free Association Books, London.

Miller E..J. & Gwynne G.V. (1974) A Life Apart - A Pilot Study of Residential Institutions for the Physically Handicapped and the Young Chronic Sick, Tavistock Publications, London.

Minzberg, H. (1973) The Nature of Managerial Work, Harper & Row, New York.

Mischel, W. (1973) Towards a Cognitive Social Learning Reconceptualisation of Personality, in Psychological Review, 80, 252-283.

Mitchell, R.E., & Trickett, E.J.(1980) Task Force Report: Social Networks as Mediators of Social Support. An Analysis of the Determinants of Social Networks. Community Mental Health Journal, Vol. 16, (1).

Mithaug, D.E., & Hanawalt, D.A. (1978) The Validation of Procedures to Assess Pre-Vocational Task Preferences in Retarded Adults, Journal of Applied Behavioural Analysis, Vol. 11, No.1, p.153-162.

Mittler, P. (1979) People not Patients-Problems and Policies in Mental Handicap, Methuen and Co. Ltd., London.

Mittler, P. (1982) Into the Community's Care, Nursing Mirror, January 7th, 1982, p 18 - 21, London.

Moores, B., & Grant, G. (1977) Feelings of Alienation Among Nursing Staff in Hospitals for the Mentally Handicapped, International Journal of Nursing Studies, Vol.14, p. 5-12.

Moore, J.G. (1983) 'Burn-Out'- A New Name for an Old Problem, Midwife, Health Visitor and Community Nurse, Vol. 19, pp.348-352.

Morris, P. (1969) Put Away: A Sociological Study of Institutions for the Mentally Retarded, Routeledge & Kegan Paul, London

Morris , J. (1975) Managerial Stress and the 'Cross of Relationships', in Gowler, D. & Legge, K. (eds) Managerial Stress, Gower Press, Epping.

Moser, C., & Kalton, G. (1972) Survey Methods in Social Investigation, 2nd Edition, Heinneman, London.

National Childrens Bureau (1977) Who Cares? (Page, R., & Clark, G.A.) p.16, London, in Wagner (1988) Vol 1.

National Development Group for the Mentally Handicapped. (1977) Mentally Handicapped Children: A Plan for Action, Pamphlet No. 2, London, HMSO.

National Development Group for the Mentally Handicapped (1978) Helping mentally Handicapped People in Hospital, A Report to the Secretary of State for Social Services, HMSO, London.

National Development Group for the Mentally Handicapped (1980) Improving the Quality of Services for People with a Mental Handicap- A Checklist of Standards, Department of Health and Social Security, London.

National Development Team (1989) A Summary of the Lessons Learnt from the Experience of Team Members from Discussions at Workshops on 2-3 December 1988 & 17-18 March 1989, at the Kings Fund College, Department of Health, London.

Nie, H, N., Hull, C,H., (1975) Jenkins, J,G., Steinbrenner,K. SPSS - Statistical Package for the Social Sciences, Second Edition, McGraw Hill, New York.

Nightingale, F. (1867) Suggestions on the Subject of Providing, Training and Organising Nurses for the Sick Poor in Workhouse Infirmaries, in, Letters to Sir Thomas Watson Bart p.3, London.

Nirje, B. (1970) The Normalisation Principle- Implications and Comments, British Journal of Mental Subnormality, Vol.XV1, Pt.2, No.31, Kidderminster.

Nolan, P. (1986) Mental Nurse Training in the 1920's, The History of Nursing Group Bulletin 10, Royal College of Nursing, pp.15-23, London.

Nolan, P. (1989) 'Attendant Dangers', Nursing Times, March 22nd, Vol.85, No.12, pp.56-59, London.

Nursing Times (1979) Special Report - The Jay Recommendations, Nursing Times, March 8th, 1979, p.392 - 394, London.

O'Brien, J., & Tyne, A. (1981) The Principle of Normalisation: A Foundation for Effective Services, Campaign for Mental Handicaps, London.

Oppenheim, A.N. (1986) Questionnairre Design and Attitude Measurement, Gower, London.

Oswin, M. (1971) The Empty Hours- A Study of the Weekend Life of Handicapped Children in Institutions, Allen Lane, The Penguin Press, Harmondsworth.

Oswin, M. (1976) Children Living in Long-Stay Hospitals, Heineman, London.

Owens, G., & Birchenall, P. (1979) Mental Handicap: the Social Dimensions, Pitman Medical, London.

Owen, S. (1989) Strategies for Stress. in Nursing Times, September 13th, Vol. 85, No. 37.

Parsons, T. (1964) Social Structure and Personality. Free Press, New York.

Pearlin, L.I. (1962) Alienation from Work: A Study of Nursing Personnel, in American Sociological Review, Vol.27, p.314-26.

Pines, A., & Maslach, C. (1978) Characteristics of Staff Burnout, in Hospital and Community Psychiatry, Vol.29, No.4, pp.233-237.

Pines, A., & Maslach, C. (1980) Combating Staff Burnout in a Day Care Centre: A Case Study, in Child Care Quarterly, Vol.9, p.5-16.

Pinker,R,A. (1966) English Hospital Statistics, 1861-1938, Heinneman, London.

Plant, R. (1987) The 'Role Effectiveness Profile: Tool for Self Assessment', in Managing Change and Making it Stick, Fontana, London.

Regional Nursing Officers Group. Minutes of a Meeting 6th January 1987, (Unpublished).

Ramon, S. (1985) Psychiatry in Britain, Croom Helm, London.

Renshaw, J., Hamuson, R., Thomason, C., Danton, R., Judge, K., Knapp, M. (1988) Care in the Community: The First Steps, PSSRU, University of Kent, Kent.

RESCARE. (1986) Minutes of a Conference Convened by Rescare on 7th April 1986, London. (Unpublished).

RESCARE. (1988) RESNEWS, 1988, Issue no. 2, June, 1988, London.

Revans, R,W. (ed). (1974) Hospitals: Communication, Choice and Change. Tavistock, London.

Riordan, J. (1988) Comparison and Predictors of Job Satisfaction of Kansas Nurses Among Varied Work Settings, The Kansas Nurse, November 1988, p.4-5.

Rizzo, J., House, R. & Lirtzman, S. (1970) Role Conflict and Ambiguity in Complex Organizations, Administrative Science Quarterly, Vol.15, p.150-163.

Robb, B, (Ed). (1967) Sans Everything: A Case to Answer, Edinburgh, Thomas Nelson.

Roosevelt, E. (1958) In Your hands - A Guide for Community Action for the Tenth Anniversary of the Universal Declaration of Human Rights, Speech given to the United Nations, New York, Thursday March 27th, 1958, 10.00am.

Rotter, J.B. (1964) General Expectations for Internal Virus Control versus External Control of Reinforcment, in Psychological Monograph, 80, (Whole No. 609).

Royal College of Nursing, (1985) The Role and Function of the Domiciliary Nurse for People with a Mental Handicap, RCN., London.

Royal College of Nursing. (1985) The Education of Nurses: A New Dispensation, RCN., London.

Royal College of Nursing. (1987) Residential Services for People with a Mental Handicap in the Private Sector - Assuring Quality, RCN., London.

Royal College of Nursing. (1988) 'Royal College of Nursing Says Griffiths Proposals Fail to Meet the Challenge in the Community, Press Release 16th March 1988, RCN., London.

Royal College of Nursing. (1988) Response to Sir Roy Griffiths Review on Community Care - Agenda for Action, (May 1988) Society of Mental Handicap Nursing, RCN., London.

Royal College of Nursing. (1988) Response to 'The Wagner Report' on Residential Care, (May 1988), Society of Mental Handicap Nursing, RCN., London.

Royal College of Nursing, (1989) Survey on the Implementation of Care in the Community Initiatives by Health Authorities/ Boards and Counties within the United Kingdom, RCN, London.

Royal College of Nursing (1990) Is there a Future for Community Nursing? Speech by General Secretary Christine Hancock, 23.6.90, London.

Royal Medico-Psychological Association (1921) The Red Handbook, London.

Ryan, J., & Thomas, F. (1980) The Politics of Mental Handicap Penguin Books, London.

Sarata, B.P. (1974) Employee Satisfaction in Agencies Serving Mentally Retarded Persons, in American Journal of Mental Deficiency, Vol, 79, No.79, 4, p.434-442.

Schon, D. (1972) Beyond the Stable State, Free Press, New York.

Scofield, R.S. (1968) 'The Measurement of Literacy in Pre-Industrial Britain, in, Goody, J. (ed.), Literacy in Traditional Societies, Cambridge University, Press.

Seyle, H. (1950) Stress, Acta, Montreal.

Seyle, H. (1976) The Stress of Life, McGraw-Hill, New York.

Shyrock, R. (1959) The History of Nursing- An Interpretation of the Social and Medical Factors Involved, Saunders, USA.

Siegel, J. (1956) Non Parametric Statistics for the Behavioural Sciences, McGraw Hill, USA.

Sines, D.T., & Bicknell, J. (1985) Caring for Mentally Handicapped People in the Community, Harper and Row, London.

Sines, D.T, (ed). (1988) Towards Integration - Comprehensive Services For People with a Mental Handicap, Harper & Row, London.

Sines, D.T., & Parrish, A. (May 1988) 'The politics of Mental Handicap Care', Lampada, Issue no. 15, p.15, RCN., London

Simon G, (ed). (1981) Local Services for People with a Mental Handicap: The community Team, The Community Unit and the Role and Function of the Community Mental Handicap Nurse and Other Members of the Community Team, British Institue of Mental Handicap, Kidderminster.

South East Regional Health Authority. Policy Statement on Services for People with Learning, Difficulties - A Consulative Document, SETRHA, Eastbourne.

'Southern Health Authority'. (1987) Operational Policy for Residential Services, Portsmouth.

'Southern Health Authority'. (1989) Profile of Local Services, Portsmouth.

Spencer, D.A. (1983) Stress in Work with Mentally Handicapped People, in Mental Handicap, Vol.11, March 1983, p.7-8.

Stacey, M. (1970) Methods of Social Research, Pergamon Press, London.

Stockwell, F. (1972) The Unpopular Patient, Royal College of Nursing, London.

Stone, L. (1967) Social Change and Revolution in England, Methuen and Co, London.

Sykes, G.M., & Matza, D. (1957) Techniques of Neutralisation: A Theory of Delinquency, American Sociological Review, 667-70.

Tierney, A., Closs, J., (1988) On Measurement and Nursing Research, Atkinson, I., Anderson, J., in Nursing Times, Vol, 84, no. 12, Murphy-Black,T., & Macmillan,M. March 23rd, p.55-58.

Tizard, J. (1964) The Brooklands Experiment,in Community Services for the Mentally Handicapped, Part 4. London. Oxford University Press.

Tizard, J. (1974) Services and Evaluation of Services in Clarke, A., & Clarke, A. (1974), Mental Deficiency The Changing Outlook, Methuen, London.

Todd, C., Robinson, G. (1989) Twelve Versus Eight Hour Shifts: Job Satisfaction of Nurses and Quality of Care Provided, Centre for Applied Health Studies, University of Ulster, Coleraine.

Topliss, E. (1978) 'Health Care Policies', in Brearley, P, (ed), The Social Context of Health Care, Blackwell and Robertson, London.

Towell, D. (1975) Understanding Psychiatric Nursing, Royal College Nursing, London.

Townsend, P. (1962) The last Refuge: A Survey of Residential Institutions and Homes for the Aged in England and Wales, Routledge & Kegan Paul, London

Townsend, P. (1973) The Social Minority, Chapter 12, pp. 196-207, Allen Lane, London.

Tredgold,A.F. (1909) 'No Myth but a very Serious Reality', Eugenics Review, 2, p. 97.

Tredgold, R., & Soddy, K. (1963) Tredgold's Textbook of Mental Deficiency, Tenth Edition, Bailliere, Tindall & Cox, London.

Tuke, D.H. (1882) The History of the Insane, Kegan Paul, Trench & Co., London.

Turrell, E,A,T. (1986) Checking the Organisations Health, in Change and Innovation: A Challenge for the NHS, Institute of Health Service Managers, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1985) The Learner: Student Status Revisited!, Educational Advisory Committee, Project Paper 2, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1985) Project 2000- One, Two, Three: How Many Levels Should There Be?, Educational Advisory, Committee, Project Paper 3 , UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1986) Project 2000: A Preparation for Practice, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1987) Project 2000: Paragraph 6.30 Redrafted, CC/87/20, UKCC, London.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1988) Project 2000: Consultation Papers, UKCC, London

Ustinov, Peter. (1984) Memed - My Hawk, Gala Charity Premiere Brochure in Aid of the Oxfordshire Dyslexia Association, Peter Ustinov Productions, London. (p.11).

Vousden, M. (1985) Taking the Strain, Nursing Times, August 14th, Vol. 161, No. 7.

Wagner, G. (Chairman) (1988) Residential Care - A Positive Choice, Report of the Independent Review of Residential Care, Vol. One, National Institute of Social Work, HMSO, London.

Wagner, G. (Chairman) (1988) Residential Care:The Research Reviewed- Report of the Independent Review of Residential Care, Vol. Two, National Institute of Social Work, HMSO, London.

Wakely, J. (June 1975), Mental Subnormality Nursing, (Editorial), Supervisor Nurse, Vol.6, No.6, p.4, U.S.A.

Walker, H. (1987) Burn-Out or Cop Out?, Social Services Insight, October 9th, pp.11-13.

Walton, I., & Brown, J. (1989) Changing Patterns of Care for People with Mental Handicap: Nurse Training and Education, Final Report, Department of Social Policy and Social Work, University of York.

Walton, I., & Brown, J. (1989b) The Challenge of Change - Nurse Training and Education, Dept., of Social Policy, University of York.

Walk, A. (1961) Gloucester and the Beginnings of the R.M.P.A., The Journal of Mental Science, Vol.107, No.449, pp. 603-632, July 1961, London.

Walker, A. (1989) 'Community Care' in McCarthy, M. (Ed) The New Politics of Welfare - An Agenda for the 1990s? Macmillan, London.

Ward, L. (1984) Planning for People: Developing a Local Service for People with a Mental Handicap, Kings Fund, London.

Wardwell, et al. (1973) Behavioural Variables and Myocardial Infarction in the South-eastern Conneticut Heart Study, Journal of Chronic Disability, 26, p. 447-461.

Watkin, B. (1975) Documents on Health and Social Services - 1834 to the Present Day, Methuen and Co., Ltd, London.

Weber, M. (1930) The Protestant Ethic and the Spirit of Capitalism, (Trans. Parsons, T.), (1930), 1948, London.

Welsh Office. (1983) All Wales Strategy for the Development of Services for Mentally Handicapped People, February 1987, HMSO, Cardiff.

Welsh Office. (1987) All Wales Strategy for the Development of Services for Mentally Handicapped People. Review of Progress Since March 1983, February 1987, HMSO, Cardiff.

'Welshpool Health Authority'. (1988) Operational Policy, Cardiff.

'Welshpool Health Authority'. (1988-1989) Schedule of Hospital Residents Resettled Through the Resettlement Team, Cardiff.

'Welshpool Health Authority'. (1989) Relocation Newsletters, Cardiff.

West Midlands Regional Health Authority. (1980) Operational Brief for Community Units for the Mentally Handicapped, W.Midlands, RHA., Birmingham.

Wertheimer, A. (1972) Cared for and Caring, Mind and Mental Health, 30, 39-43, London.

Wertheimer, A. (1986) Hospital Closures in the Eighties, Campaign for Mental Handicap Publications, Cambs.

White, R. (1978) Social Change and the Development of the Nursing Profession-A Study of the Poor Law Nursing Service, Henry Kimpton, London.

Wilkin, D. (1979) Caring for the Mentally Handicapped Child, Croom Helm, London.

Wing, L. (1989) Hospital Closure and the Resettlement of Residents - The Case of Darenth Park Mental Handicap Hospital, Occasional Papers on Social Administration, Avebury, London.

Wood, T. (1979) The Jay Report, Botleys Park Hospital, June 1979, (unpublished paper), Chertsey, Surrey.

Wolfensberger, W. (1972) The Principle of Normalisation in Human Services. National Institute on Mental Retardation, Toronto.

World Health Organisation, (1954) The Mentally Subnormal Child, Geneva.

Wormald., J Wormald, S. (1913) A Guide to the Mental Deficiency Act 1913, P.S.King & Son. Westminster.