The Role of Training in Improving Community Care Staff Awareness of Mental Health Problems in People with Intellectual Disabilities

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Background Care staff play a key role in identifying individuals with intellectual disabilities and additional mental health problems. Yet, few receive training in mental health, and evidence about the effectiveness of training is scant.

Materials and Methods A pre–post study is reported, using a mental health screen and a self-report questionnaire to examine staff awareness of mental health problems and to measure whether training improved knowledge of psychopathology, attitudes towards mental health services and referral decisions.

Results Prior to training, deficits in awareness were evident. The Psychiatric Assessment Schedule for Adults with a Developmental Disability (PAS-ADD) Checklist detected significant psychopathology in approximately one-third of the individuals judged to have no mental health problems according to staff. Four months after the delivery of training, significant improvements in knowledge, attitudes and referral decisions were observed.

Conclusion Brief training interventions may improve awareness of mental health problems, but further research is needed to understand the referral process and to demonstrate the role of training in influencing actual staff behaviour.

Keywords: carers, intellectual disabilities, mental health, training

Introduction

Limited communication skills imply that many people with intellectual disabilities experience difficulties in articulating their mental health problems. Therefore, in contrast to the general population, the decision to seek help is often not made by the person with intellectual disabilities (Fletcher 1993). Rather, the pathway to care and access to appropriate treatment is dependent upon other people such as family, community care staff and social workers recognizing the signs of mental health problems, understanding their significance and taking appropriate action (Moss et al. 2000). This implies that such individuals know what changes in behaviour indicate the onset of mental health problems and that they know when and how to access appropriate external opinion and support. An understanding of which behaviours are pertinent to mental health assessment is also essential, so that carers can participate in the diagnostic process and feed back to mental health professionals about the effectiveness of any treatments implemented. A person to advocate regarding mental health problems is particularly important, because the gatekeepers to mental health services, such as GPs, may lack the necessary communication skills and relevant expertise (Langan et al. 1993; Kon & Bouras, 1997). Emphasis on the use of generic mental health services [Department of Health (DoH) 2001] also increases the reliance on advocates to participate in assessment and treatment.

Although individuals with intellectual disabilities are especially vulnerable to developing mental health problems (Deb et al. 2001), currently their use of mental health services is relatively low (Gustafsson 1997) and the costs of untreated mental illness are high (Holt et al. 2000). Identifying and minimizing barriers in the pathway to care are therefore necessary to improve access to treatment. Research has indicated a number of factors
which influence the ability of carers to identify and refer individuals exhibiting mental health problems. These include knowledge of psychopathology (Borthwick-Duffy & Eyman 1990), service user characteristics such as the level of intellectual disabilities (Edelstein & Glenwick 1997; Iverson & Fox 1989; Edelstein & Glenwick 2001), the nature of the mental health problem (Quigley et al. 2001; Edelstein & Glenwick 1997; Edelstein & Glenwick 2001) and attitudes towards mental health services (Christian et al. 1999; Oliver et al. 2005). In sum, unless conspicuous and associated with disruptive behaviour, mental health problems are unlikely to be recognized and to prompt service referrals.

The provision of mental health training is an important step in ensuring that staff have the appropriate skills (Edelstein & Glenwick 2001) and in improving access to mental health services (Moss et al. 2000). However, relatively few staff receive any training in mental health issues (Bouras & Holt 2000; Oliver et al. 2003) and evidence about its effectiveness is scant. In the USA, Loschen & Kirchner (1998) described the development of a curriculum in dual diagnosis using ‘Problem Based Learning’ (Loschen 1997). Aimed at clinicians and care staff, it comprised 20 h of didactic training, divided into eight sessions, plus an additional 20 h of practice within a clinical setting. A total of 12 clinicians reported that the quality of the training was adequate and the experience had a positive impact on their knowledge and practice. Although the training was also designed for care staff, the materials were not evaluated for care staff. Similarly, Gibbs & Priest (1999) evaluated a diploma module aimed at increasing the knowledge of intellectual disability nurses in relation to mental health problems. The training comprised ten 3-h taught sessions and reflective diary work focusing on applying theory to practice. Participants reported that the training changed their perspective towards mental health problems and enhanced their knowledge, skills and attitudes (n = 30). With a follow-up period ranging from 6 to 18 months, a smaller subset of the sample reported that the training had a positive impact on their practice. Measuring knowledge of psychopathology more directly by using the Mini PAS-ADD (Prosser et al. 1997) as a comparator, Quigley et al. (2001) conducted a postal survey of 116 health and social care staff working in intellectual disability services. They reported low levels of knowledge about symptoms, but found that trained staff had significantly greater knowledge and greater confidence in supporting individuals with mental health problems, compared with untrained staff. However, the nature and quality of the training received was not explored. The authors have identified only one randomized controlled study (n = 84) investigating the efficacy of a dual diagnosis curriculum for care staff. Conducted by Mester (1999) in the USA, the study reported that compared with untrained staff, staff attending a 2-day workshop had significantly improved knowledge and problem-solving skills relating to mental health problems in people with intellectual disabilities.

Thus, while there is some evidence that factors such as staff knowledge of psychopathology and attitudes towards mental health professionals influence identification and referral, the outcomes of mental health training for carers require further investigation. Few studies have targeted direct carers, but they have often relied upon participants’ perception to measure its impact and no studies have assessed the impact of training on staff attitudes and referral decisions. The purpose of this study was therefore to further examine staff awareness of mental health problems and to measure the impact of an introductory mental health training workshop on knowledge of psychopathology, attitudes towards mental health professionals and referral decisions.

**Method**

**Design**

A pre–post study was used, measuring the effectiveness of an introductory ‘Mental Health & Intellectual Disabilities’ training workshop in increasing staff awareness of mental health issues. The results were compared with staff awareness of mental health issues in the absence of training over the same time period.

**Participants**

The sample was recruited from care staff working in community residential intellectual disability services in two South East London boroughs. It comprised staff from one South East London borough attending an introductory training workshop (intervention group) and a comparison group not in receipt of training, drawn from intellectual disability services in a neighbouring borough. Inclusion criteria were: at least a 3-month tenure in residential services, 3-plus months working with a specific service user and regular, virtually daily contact with that service user over the last 4-week period. Over a period of 18 months, 12 workshops were conducted and 66 staff were recruited to the intervention group. Invitations to participate in the study were posted to six service providers in a neighbouring borough, follow-up
meetings (n = 5) with service managers were held and 65 staff were recruited to the comparison group. Table 1 shows the recruitment dropout and loss to follow-up rates for the study groups.

Of the intervention group, 37 (56%) were females and the mean age was 37 years (SD = 10.3). This compares to 40 (61%) females and 38 years (SD 9.0), respectively, for the comparison group. The intervention group comprised 48 (72.7%) direct care staff and 18 (27.3%) managers. This compares to 56 (86.2%) direct care staff managers and nine (13.8%), respectively, for the comparison group. The majority of the intervention (n = 51, 77.3%) and the comparison groups (n = 54, 83.1%) had not received any prior training in mental health issues. No significant differences were observed between the groups in relation to the majority of staff characteristics (gender, age, ethnicity, qualifications, job title, receipt of related training) and service user characteristics (gender, age, ethnicity). However, staff tenure was significantly lower in the intervention group than in the comparison group (53 and 96 months, respectively; U = 1710.00, Z = −2.004, P = 0.045) and service users in the intervention group had significantly milder levels of intellectual disability (χ² = 8.33, d.f. = 129, P > 0.005).

Materials

The intervention was based on two modules (Emotional Disorders and Assessment of Mental Health Needs) from the training package ‘Mental Health in Learning Disabilities’ (Bouras & Holt 1997) and a complementary video ‘Making Links’ (Holt & Bouras 1997). Its broad aims were to raise staff awareness of mental health issues, to increase understanding of mental health needs and to explore how these needs could be assessed and met. Workshops were conducted by a training co-ordinator with substantial experience of developing and delivering training. Each workshop was 7 h in duration and divided into seven sessions focusing on: differences between mental health problems and intellectual disabilities; common mental health problems and manifestation in people with intellectual disabilities; vulnerabilities of people with intellectual disabilities; video case studies; the role of the multi-disciplinary team; and medication and treatment options.

In order to examine awareness of mental health problems prior to training, staff were asked whether the service user they worked with had a mental health problem and to describe, in broad terms, its name and nature. They also completed the PAS-ADD Checklist (Moss et al. 1996), a psychiatric symptom checklist producing three threshold scores relating to: (i) affective/neurotic disorders, (ii) possible organic conditions, and (iii) psychotic disorders. Scores above a threshold indicate significant levels of psychopathology and the need for further psychiatric assessment. A 15-item questionnaire was developed by the first author in order to measure staff awareness of psychopathology in relation to knowledge of symptoms (five items), attitudes towards mental health services (five items) and referral decisions in relation to the presence of behaviours associated with mental health problems (five items).

A total of 28 items were identified through an automated literature search, discussions with colleagues, book citations and journal articles, together with consideration of the training objectives and the potential barriers to referral. In order to ensure that the questionnaire was understandable and to assess its validity, the instrument was piloted during two workshops and staff (n = 21) were asked about their understanding of items. A total of 15 items were selected and refined following a review of completed forms and discussion with clinicians. Internal consistency (Cronbach’s alpha) was 0.68 for the whole scale, 0.62 for the knowledge, 0.54 for the attitudes and 0.59 for the referral decisions subscales. Items consisted of a statement with which staff could answer ‘agree’, ‘disagree’ or ‘don’t know’. Correct responses (and those consistent with referral) were scored ‘1’ and scores were summed to generate a total awareness score ranging from 0 to 15 and subscale scores for knowledge, attitudes and referral decisions, each ranging from 0 to 5.

Procedure

Ethical approval was obtained from the local Research Ethics Committee. For the intervention group, semi-structured interviews were conducted in the week prior to attendance at training. Data collected included socio-demographic data, staff judgement about the presence and nature of mental health problems, the PAS-ADD

<table>
<thead>
<tr>
<th>Recruitment status</th>
<th>Intervention group (%)</th>
<th>Comparison group (%)</th>
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</thead>
<tbody>
<tr>
<td>Attended training/identified</td>
<td>85 (100)</td>
<td>78 (100)</td>
</tr>
<tr>
<td>Declined to participate</td>
<td>1 (1.2)</td>
<td>4 (5.1)</td>
</tr>
<tr>
<td>Failed to attend training/ interview</td>
<td>18 (21.2)</td>
<td>9 (11.5)</td>
</tr>
<tr>
<td>Recruited</td>
<td>66 (77.6)</td>
<td>65 (83.4)</td>
</tr>
<tr>
<td>Loss to follow up</td>
<td>21 (31.8)</td>
<td>6 (7.7)</td>
</tr>
</tbody>
</table>

Checklist and the staff awareness questionnaire. Equivalent data were collected for the comparison group during semi-structured interviews at a baseline point. Follow-up data were collected 4 months (median 17.5 weeks) after attending training for the training group and 4 months after the baseline interview (median 18 weeks) for the comparison group. This included the PAS-ADD Checklist and the staff awareness questionnaire.

Analysis

Data were analysed using SPSS for Windows Version 11.0 (2001). First, chi-squared tests were used to examine the level of association between staff judgements about the presence of mental health problems and detection of mental illness by the mental health screen (scoring above at least 1 PAS-ADD Checklist threshold). Fisher’s exact tests were used in cases where expected cell counts were lower than 5. Second, descriptive statistics were used to summarize total awareness scores and subscale scale scores for each of the dimensions of awareness (knowledge, attitudes and referral decisions). The small number of items used to measure each dimension of awareness and limited information about the validity and reliability of the questionnaire implied that a cautious approach to data analysis was warranted. Therefore, non-parametric tests (Mann–Whitney U-tests and Wilcoxon signed-rank tests) were conducted in order to identify across-group and within-group differences at baseline and follow-up. Finally, Pearson’s and Spearman’s correlation coefficients were calculated in order to identify staff characteristics associated with improvements in awareness.

Results

Staff judgements about the presence of mental health problems

Table 2 shows the relationship between staff judgements about the presence of mental illness and the identification of a possible mental health problem by the PAS-ADD Checklist at baseline. No significant association was found between staff judgements and the detection of psychopathology by the screen in either the intervention ($\chi^2 = 0.895$, d.f. = 1, $P = 0.344$) or the comparison group (Fisher’s exact test $P = 0.447$).

In the intervention group, eight (30%) service users judged to have no mental health problem were identified by the PAS-ADD checklist as having a possible mental illness. The equivalent figure was 10 (19%) for the comparison group. Conversely, 23 (59%) service users judged to have a mental health problem in the intervention group and nine (75%) of those identified by the comparison group were not detected by the PAS-ADD checklist. Of those staff identifying an individual as having a mental health problem, 23 (44%) could neither name nor describe the nature of the mental health problem. Spearman’s rho indicated no significant correlation between staff decisions about the presence of mental health problems and PAS-ADD Checklist total scores for either the intervention group ($r = 0.21$, $P = 0.09$) or the comparison group ($r = 0.01$, $P = 0.91$).

Staff knowledge about psychopathology

Prior to training, the statement generating the highest number of correct responses from staff in both study groups related to depression. A total of 58 staff (87.9%) in the intervention group and 59 (90.8%) from the comparison group agreed that individuals with intellectual disabilities could suffer from depression. Conversely, the item eliciting the lowest number of correct responses related to the prevalence of mental health problems with almost two-thirds of the intervention group ($n = 42$, 63.6%) and the comparison group ($n = 42$, 64.6%) answering incorrectly. However, the majority of staff, 48 (72.7%) in the intervention group and 51 (78.5%) in the comparison group, agreed that individuals with intellectual disabilities were more vulnerable to developing mental illness compared with the general population. A substantial number of staff [17 (25.8%) and 19 (29.2%) from each group] considered intellectual disabilities and mental health problems to be equivalent. Less than half of the intervention ($n = 32$, 48.5%) and comparison groups ($n = 26$, 40.0%) agreed that challenging behaviour may signify an underlying emotional disorder.

Table 2  Staff judgements about the presence of mental health problems and detection by the PAS-ADD checklist ($n = 131$)

<table>
<thead>
<tr>
<th>Checklist</th>
<th>Staff identification (%)</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>detection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>19 (70)</td>
<td>23 (59)</td>
</tr>
<tr>
<td>Yes</td>
<td>8 (30)</td>
<td>16 (41)</td>
</tr>
<tr>
<td>Total</td>
<td>27 (41)</td>
<td>39 (59)</td>
</tr>
<tr>
<td>Intervention group ($n = 66$)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>43 (81)</td>
<td>9 (75)</td>
</tr>
<tr>
<td>Yes</td>
<td>10 (19)</td>
<td>3 (25)</td>
</tr>
<tr>
<td>Total</td>
<td>53 (81)</td>
<td>12 (19)</td>
</tr>
<tr>
<td>Comparison group ($n = 65$)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Staff attitudes about mental health services

The majority of staff agreed that psychiatric interventions extended beyond drug therapy with 45 (68.2%) from the intervention group and 43 (66.2%) from the comparison group agreeing that psychiatric assessment incorporates both physical and social needs. Nevertheless, more than half of staff in the intervention and comparison groups, 33 (50.0%) and 36 (55.4%), respectively, felt that individuals with intellectual disabilities had enough labels without adding a psychiatric diagnosis. Although the majority of staff agreed that they had a special role to play in detecting mental health problems, approximately one quarter, 15 (22.7%) and 22 (33.8%), respectively, disagreed that it was a special part of their role. At the same time, less than half, 23 (34.8%) and 29 (44.6%), respectively, knew what type of information was required by a psychiatrist to assess mental health.

Staff referral decisions

The statement generating the highest number of correct referral decisions related to a client talking to himself; a total of 51 staff (77.3%) in the intervention group and 50 (76.9%) in the comparison group, indicated that they would seek advice if presented with this behaviour. Similarly, 37 (56.1%) and 44 (67.7%), respectively, agreed that they would seek a GP opinion, if a client kept bursting into tears. Less conspicuous signs of mental illness and those associated with less disruptive behaviours, such as early waking and loss of interest, prompted the lowest number of referral decisions. For example, 3-h-long daily handwashing by service users was judged to be insufficient grounds for seeking a GP opinion by 37 staff (56.1%) in the intervention group and 40 staff (61.5%) in the comparison group.

Changes in staff awareness following training

Table 3 shows the total awareness score and subscale scores for knowledge, attitudes and referral decisions before (baseline) and after training (follow-up). At baseline, Mann–Whitney U-tests showed no significant differences between the intervention and comparison groups in respect of the baseline total scores ($U = 2114$, $Z = -0.144$, $P = 0.885$) and subscale scores for knowledge ($U = 2029.5$, $Z = -0.553$, $P = 0.580$), attitudes ($U = 2054.5$, $Z = -0.432$, $P = 0.666$) and referral decisions ($U = 1955$, $Z = -0.899$, $P = 0.369$).

The results indicate that the total and subscale awareness scores for the intervention group increased as a function of training. At follow-up, the intervention group had a median total awareness score of 12.0 (range 5–15), compared with 9.00 (range 5–14) for the comparison group; this difference was significant ($U = 495.50$, $Z = -5.71$, $P < 0.001$). Across-group analysis indicated that the intervention group subscale scores were also significantly higher than those for the comparison group for knowledge ($U = 599.5$, $Z = -5.23$, $P < 0.001$), attitudes ($U = 873.5$, $Z = -3.38$, $P < 0.005$) and referral decisions ($U = 785.0$, $Z = -4.03$, $P < 0.001$). For the intervention group, Wilcoxon signed-rank tests indicated significant increases between baseline and follow-up in relation to the total score ($Z = -5.105$, $P < 0.001$) and subscale scores for knowledge ($Z = -4.545$, $P < 0.001$), attitudes ($Z = -3.504$, $P < 0.001$) and referral decisions ($Z = -3.504$, $P < 0.001$). Analysis showed no significant changes over the same time period in scores for the comparison group in respect of total awareness ($Z = -0.780$, $P = 0.436$), knowledge ($Z = -1.34$, $P = 0.181$), attitudes ($Z = -1.07$, $P = 0.068$) and referral decisions ($Z = -0.699$, $P = 0.485$).

Of the staff characteristics, age was the only variable with a significant correlation with the change in awareness score. Pearson’s correlation coefficient indicated an inverse relationship between the change in awareness score and staff age ($r = -0.286$, $P = 0.020$), with younger staff exhibiting the greatest improvements in awareness scores following training.

Table 3  Awareness scores for the intervention and comparison groups at baseline and follow-up

<table>
<thead>
<tr>
<th></th>
<th>Awareness scores (median and range)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge</td>
</tr>
<tr>
<td>Intervention group ($n = 66$)</td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>3.00 (0–5)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>5.00 (0–5)</td>
</tr>
<tr>
<td>Comparison group ($n = 65$)</td>
<td></td>
</tr>
<tr>
<td>Baseline</td>
<td>3.00 (1–5)</td>
</tr>
<tr>
<td>Follow-up</td>
<td>3.00 (1–5)</td>
</tr>
<tr>
<td>P-value</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Discussion

Recent initiatives, such as Valuing People (DoH 2001) and the National Training Strategy [Training Organisation for the Personal Social Services (TOPSS) 2000], place emphasis on the provision of generic services to individuals with intellectual disabilities and the provision of...
generic, rather than specialist skills, to staff. The impact of such initiatives for improving access to mental health services is unclear. Demonstrating the outcomes of mental health training is therefore timely and may be important in improving the pathway to care and ensuring against the further marginalization of individuals with intellectual disabilities and additional mental health problems.

Results of the current study confirm previous research suggesting deficits in staff awareness of mental health problems in individuals with intellectual disabilities. First, there was a lack of agreement between staff and the PAS-ADD Checklist about which individuals had a mental health problem. Approximately one-third of those individuals judged by staff to be free of mental health problems had significant levels of psychopathology warranting further psychiatric assessment. Conversely, two-thirds of those individuals judged by staff to have mental health problems did not exhibit significant psychopathology. When staff did identify an individual with a mental health problem, in 44% of these cases, carers were unable to describe the broad nature of the problem. Although the study relied upon a brief screening instrument to identify individuals with mental health problems, which accounts for a degree of discordance, these findings raise serious doubts about the criteria staff used to judge the presence of mental health problems.

Second, examination of the individual items on a questionnaire indicated a number of factors which may inhibit the process of identification and referral. For example, the majority of staff were unaware that mental health problems may manifest in challenging behaviour, and about a quarter thought that intellectual disability was equivalent to a mental health problem. Beliefs about the nature of symptoms exhibited in individuals with intellectual disabilities is therefore vital in improving the pathway to care.

The findings support previous research (Spengler et al. 1990; Edelstein & Glenwick 1997) highlighting the difficulty staff experience in detecting the symptoms relating to internalizing disorders, such as depression (e.g. Moss et al. 1996). This result also highlights the critical role of causal attributions of behaviours in referral decisions. Staff are likely to be aware of the presence of the behaviours indicating mental illness, but they may be unaware of their clinical significance and the need for treatment. The most basic and vital role of support staff within this context is the awareness that a person with intellectual disabilities may suffer from a mental illness. Ensuring that staff consider the presence of a mental health problem in interpreting the complex behaviours of individuals with intellectual disabilities is therefore vital in improving the pathway to care.

The intervention evaluated in the current study was typical of the majority of on-the-job training available to staff working in intellectual disability services in terms of format and length. As such, it accurately reflected current training resources and practices and could be readily adopted by services. As in previous research (Mester 1999; Quigley et al. 2001) the study found evidence to suggest that training was associated with increased knowledge of psychopathology. In addition, the data suggest that training improved staff attitudes towards mental health services and increased the likelihood of referral decisions. Improvements in awareness were maintained, with significant increases in knowledge, attitudes and referral decisions still evident four months after the delivery of training. Correlation analysis indicated that younger staff benefited the most from training in terms of increased awareness scores. This finding is interesting in the context of previous research that highlights the increased vulnerability of younger staff to high levels of stress, burnout and turnover (Allen et al. 1990; Hatton et al. 1998). The identification of strategies that are beneficial for this group is therefore particularly important.

A major limitation of the current study was the use of a non-randomized design implying measured and unmeasured differences between the intervention and comparison groups. While such differences reduce the generalizability of the results, a within-subject analysis
lends some support to the conclusion that any significant differences observed were attributable to the training and not to the group differences. Nevertheless, the participants were volunteers and loss to follow-up was relatively high (32%) for the intervention group. This may have been because this group were asked to return follow-up questionnaires by post. This may have lead to response bias with those individuals with greater confidence in their answers being more likely to return questionnaires.

Although the findings are consistent with studies in Austria and Greece using the same training materials and awareness questionnaire (Tsiantis et al. 2004), additional research on its validity and reliability are necessary. Indeed, Cronbach's alpha was just acceptable for the entire scale, but <0.6 for two of the subscales. This raises questions about the internal consistency of the subscales, but may also be due to the small number of items on the subscales. Completing the questionnaire may have been problematic for staff. In practice, staff have comprehensive information through which to interpret behaviour and may pursue multiple responses to problems behaviours simultaneously. Moreover, staff may hold negative attitudes, such as individuals with intellectual disabilities having too many labels, but this may not necessarily prevent referral.

Ultimately, the impact of such training initiatives on the pathway to care and on the mental health of individuals with intellectual disabilities is uncertain. First, increasing carer awareness of mental health problems does not guarantee that they will change their actual behaviour. Second, referral is unlikely to rest solely on the awareness of care staff. Rather, a range of other variables are also likely to influence the care pathway. Amongst others, these include the formal and informal culture of the setting in which the mental health problem occurs, the awareness of other individuals such as social workers, the experience of gatekeepers such as managers and GPs and the availability of services. Clearly, training initiatives for other professionals influencing the pathway to mental health care is also necessary. The routine use of sensitive screens by community health and social care providers in conjunction with brief training may also represent an effective means of increasing access to mental health services. This would also help to reduce reliance on the skills and experience of care staff in identifying individuals with potential mental health problems; this is especially important because the workforce is highly mobile in intellectual disability services.

Overall, little is understood about the referral process itself and a conceptual model for understanding how carers behave towards individuals with recognized and unrecognized mental health problems is lacking. More evidence about the nature and relative role of those factors influencing the pathway to care is therefore required to build theoretical models of staff behaviour within the context of mental health problems. As demonstrated in the field of challenging behaviour (e.g. Hastings & Remington 1994) examining the cognitive processes underpinning referral decisions, such as documenting the causal attributions of a range of mental health problems, may be fruitful in achieving some progress towards this goal.

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References


