Community Psychiatric Nursing

A RESEARCH PERSPECTIVE
VOLUME 2

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Edited by
Charles Brooker
and Edward White

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Foreword

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The move towards a comprehensive and local mental health service, which gathered pace in the 1970s, has been one of the most profound changes in psychiatric nursing. In 1968, because of the scarcity of services, there were very few community mental health nurses. In 1990 the figure was 4990. At the same time the number of people in United Kingdom psychiatric hospitals and units fell from 132 000 in 1968 to 60 000 in 1989.

A number of important developments underpinned this shift. For instance, significant pharmaceutical advances and the abandoning of some of the treatments favoured in the past have given nurses an important role in the administration of new treatment as well as in monitoring. Behavioural, psychodynamic and cognitive psychotherapies – traditionally associated with psychologists – are all areas in which nurses have a significant input, or take the lead.

The growth of user organizations in mental health care has increased the opportunities for patients and clients to participate in their own care. Meanwhile, a vast array of legislative change has greatly affected the way in which mental health nurses now practise in this country. In 1983, the Mental Health Act changed the role of the mental health nurse, and this, along with other Acts including the Sex Discrimination Act, the Race Relations Act, the Disabled Persons Act and the NHS and Community Care Act, has influenced the nurse–patient relationship by focusing on the rights of individuals.

Today's community mental health nurses face a number of new and difficult challenges. No part of society is untouched by mental illness, and anyone may at some time require the services of a mental health nurse. Poverty, unemployment, homelessness and pressures on families as well as demographic factors such as the increasing numbers of elderly people impact on the mental health of the nation. Multiracial and multicultural communities present new areas of need.

The Health and Safety Executive believes that 40 million working days are lost to stress alone every year. So something like 30 days are lost to stress and subsequent mental illness for every single day that is lost to industrial disputes.

The nature of community health services varies considerably from region to region in terms of referral systems, case load sizes and profiles. There is a very real concern about the split between health care and social care. This is an unreal dichotomy for many people with long-term problems where needs can be interdependent and may fluctuate considerably within a short time span. Evidence from RCN members indicates that this causes problems about which authority will purchase the services needed.

The knowledge of how to care for distressed people is central to psychiatric nursing. But today's nurse has to combine that with an imaginative approach, intelligence and self-awareness. Mental health nurses do not simply follow regulations anymore.

For people with a mental health problem, the most important need is appropriate assessment followed by effective care. Mental health nurses can provide information about options for care and potential outcomes, assess the need for care and, within a nursing framework, provide that care. They can be skilled in psychological interventions, aid rehabilitation and be involved in the promotion of mental health.

As a group, community mental health nurses call upon the knowledge derived from medicine, social and behavioural science and physiological sciences.

In short, the community psychiatric nurse is an autonomous practitioner who works with a multidisciplinary and multiprofessional approach to provide care and prepare support staff to alleviate the problems of people who are mentally ill.

Although mental health nursing is essentially practical, it must be founded on a theoretical base. The increasing amount of mental health research must be welcomed, as is the increasing influence of mental health nurses in academic departments. Their influence is also helping to promote the educational objectives of the *Strategy for Nursing* document (DoH, 1989) and the relevant mental health components in the other activities of their departments.

The mental health nurse has a unique contribution to make in so many areas of nursing pracice and in so many settings. And for the whole family of nursing, it is essential that mental health nurses attempt to demonstrate and communicate the value of their branch of nursing. We live in a culture in which nurses and nursing are too often undervalued, and it is the continuing objective of the Royal College of Nursing to change this perception.

Many people have an unclear idea about what nurses do and it is quite common to hear people say, 'I couldn't do your job'. Often their reason for saying this is related to the fact that nurses are involved in so much intimate care and work which is perceived to be repetitive and somehow distasteful.

This is illustrated by the following example which was studied by the RCN as part of the work undertaken to demonstrate that nursing really does make a difference to patient outcomes. A community psychiatric nurse daily visited an elderly lady who lived with her sister. The patient would hide in the bedroom for most of the time while the CPN played drafts and had tea with her sister. Without the visits, the patient would rapidly become ill and need to be admitted to hospital. Meanwhile, the daily visits, chats and cups of tea enabled her sister to cope. All the time the CPN was assessing this fragile situation.

This second volume of *Community Psychiatric Nursing: A Research Perspective* is another welcome addition to the increasing amount of mental health nursing research, and it is an essential demonstration of the cost effectiveness and value of this branch of nursing.

REFERENCE

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Introduction

The idea for this, the second volume of the series, was conceived during conversations we had when we shared a room in the Department of Nursing at the University of Manchester. We were both employed there as contract researchers and knew that we had shared a very similar career path, including previous posts as community psychiatric nurses (CPNs), as service planners and as senior lecturers in higher education. Similarly, we had both held the post of research officer to the Community Psychiatric Nurses Association (CPNA), at different times, continuously from 1984 to 1992.

It was as CPNA research officers that we undertook the Second and Third National Quinquennial Community Psychiatric Nursing Surveys. In our view, these additions to this longitudinal data set have contributed to the environment in which many important debates have begun. These relate to the organization of CPN services and the individual work practices and educational preparation of CPNs. The information provided by the three studies has not only described but also helped to explain these trends over time. These data have continued to be interrogated for service and educational personnel in the National Health Service and by other researchers.

The third survey differed from the other two by obtaining a substantial external research grant from a concerned national agency. The success of such funding provided an indication of the growing interest in this substantive area. Volumes 1 and 2 of this series have contained 24 contributions and it is of interest to reflect on the sources of funding for these. Central government has played a significant role in underwriting the costs of CPN research, both through commissioned projects and research studentships. We are pleased that this present volume has been able to present the findings from much of this work.

Community psychiatric nursing research has not only been funded by the Department of Health (DoH), of course, and monies have been forthcoming from a wide variety of other sources, including the English National Board for Nursing, Midwifery and Health Visiting (ENB) and from district health authorities (DHAs). Such funding has allowed individuals to undertake research for awards at Diploma, Baccalaureate and higher degree level. Examples of this work have also been able to enter the public domain through both volumes and have so helped to inform the policy debate.

However, in the past, a tension has arisen between customers (Department of Health) and contractors (academic researchers) about the areas of research deemed worthy of attention. For, as the former chief scientist to the Department of Health recently commented, policy makers are:

> ... less likely to welcome agencies who want to debate the policy and its development, or the credibility of the proposals to advance it, than research which illuminates and propels the policy development in hand ... given the pressure of government business they are also unlikely to want to devote much time to developing a long-term research strategy, or contemplating questions for the future. Researchers, however, **do** want to develop long-term plans and to have time to speculate and innovate.
>
> (O'Grady, 1990)

O'Grady concluded that the relative strengths of these positions could not continue to co-exist without modification. As we write, new arrangements are being developed in which the relationship between research and the policy-making process will be made more explicit (Department of Health, 1991a). The formation of the Central Research and Development Committee (CRDC) at the DoH has a mental health sub-group and both benefit from nursing representation, which may bode well for the future. This innovation will strengthen the position of regional health authorities (RHAs); indeed, most NHS research and development activity will become their responsibility in the future (Department of Health, 1991b). The recent establishment of the Centre for Mental Health Service Development (CMHSD) at King's College, University of London, could complement these initiatives by acting as a broker between funding agencies and RHAs. This, in addition to their direct consultancy services.

Thus, it behoves CPN practitioners, managers, researchers and educationalists to feed into the systems which will be designed to identify, at RHA level, the research needs of specific populations. Such activity might be best advanced by appropriate service-based personnel and academics working in close alliance.

However, we would wish to temper any optimism about the new procedures by which research priorities are being determined. If CPN research is to continue to command a market share of financial resources, a number of pre-conditions will need to be met. These will include:

1. An equitable nursing voice being heard in both the Central Research and Development Committee and Advisory Group on Practices for Mental Health.
2. Mental health nursing research expertise being utilized at RHA level to ensure methodological rigour, as priorities are set.
3. Concomitant work being undertaken by responsible national agencies to articulate the strategic policy position of community psychiatric nursing organization and education.

Several initiatives have already begun to address the third point above, which is arguably the most pressing for community psychiatric nurses. For example, the Royal College of Nursing (RCN) recently hosted a symposium in London, at which national figures in psychiatric nursing urged the RCN to publish a paper identifying the need for a national review of psychiatric nursing. Indeed, as we write, such a document is in the process of being drafted. Independently, the English National Board has also pressed the Department of Health to undertake just such an exercise, based on the findings of research it had commissioned to help set the agenda for the future of psychiatric nursing over the next decade (White, 1991). When the last national review was undertaken 24 years ago, **community** psychiatric nursing fell outside the terms of reference and has yet to be scrutinized systematically. While we both acknowledge that research is but one contribution to knowledge, we also believe it to be a crucially important activity in a cash-limited National Health Service.

We offer the contents of this book, therefore, written by a cross-section of authors, as evidence of the increasingly respectable nature of CPN research and the role such work should play in helping to shape the future of community psychiatric nursing service and education.

We are pleased to offer our gratitude to all those who contributed to this second volume. We are also indebted to Rosemary Morris, our Senior Editor at Chapman & Hall, for her vision and support.

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CHAPTER ONE

Community psychiatric nursing 1980 to 1990: a review of organization, education and practice

Edward White

INTRODUCTION

The origins and development of community psychiatric nursing (CPN) since the first experimental secondment of two 'outpatient nurses', as they were originally known, to extramural duties in the London Borough of Croydon in 1954, has been previously reported elsewhere (see, for example, White, 1986). During the 37 years since, a national network of CPN services has developed. The organization and management of these services vary considerably, as do local and individual work practices. These differences affect not only the shape and style of service provision between the four home countries, for example, but also the differences within and between the regional and district health authorities (RHAs and DHAs). Some of these differences, and their changes over time, will become the attention of the later part of this introductory chapter, which will also address some of the policy implications which this structural analysis of CPN services might imply.

From 1974 onwards, the availability of an academic year-long, post-registration course in community psychiatric nursing has grown to some 25 centres (White, 1990a). The prevailing educational model has tried to keep in synchrony with the development of a CPN role which was first argued by Barker (1981) to contain four main components: that of assessor and therapist to clients and relatives; as consultant to other professionals and as clinician to monitor the effects of wide range of psychotropic drugs. The administration of long-acting psychoactive injections, although still poorly understood as a contribution to the process of client care, has long been regarded as the *sine qua non* of community psychiatric nursing. Moreover, such practice has provided an indication of the predominant client group, the referral source and the operational base with which CPNs have been linked historically; that is, with previously hospitalized individuals with disorders alleviated by the regular administration of such medicines, particularly those with schizophrenia as a diagnosis; the psychiatrist and the psychiatric hospital, respectively.

The extent to which these predictions, assumptions and stereotypes continue to hold empirically will be examined with close reference to selected findings from the Third National Quinquennial Community Psychiatric Nursing Survey (White, 1991a), which has been undertaken and published every five years since 1980 (Community Psychiatric Nurses Association, 1981, 1985). It has done so to report the contemporary shape of community psychiatric nursing services in the United Kingdom and to attempt to monitor movements in CPN service organization and CPN work practice beween each quinquennium. In effect, therefore, it has become a national CPN census. The quinquennial survey is now believed to be the most comprehensive, regular and independent examination of any community nursing group in the United Kingdom, or indeed any other occupational group connected with mental health care.

On the two previous occasions, this study has been funded by a national charitable organization (the Community Psychiatric Nurses Association, CPNA) with additional financial support from the Department of Health and Social Security (as was) in 1985. The 1990 version was wholly funded by the English National Board for Nursing, Midwifery and Health Visiting, which is the regulatory body for the educational preparation of all nurses, midwives and health visitors in England.

STUDY DESIGN

Design of the present study began in January 1989 with an invitation to representatives of each of the four National Boards and to the Department of Health, for them to declare areas of policy interest which the study might address. The Executive Council of the CPNA was similarly invited, and the two previous surveyors (McKendrick and Brooker in 1980 and 1985, respectively) were consulted regarding their methodological recollections. In the event, the Department of Health declined the invitation because 'the research had not been commissioned from that source' (Department of Health, 1989a). All other agencies, however, accepted the invitation and had their policy interests accommodated, where possible, within the overall research design.

A complete postal enumeration was decided upon in favour of a random stratified sample, given that relevant stratification variables were likely to be out of date, or unavailable. Successive drafts of the instrument were made available to all representatives, in addition to academic colleagues of the researcher (EW), for criticism and amendment.

The present study intentionally took a departure from the two previous study designs, by seeking to capture data at the level of individual CPNs, in addition to the capture of data at the level of CPN service as before. This, because from exploratory investigations, it was no longer appropriate to conceptualize the organization of service provision only as a single, homogenous, CPN team located within each DHA (and their counterparts in Scotland and Northern Ireland). Two separate questionnaires were developed for each purpose, drawing on exemplar advice from the literature (for example, Hoinville and Jowell (1978), Marsh (1982), Moser and Kalton (1971), Oppenheim (1966)). In addition to new variables, several of the variables used in the two previous surveys were retained to allow for inter-quinquennial comparisons in the broad substantive areas of contemporary community psychiatric nursing practice, staffing, organization and education. The census point for all data requested was as at 31 December 1989.

The changing landscape of Inner London District Health Authority boundaries reduced the number of English DHAs between 1985 and 1990. In North West Thames RHA, Brent DHA combined with Paddington and North Kensington DHA to create Parkside Health Authority, and Victoria DHA combined with Hammersmith and Fulham DHA to create Riverside Health Authority. The Bethlem Royal and Maudsley Hospitals have been treated as a separate DHA by this study. Bloomsbury DHA and Islington DHA also combined, but after the data collection period. The total number of English DHAs in 1990 was therefore 191. The number of Welsh DHAs remained constant at 9.

Expert local advice was sought regarding the most appropriate administrative unit to target for both Scotland (Dow, 1989) and Northern Ireland (Parahoo, 1989). In Scotland, chief area nursing officers (CANO) at health board (HB) level were identified, of which there were 15. In Northern Ireland, assistant chief administrative nursing officers (ACANO) were identified at the level of health and social services boards (HSSB), of which there were 4. In total, therefore, 219 DHAs, HBs and HSSBs were identified in the United Kingdom, each with a named correspondent. Table 1.1 shows the changes observed in the number of respondent administrative units, by country, between 1985 and 1990.

Sampling frame

The basis for the sampling frame used for chief nursing officers (CNO) and their equivalents was the 1989 edition of the *Hospitals and Health Services Year Book* (Institute of Health Service Administrators, 1989). Every CNO, CANO and ACANO in the United Kingdom was posted a set of survey

Table 1.1 Changes to the number of administrative units identified as survey respondent areas, over time

Country	*1985*	*1990*
England	192	191
Wales	9	9
Scotland	33	15
Northern Ireland	17	4
United Kingdom	251	219

questionnaires. Each set contained a separate questionnaire for the capture of data regarding the CPN service at the level of DHA, HB or HSSB (the so-called Part A questionnaire), together with 20 other questionnaires for completion by every individual community psychiatric nurse employed within the DHA, HB or HSSB (the so-called Part B questionnaires). Where fewer than 20 CPNs were employed, the excess questionnaires were discarded. Where more than 20 were employed, additional questionnaires were either supplied by the researcher upon request, or photocopied locally from an original. Each CNO, CANO and ACANO was invited in a covering letter to forward the set of questionnaires to the person identified as best placed in their own organization to be responsible for ensuring their completion and safe return to the researcher. A reminder letter was sent to non-respondents and, where necessary, extensive follow-up was undertaken by telephone. To encourage the co-operation of their DHA colleagues, the welcome assistance of all regional nursing officers (RNOs) in England was established at the November 1989 meeting of the RNO Group, held at the Department of Health, London.

Data were coded by the researcher and dispatched to an external data preparation bureau for inputting. The resultant data file was transferred on magnetic tape to the University of Manchester mainframe computer and then down-loaded for use on a Hewlett Packard Vectra ES/12. After cleaning procedures were completed, analyses were performed on these data using Version 2.0 of SPSS/PC (Norusis, 1988). The form in which the data was to be held fell outside the terms of the 1984 Data Protection Act. In some of the following Tables in this chapter, a convention has been adopted in which fractional percentages of 0.5 or greater have been rounded to the next higher integer; fractional values of less than 0.5 have been dropped and may therefore effect totals. The term 'significant' will mean that the likelihood of result happening by chance was less than five times in 100 (or $p=<0.05$).

Response rates to postal questionnaires vary considerably and some reasons for this have been reviewed recently for a nursing readership (Robinson, 1989). The present study achieved a 87.2% response by district health authority, and their equivalent, and so exceeded a bench mark set by Ford (1986) of 'any questionnaire that produces 75 to 85% is doing extremely well'. It has long been known that postal surveys that have clear aims and that are well designed, produce high response rates especially in the health service, when the topic is understood by the respondent as being of high professional interest (Cartwright, 1978; Dunnell and Dobbs, 1982). The response rate achieved in the present study might have been yet higher had prospective respondents not been subject to a number of similar requests for information from other enquirers prior to the present research (Boodhna, 1990; Caldwell, 1989; Flaye, 1990; Jarvis, 1990; Parahoo and Robinson, 1989; Thomas, 1989). The notion of 'questionnaire-completion fatigue' thus emerged as a possibility for respondents, especially when the number of such requests was compounded by those made by students (year upon year) attending community psychiatric nursing courses, and others, which usually fail to enter the published literature. The innocent risks, tolls, limitations and policy consequences of such activity have been reported (White, 1989), although the need for this could again be looped back to the dearth of usable information.

Tables 1.2 and 1.3 relate, first, to response by DHA, HB and HSSB (Part A), then to the response by individual community psychiatric nurses (Part B), respectively.

PART A - DATA AT THE LEVEL OF SERVICE

Of the 219 sets of questionnaires posted to each DHA, HB and HSSB in the United Kingdom, 191 responded with Part A, which produced a response rate of 87.2%. One district health authority and one health board corresponded with the researcher to apologise for being unable to take part in the study, because they were under a 'heavy pressure of work' and were 'an already hard-pressed service, likely to face a further budget reduction', respectively. Despite the differences noted in Table 1.1 and the methodological differences described earlier, such a response accorded almost identically with the overall 1985 rate of 86.5%. When the response by DHA, HB and HSSB was collapsed into English regional health authorities and/or countries, the rates were distributed as shown in Table 1.2.

PART B - DATA AT THE LEVEL OF INDIVIDUAL CPNs

The sum total of individual community psychiatric nurses who responded with Part B questionnaires numbered 3181. This represented 73.1% of the 4351 CPNs (4213 full-time 138 part-time) who were reported by Part A respondents as being employed, as at 31 December 1989 (the census date of the survey). Seven Part B questionnaires were also received from individual CPNs employed in four different district health authorities. They were, however,

Table 1.2 Distribution of respondents by English regional health authority and/or country in the United Kingdom, with 1985 comparison

RHA and country	*No. DHAs HBs, HSSBs*	*Number of respondents*	*% response 1990*	*% response (1985)*
Northern	16	15	94	94
Yorkshire	17	14	82	94
Trent	12	11	92	83
East Anglian	8	7	88	75
NW Thames	13	12	92	93
NE Thames	16	12	75	81
SE Thames	16*	14	88	93
SW Thames	13	10	77	100
Wessex	10	8	80	100
Oxford	8	7	88	100
South Western	11	11	100	82
West Midlands	22	19	86	91
Mersey	10	8	80	100
North Western	19	16	84	100
England	191	164	86	92
Wales	9	9	100	78
Scotland	15	14	93	73
N. Ireland	4	4	100	53
United Kingdom	219	191	87.2%	86.5%

*Includes the Bethlem Royal and Maudsley Hospitals as separate DHA.

Table 1.3 Reported number of community psychiatric nurses in respondent services and individual CPN respondents, distributed by country

Country	*No. reported CPNs (Part A)*	*Individual CPN respondents (B)*	*% of reported CPN workforce*
England	3730	2718	73
Wales	241	114	47
Scotland	270	248	92
N. Ireland	110	101	92
United Kingdom	4351	3181	73

unaccompanied by Part A counterparts and, after considerable (but eventually unsuccessful) follow-up, were excluded from the analyses.

Data at the level of individuals presented here, therefore, not only represented nearly three-quarters (73%) of staff employed in respondent services in the survey, but also about two-thirds (64%) of all United Kingdom CPN services. Table 1.3 shows the distribution of individual respondents by country. Cognizance should be taken of the response rates described above and an appropriate parsimony should be exercised in the use of any of the following information.

FINDINGS

Using these data, it has been possible to extrapolate an estimated United Kingdom workforce of some 4990 CPNs. In turn, this figure can be used in a calculation to estimate the rate of growth in the national CPN workforce, therefore, of about 54% over the quinquennium, which compared with an estimate of 65% for the period between 1980 and 1985. Such growth has had a comcomitant effect on the CPN to population ratios, which varied both by country and regional health authority (Table 1.4).

Table 1.4 Distribution of CPN: population ratios, by regional health authority and country, over time (part-time CPNs excluded)

	CPN to population ratio			
RHA/country	*1980*	*1985*	*1990*	*% change 1985–1990*
Northern	53 300	21 300	14 300	−32.9
Yorkshire	75 200	34 500	12 000	−65.2
Trent	72 400	27 150	13 900	−48.8
East Anglian	74 000	20 000	12 100	−39.5
NW Thames	58 900	22 800	14 500	−36.4
NE Thames	31 700	19 000	11 700	−38.4
SE Thames	38 600	21 250	11 700	−44.9
SW Thames	60 000	18 130	11 100	−38.8
Wessex	38 300	17 800	11 400	−36.0
Oxford	39 500	21 300	13 400	−37.1
South Western	37 800	18 000	11 500	−36.1
West Midlands	42 000	22 300	13 300	−40.4
Mersey	42 300	24 200	12 900	−46.7
North Western	37 400	22 300	13 200	−40.8
England	50 000	23 800	12 700	−46.6
Wales	—	—	12 400	
Scotland	—	—	16 100	
N. Ireland	—	—	17 700	
United Kingdom	—	—	13 100	

However, any inferences which might be drawn from these differences should be tempered with caution, given a host of confounding factors which might be in play to explain such differences. Not the least of these would be the distribution of the populations within countries, RHAs and DHAs; differences in the geographical area and terrain; differences in the indices of social deprivation among populations; differences in the level and style of other psychiatric service provision; differences in relationships with psychiatrists and general practitioners and resulting referral practices; differences in local strategic policy positions and the differential allocation of financial and other resources; differences in hospital retrenchment or closure plans and so on and so forth. The extent to which the reported CPN to population ratios (especially in RHAs, for example) were indicative of any or all of these factors, would be an important matter for separate investigation.

Manpower planning targets

A little over half (54.5%) of CPN services in the United Kingdom reported having a manpower planning target, ranging between 1:5000 to 1:25 000 for achievement within the next five years or so. Most commonly, the target ratios were between 1:10 000 to 1:12 000. The resource implications of such targets committed one health board in Scotland to recruiting an additional 60 CPNs, while other DHAs looked to about seven staff each.

The basis upon which such manpower planning targets were calculated, at DHA level, however, cited ratios variously recommended by regional health authorities, the Department of Health (DoH) and the Community Psychiatric Nurses Association. Moreover, different ratios were claimed by different CPN services for a single recommendation. For example, the CPNA was cited for recommendations between 1:6000 and 1:12 000; the DoH cited for recommendations between 1:7000 and 1:18 000. Indeed, two CPN services in two differnt DHAs, but within the same RHA, cited 1:8000 and 1:12 000 as their regional recommendation.

In fact, supplementary investigations with regional nursing officers confirmed that only two out of the 14 RHAs in England recommended a CPN to population ratio to DHAs for planning purposes (neither of which was the RHA in which the differnt ratios were cited in the earlier example). The Department of Health confirmed that it did not issue norms. Moreover, the present writer had earlier reworked the mathematics of the original basis for the Community Psychiatric Nurses Association recommended ratio and found that it was seriously methodologically flawed (White, 1989).

The present study found, therefore, that services using top-down guidance for planning community psychiatric nursing growth and development were essentially bereft of a creditable basis so to do. For a typical DHA with a population of 250 000, the innocent adoption of a manpower planning target ratio of 1:10 000 rather than (say) 1:12 000, would commit that district to an extra revenue cost of about £74 000 (at October 1991 prices: G grade nurse, at the mid-point, with oncost); while the erroneous adoption of 1:12 000 rather than 1:10 000 would under-resource a service by four whole-time equivalent community psychiatric nurses, or 20% of a median average sized contemporary CPN service.

It is of interest to report that when the size of an individual CPN service at DHA level was standardized to a population of 100 000, the variation between DHAs ranged from about three CPNs (3.21) to nearly 22 CPNs (21.67); more than a seven-fold difference in the level of CPN service provision within DHAs across the United Kingdom (White, 1990b). The need for policy-oriented research to develop suitable methods which would ensure a more systematic basis to CPN service planning and development, has thus become self-evident. Similar research to this has already been funded by the Department of Health to assist health visiting and district nursing to determine their staffing requirements for the future.

Involvement of service users

Other selected findings from the present study showed that almost three-quarters (70.2%)of CPN services in the United Kingdom do not have an established method for the involvement of service users in the planning of community psychiatric nursing services. Despite the methodological issues in so doing, Munton (1990) recognized that eliciting clients' views and acting upon them increased their power and influence over the nature of service provision, with a concomitant reduction in these features held by the health care professionals. Such an observation might provide part of the explanation why a more substantial proportion of CPN services was not found to involve services users.

Measuring performance

More than half (53.4%) of CPN services did not have a recognized method for measuring CPN service performance. The ability of a service to predict its performance, to a pre-specified quality within explicit parameters, has become a crucial area for research to enable providers to demonstrate indicators of expected service standard to prospective purchasers. Moreover, for CPN services concerned to ensure the notions of active participation and informed choice by their clientele, the same information could be made directly available to prospective individual service users. Post hoc accounts of their experience (in relation to what they were led to expect) could then form an integral part of a service evaluation strategy, the reports of which could be made available for all levels of public scrutiny. The present study showed that the opportunity to exercise such an option, even if it were regarded desirable, was open to less than half of the CPN services in the United Kingdom (as at 31 December 1989).

Education and training

Increasingly, one other such proxy measure of quality has become the level of specialist skilled staffing and associated education and training (Department of Health, 1989b). Over three-quarters (78%) of services in the United Kingdom had CPN staff seconded to the substantive academic year-long community psychiatric nursing course. Such a proportion was noteworthy, given that only a quarter (25.1%) of services reported that a current post-basic nurse education strategy had been published at DHA or equivalent level, in which the educational requirements of CPNs had been identified. Moreover, only four in ten services (41.4%) reported that specifically identified finance for post-basic community psychiatric nurse education was guaranteed each year. Almost without exception, CPN services in the United Kingdom usually had nursing students placed with them for 'community experience', as part of their programme of education. The level of available capacity to accept nursing students varied by service at DHA level, and ranged from those who reported having much spare capacity, to those who were (as one service put it) 'saturated' with nursing students (Table 1.5).

Table 1.5 Distribution of the proportion of the United Kingdom CPN services' capacity to accept nursing students for 'community experience', reported on a seven point bi-polar scale

	Proportion of CPN services							
No spare capacity	1	2	3	4	5	6	7	*Much spare capacity*
	23%	27%	20%	16%	7%	5%	2%	*Much spare capacity*

The distribution shown in Table 1.5 of the reported capacities for CPN services to accommodate nursing students for community experience placements showed a marked skew toward there being no spare capacity. This was a salutary finding, given the immediate requirement on services to accommodate supernumary students of nursing on a mental health branch programme of Project 2000 courses, which will substantially rejig the educational orientation toward community settings.

INDIVIDUAL CPNs AND THEIR CIRCUMSTANCES

Thus far, this chapter has provided a summary description at the level of CPN service. The intention has been for it to act as the backdrop for the next section, which will reveal the circumstance of individual CPNs employed in United Kingdom services as at 31 December 1989. This will be a necessarily selective procedure, as the scope of the complete study included some 75 separate variables. All of these variables can be analysed by district, region or country (or whatever) for the purpose of comparison. By way of example, the pay grade at which CPNs were employed is distributed below by RHA and country (Table 1.6).

Table 1.6 Distribution of CPN pay grades, by regional health authority and country

RHA and/or country	*Grade (%)* D	*E*	*F*	*G*	*H*	*I*
Northern	1	5	6	77	10	2
Yorkshire	5	7	7	72	8	0
Trent	1	5	7	76	10	2
East Anglian	7	3	10	73	7	0
NW Thames	0	5	8	74	13	1
NE Thames	1	8	13	63	15	1
SE Thames	1	1	4	81	11	1
SW Thames	2	5	10	70	10	2
Wessex	1	3	8	82	6	1
Oxford	1	4	4	76	11	4
South Western	2	1	5	84	6	3
West Midlands	4	5	7	74	9	1
Mersey	12	6	5	63	14	0
North Western	3	7	4	73	11	2
England	3	5	7	74	10	1
Wales	2	4	6	77	9	2
Scotland	1	5	2	85	6	1
N. Ireland	0	2	0	91	4	3
United Kingdom	2	5	7	76	9	1

Grading

It was observed that a larger proportion of men were found in the higher gradings, while proportionately more women were found in the lower gradings. Further analyses showed that 77% of I-graded posts were occupied by male CPNs, while 81% of D-graded posts were occupied by female CPNs: a highly significant difference (p=0.000). About eight out of ten (76%) of all CPNs working in services in the United Kingdon reported G grading, although substantial variations also existed between regional health authorities and between countries. Again by way of example, in South East Thames Region, 6% of CPNs were graded lower than G; in the Mersey region, 23% were so reported. Cogent explanations for these regional differences in nursing skill-mix have yet to be understood properly, and form part of a burgeoning portfolio of unmet CPN manpower information needs, described earlier.

Education

A similarly vexed substantive area of community psychiatric nursing has been the educational preparation of CPNs. The present research showed that a little

Table 1.7 Proportion of substantive CPN course completers by regional health authority and country

RHA/country	*Proportion of completers in RHA* *1990* *(%)*
Northern	**54.5
Yorkshire	30.1
Trent	26.8
East Anglian	29.7
NW Thames	35.1
NE Thames	34.8
SE Thames	45.2
SW Thames	41.9
Wessex	29.1
Oxford	43.2
South Western	25.7
West Midlands	*22.4
Mersey	40.5
North Western	38.8
England	34.6
Wales	15.8
Scotland	61.7
N. Ireland	79.2
United Kingdom	37.5%

* Lowest in England.
**Highest in England.

more than one-third (37.5%) of the United Kingdom CPN workforce had completed the post-qualifying, academic year-long, substantive CPN course (that is, JBCNS course 800, JBCNS/ENB 810, ENB 811, and more recently superseded by ENB 812) (Table 1.7).

This, too, varied by country and by RHA. It can be seen that while about four out of five (79%) CPNs in Northern Ireland were substantive CPN course completers, Wales reported only one in six (16%). These findings will remind community psychiatric nurses in Scotland and Northern Ireland that one of the arguments used in the successful call to make the training of district nurses mandatory, was that 75% of of their workforce already held the substantive qualification when their 'uprising' first gained force in 1977 (Kratz, 1982) (Table 1.8)

Table 1.8 Differences in the reported proportions of the total CPN workforce having completed the substantive community psychiatric nursing course (800/810/811), over time

	Proportion of CPN course completers			
	*1980 (n=315)**	*1985 (n=618)*	*1990 (n=1192)*	*% change 1985–1990*
United Kingdom	'Not more than 20%'	22.4%	37.5%	+15.1%

*Included CPNs not having completed the course.

During the recent five-year period, when the size of the United Kingdom CPN workforce grew by about half as much again, to find that the proportion of the qualified workforce had risen by 15% over the same period was unexpected. Moreover, such an increase was not universally the case at regional level. For example, the proportion in Wessex Regional Health Authority actually fell below its 1985 level.

Almost two-thirds (62.5%) of CPNs employed in England, therefore, did not hold the substantive qualification; this, when one in five places remained vacant on CPN courses in 1989. As with the previous year, there were sufficient applications from prospective students to fill all available places on all CPN courses, but not sufficient funding to exploit the educational opportunities (Rushforth, 1990). Three course centres closed in 1989. One of them, a diploma-level community psychiatric nursing course, produced a national award winning student project which involved the development of a health education package for people with schizophrenia, their families and friends (Hilton, 1990). The course was defended against closure by the English National Board which reported that it was 'one of the best, if not *the* best' CPN course in its part of England. Even so, such a defence failed. The regional health authority in which the course was located had its confidence in the whole notion of community psychiatric nurse education systematically undermined by talk about the apparent significance of the 1982 Registered Mental Nurse (RMN) Syllabus and predictions about the Mental Health Branch Programme of Project 2000 courses; this, in the complete absence of any controlled outcome data from the study of either. Indeed, the only recent research to be published in the substantive literature was a six-year follow-up study of Sheffield Polytechnic CPN course students, which found (contrary to the growingly specious rhetoric) that students positively connoted their educational experience, as did their seconding managers (Brooker, 1990a).

It has been less than five years since the first 1982 RMN syllabus course attenders joined the qualified psychiatric nurse labour market. Of those in the present study who had subsequently become employed as community psychiatric nurses, a quarter (24.4%) had already gone on to undertake and *complete* the substantive CPN course by 31 December 1989. The size of this proportion might serve to blunt the Chinese whisper (see, for example, South Western Regional Health Authority, 1990) that the 1982 RMN syllabus (either used for a conventional three-year psychiatric nurse training or, in the future, as the basis of the 18-month Mental Health Branch Programme of a project 2000 course) has adequately equipped psychiatric nurses for community work, and that specific post-registration community preparation is (therefore) unnecessary, because this might or might not be the case. Here, too, evaluative studies concerned with the cost-effectiveness of different modes of CPN education and training have yet to be commissioned and their findings yet to appear in the published literature (for example, full-time courses versus part-time; courses based in institutions of higher education versus those based in colleges of nursing, versus those by distance learning packages and so on). Nor have there yet been published accounts of the relative costs between CPN courses and other clinical nursing courses. Nor the relative costs of non-clinical courses for nurses, and/or others, in the NHS; in particular, management courses at all levels. This, quite apart from the lamentable absence of published reports regarding the efficacy of any and all of them. The case for commissioning policy-oriented educational research has thus been longstanding and self-evident (White, 1991b).

In the present study, about half (49.8%) of the CPNs in the UK had completed courses other than, and sometimes in addition to, the substantive CPN course, which were acknowledged locally as being relevant to work practice. One hundred and sixty-one separate course titles were identified by the present research. These tended to have been, however, of the short (one, two or three day) introductory kind; only 3% of all 161 courses were of sufficiently meaningful length to record on the Professional Register of the United Kingdom Central Council. Of all the clinical nursing courses attended, three courses predominated; basic counselling, family therapy and bereavement counselling. These three courses accounted for almost a third (30%) of all 161 non-substantive course attendances.

CPNs who had completed the substantive CPN course reported having a relationship with a person which was understood by both to be a 'clinical supervision' significantly less frequently than CPNs who were not course completers (p=0.006). An explanation for this finding, together with an examination of the nature of such relationships, their costs and their impact on the quality of the services provided, would require a separate study (or set of studies) which adopt a different methodological approach than the present survey, which has made this summary structural analysis possible. Any such work should take cognizance of the contemporary position of one in seven (14.7%) of the national CPN workforce, who had neither completed the substantive course nor had clinical supervision of their work.

Specialization

A similar theme recurred in relation to the notion of specialization of practice by CPNs. Here, too, it should be acknowledged that implicit in any claim to 'specialize', especially in terms of therapeutic approach, was a set of assumptions about the quality of such work; that is, the work of specialists is somehow different from and, by extension, better than the quality of similar work of individuals, who might not make claim to such a title. Such assumptions were not examined in the present study and they remain open to conjecture until separate empirical research in this substantive area is commissioned. Similar studies have already been undertaken (Wade and Moyer, 1989) to examine the work of clinical nurse specialists in stoma care and diabetic care.

With that caveat declared, the present 1990 survey addressed the notion of specialization differently from its 1985 counterpart. A distinction was drawn between specialism by therapeutic approach, and specialism by client group. In addition, the term 'specialize' was operationalized as 'working intentionally and predominantly with'. Using this definition, about one CPN in every seven (14%) reported that they specialized in working with a particular therapeutic approach (Table 1.9).

Of those that did so specialize, family therapy and counselling predominated over behaviour therapy and other minority preferences. Overwhelmingly, therefore, nearly nine out every ten (86%) CPNs approached their work generically.

Moreover, about four CPNs in ten (42.1%) reported that they specialized in working with a particular client group. Of those who did so report, nearly 60% (59.5%) identified elderly people as the most favoured client group, followed (a very long way off) by people with long-term mental illnesses; then by people with drug- and alcohol-related problems; by children and adolescents; then followed, at less than 5% (or 0.02% of the national CPN workforce), by people living with autoimmune deficiency syndrome (AIDS) and human immunodeficiency virus infection (HIV) (Table 1.10).

Table 1.9 Distribution of therapeutic approaches with which CPNs reported specializing, over time

Therapeutic approach	*1985*	*(n)*	*1990*	*(n)*
Family therapy	0.2%	(2)	28.9%	(129)
Behaviour therapy	4.5%	(36)	19.5%	(87)
Counselling	—		12.8%	(57)
Cognitive therapy	—		12.1%	(54)
Family and behaviour therapy	—		7.0%	(31)
Other (14 minority approaches reported)			19.7%	(88)
			100%	(446)

Table 1.10 Distribution of client groups with whom CPNs reported specializing, over time

Client group	*1985*	*(n)*	*1990*	*(n)*
Elderly	64%	(505)	59.5%	(796)
Drugs/alcohol	9%	(72)	10.1%	(134)
Rehabilitation/resettlement	5.2%	(42)	17.3%	(231)
Children/adolescents	4.5%	(36)	7.5%	(101)
AIDS/HIV	—	(–)	4.7%	(63)
Forensic	—	(–)	1.0%	(13)
			100%	(1 338)

The relationship between those who reported to specialize, either in therapeutic approach or client group, and the pay grade at which they were employed was examined. As might have been reasonably predicted, the proportion of each pay grade comprised of CPNs who reported specializing in a particular therapeutic approach increased the higher the grade; less than 3% of all D-graded CPNs, rising to nearly 30% of all I-graded CPNs ($p=0.000$) (Table 1.11).

However, the converse was the case for CPNs who reported specializing with a particular client group, where the larger proportions were found in the lower pay grades ($p=0.000$). A possible explanation for these findings was that specializing in the care of the elderly was also significantly associated with lower grades; work in which female CPNs predominated. Indeed, such a finding concerning the significant association between the care of elderly people, female community psychiatric nurses and low pay grades will be unsurprising to those familiar with the general literature on the role of women in care of elderly people, especially relatives, and how such efforts

Table 1.11 Proportion of each pay grade occupied by CPNs who reported specializing in a particular therapeutic approach and client group

Reported to specialize with a particular:	*Proportion of grade (%)*					
	D	*E*	*F*	*G*	*H*	*I*
Therapeutic approach	2.7	8.9	9.1	13.4	25.0	29.5
Client group	66.7	60.3	47.5	39.9	40.7	43.2

are undervalued (Bonny, 1984; Equal Opportunities Commission, 1984; Lewis and Meredith, 1988; Matthew, 1990).

CPN caseloads

The size and composition of CPN caseloads in the United Kingdom has attracted close attention (Wooff, Goldberg and Fryers, 1988). The present study can report, for the first time with any confidence since Parnell's (1978) work, that the mean average size of a community psychiatric nurse caseload in the United Kingdom, as at 31 December 1989, was 35.6 clients (Table 1.12).

The mean average size of a CPN caseload varied by country. The caseload of a CPN working in Northern Ireland, for example, was larger than an English counterpart by over half as much again. The proportion of clients on CPN caseloads who had ever had an admission to a psychiatric in-patient facility (that is, for example, to a psychiatric hospital or to a psychiatric unit of a district general hospital) also varied by country. Such clients represented

Table 1.12 Distribution of mean average CPN caseload size and summary composition, as at 31 December 1989, by country

Caseload detail	*England*	*Wales*	*Scotland*	*N. Ireland*	*UK*
Size (mean average)	34.3	42.1	40.5	51.9	35.6
Proportion of caseload of clients:					
Who had a previous psychiatric admission	47.9%	58.9%	57.4%	68.7%	50.2%
Who were chronically mentally ill	42.6%	52.3%	45.6%	50.9%	43.7%
Who had schizophrenia as medical diagnosis	26.0%	33.1%	27.4%	43.6%	27.2%

almost exactly half (50.2%) the mean average UK caseload, and well over two-thirds (68.8%) of a Northern Ireland CPN caseload. The proportion of clients who were chronically mentally ill (a term the writer was persuaded to believe from the literature, and individual survey responses, had a currency in popular parlance) was over 43% of UK caseloads. In particular, this client grouping contained over 27% with a medical diagnosis of schizophrenia. It follows, therefore, that over six out of ten (62.4%) clients who were reported chronically mentally ill, were diagnosed as having schizophrenia; who themselves constituted well over a quarter (27%) of a mean average UK CPN caseload.

To give these data a sense of national perspective, it can be extrapolated that the estimated total number of individuals on CPN caseloads in the United Kingdom, as at 31 December 1989, was 177 611 people; of whom 89 170 had had a previous admission to a psychiatric in-patient facility. Moreover, 77 551 were chronically mentally ill; of whom 48 373 suffered from schizophrenia. The work of others has estimated that about 250 000 people currently have schizophrenia in the United Kingdom (National Schizophrenia Fellowship, 1990). The total number of clients with schizophrenia on CPN caseloads, therefore, represented about one in five (19.2%) of the reported prevalence. This, at a time when a quarter (24.5%) of all English community psychiatric nurses in the present study reported having not a single client with schizophrenia on their caseloads.

Consultant referrals

The mean average proportion of referrals from consultant psychiatrists to community psychiatric nurses in the UK was nearly 43%. This represented

Table 1.13 Distribution of sources of client referral to community psychiatric nurses, over time

Referral agent	*Proportion of referrals*		*% change 1985–1990*
	1985	*1990*	
Psychiatrist	59.2%	42.7%	−16.5%
General practitioner	23.3	35.8	+12.5
District nurse/health visitor	5.0	3.9	−1.1
Other hospital staff	5.0	5.5	+0.5
Social services	3.2	3.6	+0.4
Relatives/self	2.2	4.4	+2.2
Other	2.2	4.1	+1.9
Total	100.0	100.0	

a reduction of over 16% in psychiatrist referral volume since 1985. About one in 13 (7.5%) CPNs still received referrals *exclusively* from consultant psychiatrists; a proportion exactly the same as those who now no longer received a single referral from a psychiatrist (Table 1.13).

GP referrals

At the same time, the mean average proportion of referrals from general practitioners (GPs) to CPNs had increased to nearly 36%. This represented an increase of over 12% in general practitioner referral volume, from the 1985 proportion of about 23%.

The relationship between the source of CPN referrals and the location of the CPN's operational base has been commentated on before (Skidmore, 1986), though its nature has remained poorly understood. In the present study, community psychiatric nurses reported being based in up to 17 separate locations per district health authority within a total of 38 different types of accommodation. For a little more than a quarter (28.3%) of CPN services, the main base remained the psychiatric hospital; while for a further quarter (23.1%) of services, a main CPN base could no longer be identified. The notion of a 'main base' was originally and appropriately identified as a variable for the 1980 survey. It persisted through the 1985 and the 1990 versions, though the increasingly dispersed, or federated, nature of CPN service organization has now drawn into question the strict sense in which such bases were reported as 'main'. Data yielded by the present study suggested that 'main' might have described only an artifact of service development, or the location which houses the CPN manager, or the CPN secretaries, or other administrative apparatus. It was no longer always the location which housed the largest number of CPNs, as was the case in the past. Thus, in 1990, a distinction was drawn between the 'main base' reported by CPN managers and the more telling 'operational base' reported by individual CPNs (Table 1.14).

By inspection, CPN service organization differed markedly by country. For example, England differed from Scotland in the continued use of a psychiatric hospital as an operational base: the difference between England and Northern Ireland in the proportion of staff operating from a psychiatric unit of a district general hospital can also be noted; so, too, the organizational differences between Northern Ireland and Scotland in the use of health centres and general practices.

The nature of any relationship between the location of the base from which CPNs operate, the source of CPN referrals and the types of caseload clientele, has also continued to interest investigators (for example, Simmons and Brooker, 1986). The present study has become the first to provide evidential data to inform a United Kingdom-wide perspective.

Table 1.14 1990 distribution of community psychiatric nurses (reported at the level of individuals), by operational base, by country

Operational base	*England*	*Wales*	*Scotland*	*N. Ireland*	*UK*
Psychiatric hospital	18.4%	39.5%	56.9%	32.7%	22.6%
Psych.unit of DGH	15.7	9.6	6.5	1.0	14.3
Health centre/GP practice	21.3	22.8	18.5	63.4	22.5
Day hospital	9.1	10.5	3.2	—	8.4
CMH centre	20.8	13.2	4.0	—	18.5
Other	14.7	4.4	10.9	2.9	13.7
	100	100	100	100	100

Table 1.15 Correlation coefficients of the proportions of CPN caseload referred by consultant psychiatrists and general practitioners comprised of clients with a previous admission to psychiatric in-patient facility, who were chronically mentally ill and with a medical diagnosis of schizophrenia

	Proportion of CPN caseload comprised of clients		
	Previous psychiatric admission	*Chronically mentally ill*	*Medical diagnosis of schizophrenia*
Proportion of CPN caseload referred by:			
Consultant psychiatrists	0.4245*	0.3884*	0.3289*
General practitioners	−0.4210*	−0.3916*	−0.3348*

*p=0.001

The coefficients in Table 1.15 confirmed that the proportion of referrals to CPNs from consultant psychiatrists was significantly *positively* correlated with the proportion of clients on CPN caseloads with a previous admission to psychiatric in-patient facility; and with clients who were chronically mentally ill and with clients with a medical diagnosis of schizophrenia. Concomitantly, the proportion of referrals from general practitioners was significantly *negatively* correlated with the proportions of the same three variables. Although the two relationships fell short of being causal (that is, the referrer was not mutually exclusively identified with a single client type), these data can nevertheless be summarized, thus: the more referrals from psychiatrists, the more clients with long-term mental illnesses, while the more referrals from GPs, the less of such clientele.

Further analyses showed that CPNs who operated from a base in a psychiatric hospital, or a psychiatric unit of a district general hospital, had a significantly greater proportion of referrals from consultant psychiatrists. Concomitantly, CPNs operating from non-psychiatric hospital bases had a significantly greater proportion of referrals from general practitioners. CPNs who operated from bases in a psychiatric hospital also had caseloads with a significantly greater proportion of clients having had a previous psychiatric admission, of clients who were chronically mentally ill and of clients with a medical diagnosis of schizophrenia, than did CPNs who were based elsewhere. Thus, a convincing relationship has been established empirically between a psychiatric hospital base (or a psychiatric unit of a district general hospital) and a significantly skewed referral volume from consultant psychiatrists, of a clientele with long-term mental health care needs.

CLOSER IDENTIFICATION WITH PRIMARY HEALTH CARE?

These original findings have therefore confirmed the continued movement of the CPN workforce (now some 5000 strong) away from its original sources of referral, its original operational base and its original client group, towards a closer identification with primary health care providers, their work places and their clientele. Such movements have not been free of angst (Department of Health, 1989c) and for the first time in nearly four decades of almost completely unfettered and parochial development, community psychiatric nursing has had to stop and reflect, and to reconcile itself to the demands of the recently published *Care Programme Approach* health circular (Department of Health, 1990). This has reconfirmed the primacy of the psychiatrist in interprofessional working and has required key workers to be identified to monitor both the health and social care which patients discharged from psychiatric hospitals are to be given. While key workers are to be drawn from any discipline, it has been predicted that CPNs will be identified to occupy many, if not most, of these positions (White and Brooker, 1990). The findings presented in this chapter have suggested, therefore, that many CPNs might be required to re-orientate their contemporary working practices and realign themselves back into closer working relationships with psychiatrists; a feature which, although it might not be universally popular with some CPNs, nor some general practitioners with whom working alliances have developed over the last decade, would be welcome with most psychiatrists (see, for example, Northampton District Health Authority, 1991). Indeed, the lobby to get the pendulum to swing back has been long established (Goldberg, 1985).

Long-term vs short-term mental illness

In this event, the future work of CPNs would be refocused towards a clientele with long-term mental illnesses and away from those requiring short-term CPN intervention. These are often rerferred to, in an increasingly pejorative way to (artificially) exaggerate the division, as the 'worried well', and frequently caricatured as the general practitioner referral. Such clients have become popular with CPNs, 'appropriate' in the vernacular, not only because of a commitment to notions of health promotion and the prevention of ill health for their clientele (Standing Advisory Group for Community Psychiatric Nursing Education, 1991), but also because of their apparent responsiveness to intervention and concomitant job satisfaction for CPNs themselves. Not uncommonly, these outcomes are regarded as elusive when working with chronically mentally ill people with long-term needs.

Some community psychiatric nurses may have inadvertently de-skilled themselves for future work with chronically mentally ill people by having concentrated on other clientele. Such is the service-led demand for particular educational preparations that the need for appropriate training and re-training skill-specific packages has thus emerged. An example of these has been researched recently at the University of Manchester (Brooker, 1990b), while another is in its inaugural year at the London School of Economics (Ramon, 1990). When community psychiatric nurses have been (re-)equipped with appropriate skills, they might feel less insecure and pessimistic about the prospect of work with such clients. Given such a scenario, the work with less seriously mentally ill people might devolve increasingly to other branches of nursing. In particlar, practice nurses may emerge as the predominant occupational group to work with the minor psychological distress which presents to general practitioners (White, 1991c); indeed, Department of Health-funded research has already begun to examine the role and function of practice nurses in the treatment of depression (Wilkinson, 1990). General practitioners might also directly employ community psychiatric nurses, or purchase other counselling services (or both) in support of practice nurses (for example, Roy, 1990).

An additional impetus to review the appropriateness of different educational preparations has, again, come out with community psychiatric nursing. Calls have been made (Guinan, 1990) for the British Psychological Society to adopt a formal public position on the practice and teaching of therapies based on psychological theories and principles, which will state minimum acceptable levels of education, training, experience and supervision for professional practice by non-psychologists in other professions and, in particular, CPNs.

CONCLUSIONS

Clearly, CPNs will have to review fundamentally their service roles and reconcile them to the changes in the National Health Service, and re-think the educational consequences. Such a review will be a *necessary*, but not a *sufficient*, condition to achieve all the potential advantages to client care which are envisaged by the reformation. Self-evidently, for these to be realized, *all* professional groups involved in community mental health care provision will have to address the issues and eventually accommodate them in negotiation, not only one with another, but with service users. This requirement has remained both constant and independent of the changes over the ten-year period covered by this brief structural review, from which some of the substantive areas requiring new research have been revealed.

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CHAPTER TWO

A study to investigate the views of patients and their carers on the work undertaken by nurses to prepare the patient for discharge from hospital

Katharine E. Ferguson

INTRODUCTION

This chapter raises two important and topical issues in the field of psychiatric nursing care. First, the need to explore users' perceptions of the service they receive and to consult with them about what they want and, second, the need to adequately prepare clients – both patients and their carers – for discharge, taking into account their perceived needs. This is of particular importance with the expansion of community care. A study is described here which explores the perceived needs of a group of people recently discharged from a psychiatric hospital, and those caring for them. In particular, the need for information and advice is examined, both in relation to hospital admission itself and preparation for discharge. The ability of the nurses working on the wards to anticipate their clients' information needs is also investigated using a questionnaire. The findings support the literature in that patients and families are frequently unhappy about the amount of information and advice they receive from professional staff, both in hospital and in preparation for discharge. Nurses are seen as having a key role to play in the education of patients with mental health problems and their carers.

LITERATURE REVIEW

The importance of gathering the views of clients on their needs and experiences of psychiatric treatment and care

Studies of users' perceptions of their needs and experiences of psychiatric care are sadly few and far between. There seems to have been the misconception by professionals that the patient's judgement and opinions are so drastically affected by their illness, they are not worthy of consideration.

> Psychiatry has always undervalued the capacities of the patient, has tended to regard his views as, at best, the unbalanced and exaggerated preoccupations of an oversensitive soul, and in any event, the view of an unbelievable witness.
>
> (Lomas, 1967)

Shields (1985) agrees that the low status of this group of patients has led to a failure to take them seriously, saying, 'It has been said that there is not enough research done in psychiatry, and nowhere is this truer than in seeking patients' views of their treatment and care'. The perceived needs and views of carers of psychiatric patients have been similarly neglected.

> Often the family is used only as a resource for gathering information about the patient, with little attention to their needs and concerns . . . in many cases, whatever contact is made with the family contains the implication that they are to blame for the patient's problems, further stimulating guilt and pain.
>
> (Anderson, 1977)

There is a growing recognition, however, that account needs to be taken of clients' expressed needs and views about the service they receive from the 'caring professions'. As Mayer and Timms (1980) have stated, with reference to social work clients, 'Clients define the problems, experience the help and live with the results of it, therefore are best qualified to say whether it helped them or what they needed.' The MIND report of 1983 emphasizes the importance also of paying more attention to the wishes and practices of carers: 'The new pattern of services should integrate with, not cut across, the patient's natural systems of support' (MIND, 1983). Simmons (1984) supports this view, saying, 'Services should no longer be simply what professionals think is required or what they wish to provide, but should involve full consultation with those on the receiving end.'

Clients' perceptions of the adequacy of preparation for discharge from psychiatric hospital

As has already been mentioned, studies assessing clients' views of psychiatric services and treatment are relatively rare. Consumer satisfaction studies in general hospitals have shown that many patients are not happy with the amount and quality of information they receive from staff (Ley, 1972; Ley and Spelman, 1967; Pender, 1974; Wilson Barnett, 1979). Specific work on discharge of patients shows that there is frequently inadequate recording by staff of discharge plans and information given, and poor understanding by patients of their illness and care plans (Cass, 1978; Roberts, 1975; Waters, 1987). Even where attempts have been made to improve routines for information giving and recording, doctors still tend to give advice on how to cope at home, and follow-up care at the end of the patient's stay and written records are sparse (Engstrom, 1986).

A similar pattern emerges from the limited work in the area of mental health care. Ballinger (1971), in a study of 100 patients on acute psychiatric wards, found 60% could not remember being told anything about their condition, and only 48% had received information about their medication. A King's Fund study, undertaken in 1977 reveals also that while patients expressed considerable praise for doctors and nursing staff, a number felt they had been given insufficient information on their condition and treatment (Raphael, 1977). Mayer and Rosenblatt (1974) found dissatisfaction levels among patients to be especially high with information given in preparation for discharge. More recent work supports the need for more information to be given to patients on treatment and progress, medication, and practical advice (Good Practices in Mental Health, 1988; Shields, Morrison and Hart, 1988). The problems of retrospective studies such as these must be recognized, however, as the memory of patients may have been affected adversely both by the illness itself or the side-effects of physical treatments such as electroconvulsive therapy (ECT), as well as by the passage of time.

Many families, too, feel they have been prepared inadequately for their relative's discharge from hospital. Creer and Wing carried out a study for the National Schizophrenia Fellowship in 1974: 33% of the carers reported not being satisfied with the support they received from professional staff. A number complained of not being involved in the planning of care. There were criticisms too of the lack of information, especially in relation to the treatment programme, medication, what to expect, how to care for the patient on a day-to-day basis, practical information and how to deal with crises. Some expressed a reluctance to ask for help or advice. In addition, a small study carried out by Alstead in 1981 in an acute admission ward, revealed that 75% of relatives felt they were given only the barest information from hospital staff. It has been suggested that professionals and families may often have conflicting ideas about psychiatric care and the role of professional staff

(Spaniol, Zipple and Fitzgerald, 1984). In their sample, while therapists were trying to focus on family dynamics, many carers saw as their primary need, practical advice and information on how to cope with the patient. Hence the importance of clarifying what clients and carers feel they need from mental health services.

Preparation for discharge – the importance of education for patients and carers

Giving people adequate information on what to expect and advice on how best to manage problems is, of course, important from a moral point of view. As Rosenthall, MacPherson and Marshall (1980) argue, 'Denial of information to patients amounts to what may be considered as denial of responsible adult status, and with the implication that the patient is not capable of intelligent choice and control'. However, the education of psychiatric patients and their carers, with particular focus on coping after discharge, can also be seen as a key component of a relapse prevention strategy, becoming increasingly important with the expansion of community care. Mental health education can be defined as 'a distinct group of interventions designed to assist people in acquiring knowledge, skills and attitudes that directly contribute to their mental health and to their effect on the mental health of others' (National Committee for Mental Health Education, 1977).

Rachlin (1978) talks of the importance of regarding clients as 'partners in treatment', so that there is an '*exchange* of information on symptoms and triggers, as well as guidance on management and the opportunity to discuss problems and support'. In its campaign for 'Health For All by the Year 2000', the World Health Organisation includes in its recommendations the need for 'educational programmes (which) should enhance knowledge, motivation and skills to acquire and maintain health'. A shift in the traditional professional–patient relationship is considered vital, with professionals acting as 'enablers', 'guiding and supervising non professionals in health care', and patients being encouraged to take a more active role in looking after their own health (World Health Organisation, 1985).

Education is seen as an important part of the preventive psychiatry programme proposed by Caplan in 1964. It is argued that there is potential especially for nurses working in hospitals to play a role in secondary prevention by educating clients and their carers on early signs of relapse, on developing their coping skills and advising them on where to seek help, as well as in tertiary prevention through the education of clients and families on the prevention of long-term disability.

Research has shown that education of patients with mental health problems may contribute towards reducing relapse rates by increasing compliance with psychotropic medication. For example, Youseff (1984) found that, of a group of 36 patients who received twice-weekly education sessions, the compliance rate was 82% compared to 64% in the control group. There was also a significant reduction in readmission rates in the experimental group.

The trend towards care in the community means that informal carers are increasingly taking on a primary role in the care of those with mental health problems. A study by Goldman (1980) revealed that 60 to 70% of patients with a diagnosis of schizophrenia were discharged home to their families. As Doll (1976) says, 'The family have a crucial care-giving role. They have become unwittingly and often unwillingly *de facto* therapists, who bear the day-to-day burden of coping with a mentally ill family member'. It is vital that such carers feel sufficiently knowledgeable and skilled to take on this responsibility. Hatfield (1981) stresses the importance of good collaborative relations with families if the community care experiment is to survive. Consultation and education will become, inevitably, a growing part of the work of both community and hospital nurses.

There is evidence that many carers experience considerable emotional and practical burden in looking after their relatives, making the need for adequate preparation for discharge and support from professional staff even more essential. As Clausen and Yarrow pointed out, as early as 1955, 'Living in the community is not synonymous with having recovered'. Of a sample of 120 families of psychiatric patients in Cleveland, United States, 50% were experiencing severe subjective burden in terms of emotional cost. Many also were found to be suffering disruptions to family life and routine, role strain and financial problems (Doll, 1976). Research also suggests that the health of many carers is being adversely affected. The Scottish Schizophrenia Research Group (1985) carried out a study of people caring for individuals who were experiencing their first psychiatric illness or admission to hospital. It was found that 75% of the carers were suffering from minor mood disorders severe enough to warrant treatment and, one year later, although anxiety levels were reduced, families still complained of a high number of somatic problems and disruption to family life. Williamson and Danaher (1978) criticize current approaches to care in the health service for weakening family and kinship responsibility for care and decreasing the motivation of individuals to look after their own health. They stress the need for people to be educated in 'what to treat, when to treat, how long to treat and with what'. Education for self-care is seen as a key opportunity for nurses.

Work with the families of psychiatric patients has demonstrated the potential for education as a way of helping to decrease relapse. Brown, Birley and Wing (1972) found that where families showed 'high expressed emotion' towards a relative suffering from schizophrenia, chances of relapse were increased. Later studies by Vaughan and Leff (1981) revealed that education sessions with the families on more therapeutic patterns of interaction could reduce significantly relapse rates. The work of Falloon, Boyd, McGill *et al.* (1981, 1982) also demonstrated how educational programmes on the nature, course and treatment of schizophrenia, as well as on problem-solving skills for coping with stress, could be influential in improving compliance of patients taking neuroleptic drugs. The patients also had lower relapse rates, and their families showed improved coping and problem-solving skills. Hatfield (1982) particularly stresses the value of group teaching sessions with families, as this gives them the opportunity to develop a sense of expertise and promotes self-help and social support.

The role of the nurse in patient and family education

A number of prominent nursing writers have emphasized the importance of patient and family teaching as a part of nursing care. Henderson (1966) compares nursing to teaching, in that both involve a helping relationship with the objective of developing independence in the person. Pohl (1973) describes the basic purpose of nursing as the promotion of health. She considers that the frequent and close contact of nurses with patients and families places them in a key position for adopting an educative role. Syred (1981) also sees nurses as being in a 'unique position for health education', due to their 'empathic relationship' and '24-hour contact'. Nelson, Williams and Villeneuve (1986) describe the nurse as having primary responsibility for identifying the learning needs of clients, and planning and implementing teaching programmes, both of a formal and informal nature. Changes in nurse education also reflect a growing concern about illness prevention and patient education. The new Project 2000 curricula for registration of nurses place particular emphasis on health, factors leading to health breakdown and health promotion (United Kingdom Central Council for Nurses, 1986).

Sadly, in practice, it seems that this potential role of the nurse as an educator of patients and families is often not being realized. Results from a questionnaire distributed to a large sample of general nurses in the United States showed that many of them felt unclear about patient teaching. Key obstacles mentioned were lack of time, low staffing levels and insufficient training for the role (Pohl, 1965). A more recent study by Tilley, Gregor and Thiesson (1987) found patients were getting information, typically, one to three days before discharge. Nurses complained of similar obstacles to patient education, for example, lack of time, rapid turnover of patients and short notice of discharge. Rosenthall *et al.* (1980), from their observations in hospital wards, suggest that staff often use control strategies to prevent patients and carers taking an active part in treatment. The withholding of information is seen as one form of control. They describe having observed nurses using strategies of 'postponement, withholding and deception'. The relationship between doctors and nurses is seen as one reason for inadequate exchange of information in hospitals, with doctors frequently deciding how much information should be given, and nurses taking a supportive role.

Miller (1983), in a study of the role of psychiatric nurses as patient teachers, found them to be confused about who was responsible for giving what information. There is evidence too that a large number of nurses do not see mental health education as part of their role. German (1986) found this to be the case for 40% of the community psychiatric nurses in her study, although many were in fact carrying out patient education, albeit unsystematically.

Summary of the literature

Work exploring client perceptions of psychiatric care is relatively rare. There is evidence to suggest that psychiatric patients and their carers frequently feel they received inadequate information in hospital to prepare them for discharge. The value of education programmes for users of mental health services is stressed, both from a moral point of view and as a contributing factor in reducing relapse rates. Although there is increasing emphasis on the role of the nurse as a health educator, it appears in practice that they often find difficulty in fulfilling this role.

THE STUDY

Introduction

A small scale, in-depth study was carried out over a four-month period, using two acute admission wards, to explore the perceived needs of a group of recently discharged psychiatric patients and their carers for information and advice, both while the patient was in hospital and in preparation for discharge. Patients and carers were asked how well they felt these needs had been met by the hospital staff. Needs identified by the client group were compared with those anticipated by the nursing staff working on the wards. Nurses were also asked for their views on their role as patient and family educators.

Method

A list of recently discharged patients was obtained weekly from ward staff, and these were contacted by post, requesting their participation in the study. Patients who agreed to take part were interviewed at home within four weeks of their discharge, using a semi-structured interview schedule. Any patient who was felt by nursing staff to be unsuitable to participate in the study was excluded. Where written consent was obtained from the patient, an interview was sought from their most closely involved relative or carer. All qualified nursing staff working day duty on the wards were given a questionnaire to fill in, which was then collected by the researcher. The questionnaire and interview schedules were devised from the literature and findings of the pilot study.

Results

Response rate. Twenty-three patients were interviewed from a potential sample of 48 (48%). The remainder either did not wish to be interviewed or were not at home on the two occasions when the interviewer called. Nine patients were lost from the sample as they could not be traced or they were readmitted. Thirteen patients agreed for their relative or carer to be contacted, and 12 of these took part in the study (92%). The remaining 10 patients did not wish their carer to be contacted or could not identify such a person. Eleven out of 12 nurses completed the questionnaire (92%).

Needs for information and advice. Patients made reference to a range of needs for information and advice both in relation to their stay in hospital and in preparation for discharge, but the interviews revealed wide variations between individuals in terms of what they wanted to know. As a group, patients wanted information on their diagnosis, for example, 'Why I'd gone like that'; on their prognosis, for example, 'Will I get better again?', 'How long I'd have to be in hospital'; treatment and medication; practicalities such as finance and housing, ward orientation; advice on relaxation; how to avoid further illness; enjoying free time; how to cope outside hospital, for example, 'What to expect', 'How to keep calm'; and follow-up care. No clear differences were apparent between patients who had had previous contact with psychiatric services and those who had not, except that those on their first admission were significantly more likely to express a need for advice on coping after discharge ($p<0.05$ using Fisher's Exact test). It is interesting to note how many patients commented that they felt too ill around admission to absorb much information, for example, 'I was highly anxious in hospital. I couldn't remember much of what they said', and 'I saw life as a dead end. All I wanted to know was how to get hold of another razor blade.'

Like the patient sample, individual carers varied in what they wanted to know from hospital staff, but as a group, their perceived needs for education resembled quite closely those of the patients. Many of them particularly wanted help on how to manage their relative on a day-to-day basis and in times of crisis, and 83% (n = 10) said they wanted advice on ways of preventing relapse. No significant differences were found between the information needs of carers for whom this was their first contact with mental health services, and those who had had multiple contacts ($p>0.05$ using Fisher's Exact test). Again, the time of admission was described by some relatives as a very stressful period. Three families said they felt at that point that they 'just wanted to hand over', so did not particularly want much information then. A surprisingly low interest was expressed by carers in 'getting support for themselves'. Only a minority of families had made use of the relative support group offered in one of the hospitals, and only 42% (n = 5) thought they would benefit from such groups.

Patients' views of the things they needed to know in hospital and before discharge were compared with those identified by nurses using a Chi-squared test. The findings revealed that nurses were generally able to anticipate the likely areas of need for information and advice of their patients. Similar analysis was performed in relation to the sample of carers using Fisher's Exact test. Again, nurses seemed reasonably aware of the learning needs of families as a group.

Client satisfaction with information and advice received in hospital. Although many patients commented on how friendly and kind staff had been, 70% (n = 16) of them felt that the information or advice they had received in hospital was in some way deficient, and the individual needs they identified were frequently not met. Of the patients, 61% (n = 14) said they had obtained only some of the information they required, and 8.7% (n = 2) said they had been given no information by staff. Half the patients were dissatisfied with the information they had received in preparation for discharge (n = 10), a number complaining that they did not feel well enough to be discharged, and others referring to the short notice of their discharge. In the family group, too, it appeared that individual needs for information and advice were frequently not met by hospital staff, and levels of dissatisfaction were higher than in the patient group. In fact, 58% (n = 7) of families were unhappy with the amount of information and advice they had been given to prepare them for the patient's discharge and, again, several complained of suddenness of the discharge and a lack of consultation. In contrast, a clear majority of the nurses (n = 8) felt that sufficient information was always or usually given to clients.

Both patients and carers commented that they always or usually had to ask for information from staff (74% of patients (n = 17) and 92% of families (n = 11)), and some of the families particularly expressed a reluctance to approach staff. In both groups, respondents complained of a lack of privacy when talking to staff. Conversations usually took place in the dayroom or in the nurses' office. Only 25% of families (n = 3) were seen privately by staff. From clients' and nurses' responses, it appeared that information tended to be given on an *ad hoc* basis, rather than at any specific points in the patient's stay.

Sources of information for patients and families. Nurses were seen by the patients and families (and indeed by themselves), as being key sources of information and advice. Of the patients, 50% (n=11) identified nurses as being their most useful source of information, whereas 66% of the families (n=8) did so. However, the nurses tended to see client teaching as being shared with other team members, and there was evidence of some confusion when they were asked about responsibility for specific items of information or advice. Greatest agreement was apparent in relation to giving the diagnosis, which most nurses (n=9) thought was the doctor's responsibility, and for ward orientation, which all the nurses saw as their responsibility. Student nurses were described by a number of patients as helpful as they 'mingled more', and several patients also said they had learnt about ward routines and rules by talking to and watching other patients.

Nurses' views on their role as patient and family educators. Despite the large gaps in meeting information needs which were apparent from the patient and family responses, the majority of nurses felt satisfied with the quantity and quality of client teaching they undertook (six of the nine nurses who replied (66%)). Shortage of staff was identified as the major obstacle to adequately fulfilling this role.

Limitations of the study

There are some drawbacks to this study, which should be taken into consideration when considering the results. The sample was small due to time constraints and the low response rate, which means that the results should not be generalized beyond the wards which took part in the study. The relatively low response rate, however, is characteristic of follow-up studies of users of psychiatric services (Lebow, 1982; Munton, 1990). In a review of 31 studies of consumer satisfaction with mental health treatment, Lebow found a response rate of below 60% in 18 cases, and below 40% in 10 other cases.

Where patients and families complained of not being given information, it is impossible to be sure where the breakdown in communication had occurred, that is, had staff failed to identify their particular needs? Was it that the information simply had not been given? Or was it that clients had forgotten it? It is possible that satisfaction levels of clients who were still receiving psychiatric treatment may appear higher than they really were for fear of reprisals, despite assurances of confidentiality and anonymity. As Lebow (1982) comments, 'Consumers may alter their responses as they consider who will read these surveys, how the surveyors will regard them and how the surveys will affect their requests for treatment and the careers of the practitioners who offered them treatment'. In addition, he suggests that the fact that levels of consumer satisfaction with mental health treatment are generally higher than would be expected may be due to naivety of the clients about alternative treatments and lack of assertiveness about their rights.

DISCUSSION

It is apparent from the findings that patients with mental health problems and their carers may have a range of needs for information and advice, both relating to their stay in hospital and in preparation for discharge, but that each individual's specific needs are different. People particularly want to know more about the patient's problems and the care programme. Families are especially concerned with getting practical advice on how they can best help the patient. This is in accordance with other studies on information needs of hospital patients (Dodge, 1969; Good Practices in Mental Health, 1988; Shields *et al.*, 1988) and their carers (Creer and Wing, 1974; Doll, 1976). Although the ward nurses are generally aware of the types of advice and information their clients need as a group, there is evidence that many patients and their carers are dissatisfied with the quantity and quality of information they *actually* receive in hospital. Shields *et al.* (1988), in a study of psychiatric patients who had been admitted to a district general hospital, found also that individual needs for information were frequently not met, and as many as 87% of patients were dissatisfied with the arrangements for their discharge.

The results suggest that carers' information needs in particular are seldom addressed, with 25% (n=3) of those interviewed saying they had received no information at all from hospital staff relating to their relative's problem or care programme. Research by Holden and Levine (1982) on carers of psychiatric patients revealed that, for many of them, a lack of information about the illness and its treatment was a primary source of dissatisfaction. Other studies have revealed that interactions with families are often very brief, and tend to focus on staff getting information from the carers (Alstead, 1981; Cormack, 1976).

The discrepancy between client and nurse perceptions on the adequacy of information given in hospital is also supported by Alstead's findings. Of the relatives she interviewed, 75% said they had only had minimal information from staff, while two-thirds of the ward nurses said that detailed information had been given. Due to the nature of these studies, that is, asking nurses about their practices in relation to information giving, rather than observing what they do, it is impossible to tell whether or not clients actually did receive the information. As Simmons (1984) comments, 'It is worth noting that some of the people who had received a great deal of time and been frequently consulted, felt they were told very little'. What is important, however, is that clients *feel* that there is inadequate information and advice.

It appears that patients and carers frequently have to ask staff for information and advice. Altschul (1972) and Alstead (1981) have also found that nurses tend not to initiate interactions with relatives. In addition, many people appear reluctant to approach the nurses for information and advice, a finding supported by Creer and Wing (1974). As Rosenthall *et al.* (1980) observe, 'Findings suggest a willingness of patients to defer to medical authority and to put their fate in their hands'.

It is interesting to note the low priority given by carers to their own needs. Simmons (1984) points out that families often have problems defining their own needs compared to those of the ill relative. Staff, too, may see carers' needs as being a less urgent priority. Pollock (1988) comments on this in relation to the work of CPNs: 'the care offered to carers is secondary to that offered to patients, and is limited by available resources.'

Most of the interactions between nurses and patients and their carers take place in public places in the ward. Cormack (1976) found this to be true of 66% of charge nurses' conversations with patients. Certainly, information seems to be given very much 'as and when required'. Altschul (1972), in her observations of psychiatric nurses at work, also found that interactions with patients and families tended to be *ad hoc* and without reference to theory. Alstead, too, refers to the lack of formal structure to information-giving, and points out that much information is given when discharge is imminent (Alstead, 1981).

The findings show that both the client groups and nurses themselves see nurses as occupying a key role in health education. Research by Caffarella (1984) in Maine, United States, showed that 69% of doctors and allied health workers believe nurses have primary responsibility for patient education. However, there is evidence from this study and other work (Boylon, 1982; Cohen, 1980; Miller, 1983; Stanton, 1986), that nurses are often confused about their individual teaching responsibilities in relation to the rest of the multidisciplinary team. Student nurses are identified by a number of the patient group as being more available on the ward. Altschul (1972) found students to be the highest interactors with patients and, as MacGuire (1986) comments somewhat ironically, patients have most contact with those least able to discuss their situation fully. Engstrom (1984) also found, as in this study, that patients often find each other a useful source of information.

Surprisingly, in view of the dissatisfaction expressed by many clients, the majority of nurses said they were satisfied with their role as educators.

However, as in other studies, inadequate staff levels were seen as the major obstacle to patient and family education (Ley and Spelman, 1967; Tilley *et al.*, 1987). Observation of the work of qualified psychiatric nurses in hospital reveals that much of their time is spent on administrative work (Carr, 1980; Cormack, 1976). Tilley *et al.* (1987) also cite short notice of discharge as being a barrier to adequate planning, and this was mentioned by staff, patients and carers within this study.

IMPLICATIONS FOR PRACTICE

This work indicates the need for greater attention to be paid to what users of mental health services and their key carers want to know. In addition, there is a need for a more structured approach to the transmission of the necessary knowledge and skills to enable patients and their families to cope with mental health breakdown, hospitalization and discharge.

It is suggested that assessment of perceived gaps in knowledge and skills of patients and their carers, and the meeting of these needs, should form an ongoing part of care. Learning may occur through individual sessions with staff, group work or written information, depending on client needs. An evaluation of client understanding and satisfaction is also essential. Nelson *et al.* (1986) suggest that patient teaching could easily be incorporated into the nursing process.

Nurses need to be ready to take the initiative in giving information, and carers should be recognized as having their own specific needs. Certain 'critical points' can be identified during a stay in hospital, when clients may have particular needs for information, for example, on admission, before special tests or treatments, after ward rounds and before leave or discharge. Particular attention needs to be paid to preparing patients and their relative for discharge. The care programme approach advocates a more structured approach to discharge, with key workers being appointed and an individual care plan being devised for all those discharged from psychiatric hospital, and communicated to those who will be implementing it in the community (DoH, 1989). Patients and their carers should be fully involved in planning the programme of care, and will need sufficient understanding of the problem and care options to do this. Specific educational needs will also need to be addressed within the discharge plan, for example, ways of coping with problems, the support services available.

Primary nurses are seen as having a key role to play in mental health education for patients and families. They may at times be responsible for giving information or advice to clients; they also have an important co-ordinating role, both in relation to information given by the hospital team, and also in liaising with the allocated key worker in the community to ensure continuity of care in the meeting of clients' educational needs. Appendices 1 and 2 give guidelines on likely areas of needs for information and advice of patients and carers both during the patient's stay in hospital and in preparation for discharge, as well as suggestions on which members of the team may be involved in the transmission of this information.

CONCLUSION

The philosophy behind this study is the importance of working to promote mental health and enabling individuals and their carers to cope more effectively with problems, rather than providing services which just 'patch people up' when they are ill. However, in order for people to take more responsibility for self-care, they must have the requisite information and advice on all aspects of the problem and how it can best be managed.

The evidence shows that patients and their carers are frequently dissatisfied with both the quantity and quality of information and advice they receive while in hospital and, subsequently, in preparation for discharge home. A framework for improving the structure of information giving is proposed, with the educational needs of patients and their carers forming part of the nursing care plan, for use both in hospital and in the community. Psychiatric nurses are seen as having a key role, not only as educators themselves, but as co-ordinators of information given by the multidisciplinary team.

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This study was completed for an MSc degree. A full account of the work is available from John Rylands Library, University of Manchester.

Appendices 1 and 2 appear over page.

APPENDIX 1

Guidelines on needs for information and advice for patients admitted to psychiatric wards

	Information/advice	*Person responsible*
On admission* /during hospital stay	Diagnosis, nature of problem	Doctor
	Prognosis, length of stay, chances of relapse/recovery	Doctor
	Care plan – goals, care, progress	Nurse, doctor
	Treatment, medication	Doctor, nurse
	Ward orientation, routines policies, facilities, introduction to staff, key workers	Nurse
	Special tests, nature, purpose, results	Doctor, nurse
	Legal rights	Nurse, social worker
	Practical information, e.g. finances, housing	Social worker
*Patient may not be able/ready to absorb much information at the time of admission		
Before discharge	How to cope out of hospital, e.g. structuring the day, coping with emotions/hallucinations, relaxation, self-confidence, activities of daily living, enjoying free time	All the team
	Follow-up help – community support system, care plan, how to get help	Doctor, nurse, social worker
	Medication	Doctor/nurse
	Preventing relapse	All the team
	Practical information – benefits, housing, finding work/occupation	Social worker, occupational therapist

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Liaison with key community worker

Note:

1. Areas of information and advice are suggested only as guidelines. Each individual patient should be assessed for specific educational needs.
2. In many instances, responsibility for patient teaching is shared. Co-ordination by the key worker/primary nurse is essential.

APPENDIX 2

Guidelines on needs for information and advice for carers of patients admitted to psychiatric wards

	Information/advice	*Person responsible*
On admission* /during patient stay in hospital	Diagnosis, nature of problem	Doctor
	Prognosis, length of stay, chances of recovery or relapse	Doctor
	Ward orientation - policies, routines, staff names, facilities	Nurse
	Care plan - goals, care, progress	Nurse, doctor
	Treatment/medication	Nurse, doctor
	Legal rights	Nurse, doctor, social worker
	Support for self, e.g. leaflets, individual support groups	Nurse,social worker
*Relatives may not be able to absorb much on patient's admission		
Before discharge	Follow-up care/support - what to do in emergencies, getting help, support systems, care plan	Nurse/doctor, social worker
	How to look after the patient - guidance on how best to help, dealing with emergencies, day-to-day care, avoiding relapse	All the team
	Medication, treatment	Doctor, nurse
	Practical information - benefits, housing	Social worker
	Getting support for self	Nurse, social worker

↕ ↕ ↕ ↕ ↕ ↕ ↕ ↕ ↕ ↕ ↕

Liaison with key community worker

Note:

1. Areas of information and advice are suggested only as guidelines. Each individual patient should be assessed for specific educational needs.
2. In many instances, responsibility for patient teaching is shared. Co-ordination by the key worker or primary nurse is essential.

CHAPTER THREE

Skills for CPNs working with seriously mentally ill people: the outcome of a trial of psychosocial intervention

Charles Brooker, Nicholas Tarrier,*
Christine Barrowclough, Anthony Butterworth
and David Goldberg

INTRODUCTION

Historically, CPNs have been associated directly with the community care of the client diagnosed as suffering from schizophrenia. Indeed, the main impetus for the establishment of CPN services in the mid-1950s was the introduction of the phenothiazine drugs, which established a new demand for the follow-up and aftercare of such patients (Simmons and Brooker, 1986). Early research into community psychiatric nursing mirrored this early role and was concerned primarily with relapse in schizophrenia. For example, several studies examined the effect on readmission to a psychiatric hospital when a CPN administered depot medication in the community (Sandford, 1976; Scott, Sharma and Templer, 1977). Hunter (1978) reported a retrospective study of outcome in schizophrenia where patients were followed up on discharge from hospital. He formed two groups for comparison, those referred at discharge to a CPN and those not so referred. Surprisingly, perhaps, he found that patients in the 'CPN' group had been admitted to a psychiatric hospital more often than controls, in the five years following discharge. Sladden (1979) provided the first full description of the work of a CPN team. She established that, on average, each CPN (n=5) in the team had 38 patients

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*Correspondent

with a diagnosis of schizophrenia, of whom 57% lived with their family. She argued that family therapy was needed in a large proportion of these cases, but that CPNs were not trained to deal with the family relationship problems that occurred within this often fraught environment. The nurses coped by retreating into roles that were purely 'task centred', such as the administration of long-acting phenothiazines.

However, the nature of CPN service delivery was to change substantially and gradually the CPN's role with the sufferer from schizophrenia diminished. There are a number of reasons for this change in emphasis. First, the overall CPN workforce increased during the period 1980 to 1985 and the role of the CPN diversified as services became more orientated to primary health care settings (Brooker, 1987). This trend so concerned some that Goldberg, for example, charged CPNs with 'drifting away from a hospital base' with the consequence of the 'risk that care of chronic psychiatric patients will take second place' (Goldberg, 1985). Further it was argued that the work of the CPN with clients with schizophrenia had become characterized by 'very short contact times, the administration of medication and referral for consultant opinion if symptoms worsened' (Wooff, Goldberg and Fryers, 1988).

Moreover, recent data obtained from the 1990 National Survey of Community Psychiatric Nurses (White, 1991) reveals that there have been important changes in the working practices of CPNs, psychiatrists and general practitioners (GPs). As Figure 3.1 demonstrates, GP referrals to CPNs have increased at the expense of referrals from psychiatrists; indeed, GP and psychiatrist referrals to CPNs have now equalized.

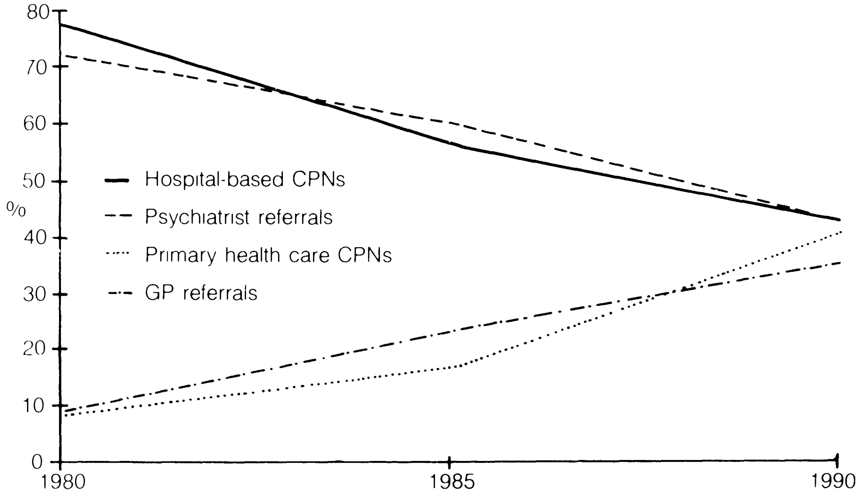

Figure 3.1 GP and psychiatrist referrals to CPNs, 1980 to 1990 (adapted from White, 1990).

White (1991) also derived an informative correlation matrix from the last set of survey data (Figure 3.2). The correlations (and the strength and direction of their significance) show incontrovertibly that GPs do not refer clients with a serious mental illness, whereas psychiatrists do refer such a clientele. If psychiatrists' referrals have reduced so greatly over the last 10 years then the CPN's role with the long-term mentally ill must have been declining.

	Proportion of CPN caseloads		
	Previously admitted	*With a 'chronic mental illness'*	*Diagnosis of schizophrenia*
Referrals from psychiatrists	0.42*	0.38*	0.33*
Referrals from general practitioners	−0.42*	−0.39*	−0.33*

*p=0.001

Figure 3.2 Correlation matrix demonstrating the association between GP and psychiatrist referrals to CPNs and caseload composition (White, 1990).

There are a number of factors which help to explain how this situation has arisen. First, as Sladden suggested more than 10 years ago (1979), CPNs lack the skills required to intervene with families (and it must be said few opportunities for such a training exist). Second, as Tyrer, Hawksworth, Hobbs *et al.* (1990) have observed, there has been a great tendency to pressurize CPNs into assuming a multiplicity of roles at the expense of being expert in any particular one. Tyrer *et al.* suggest that CPN training needs to be improved and should include more teaching in 'psychopharmacology, social support and prevention of relapse' and, further, that 'the care of recently discharged psychotic patients . . . is the bedrock of community psychiatric practice'.

A number of recent controlled studies have suggested that psychosocial intervention, based on the 'stress–vulnerability' model of schizophrenia, can be an effective way of reducing relapse in the family care of schizophrenia. These studies have been reviewed at length elsewhere (Barrowclough and Tarrier, 1984; Brooker, 1990a; Strachan, 1986; Vaughn, 1989). Although calls have been made to disseminate skills in psychosocial intervention to wider audiences of mental health professionals, few developments have been reported in the United Kingdom (Leff, Kuipers, Berkowitz *et al.*, 1982). This paper describes the outcome of training a group of CPNs to deliver psychosocial intervention in the manner described by Barrowclough and Tarrier (1987a and b). Although the nature of the training has been outlined in detail elsewhere (Brooker, 1990b), it is useful to summarize briefly the programme.

The CPNs, in the study reported here, were taught to deliver intervention which comprised: detailed assessment of all the needs of each family member; health education for all family members; family stress management programmes; and goal setting aimed at increasing the social and personal functioning of both the client and each relative. The course lasted a total of six weeks (30 full days) and the students attended on a day release basis over a period of six months. Problem solving with the families was closely monitored by the course teaching team (NT, CB) on weekly study days using tape-recorded clinical material, assessment measures and student self-report. The cost of running the experimental course was approximately £600 per student (at 1990 prices).

METHOD

The community psychiatric nurses

The trainee CPNs (n=9) were recruited from three regional health authorities after placing advertisements in the national nursing press. Each selected trainee was then matched on a number of variables (for example, length of experience as a CPN, post-basic training undertaken age and sex), with a colleague from the same health authority. Statistical analysis of this information revealed no differences between the two groups. The design of the study was then explained to the CPN's service manager, who undertook to obtain all the relevant ethical permissions and to liaise wiht the local diagnosing psychiatrists. Both groups of CPNs, that is, the control and experimental groups, were then taught, separately, to administer the outcome measures.

The families

Clients recruited to the study met the following criteria: a recent diagnosis of schizophrenia by a consultant psychiatrist; aged 16 to 65 years; organic basis to the diagnosis excluded; living with a relative or in sustained (defined as ten hours or more a week) contact with a significant other; apart from a psychiatrist, the CPN had to be the key worker involved; and the patient (and the relatives) had to be able to speak and read English well enough to complete the outcome measures.

The aim of the study was for each CPN to obtain three families who met the criteria outlined above, that is, a target sample of 54 families. Initially, 87% (n=47) of the target sample was achieved; however, 17 of these families dropped out during one year follow-up. Therefore, the 30 families who completed the trial represented 64% of the recruited sample. Demographic characteristics of completers by group are given in Table 3.1 and these are compared with the similar features of two other recent British family intervention studies. It is worth noting that the group described in this study had experienced the highest number of hospital admissions of any of the three samples and that, most probably, this reflects accurately the nature of the population being maintained in the community by CPNs.

Table 3.1 A comparison of the demographic characteristics of the pilot study sample with other British family intervention samples

	Tarrier (1988)	*Leff (1982)*	*Brooker (1990)*
Mean age	35.3	34.5	33.1
sd	12.8	–	7.8
Sex			
Female	65%	50%	30%
Male	35%	50%	70%
Marital status			
Single	54%	33%	60%
Married	35%	54%	30%
Divorced/separated	11%	13%	10%
Employment			
Unemployed	77%	54%	90%
Employed	21%	46%	10%
Education			
No qualifications	68%	67%	76%
O/A levels	25%	33%	24%
Degree	6%		–
Mean admissions	2.8	1.7	3.5
sd	3.6	–	2.7
Mean years since last admission	1.6	–	2.4
sd	3.1	–	3.0
Mean days in psychiatric hospital	91.0	–	98.0
sd	148.7	–	95.3
Total sample size	83	24	30

sd = standard deviation.

Effects of non-randomization

Although the best strategy would have been to assign families at random to the experimental and control groups, this was a practical impossibility given the recruitment strategy. It is important, therefore, in view of systematic sampling biases that may have been introduced, to comment on differences that exist between the groups. No significant differences were observed in terms of the patients; that is, age, sex, education, employment status, marital status, type of living arrangement, days in a psychiatric hospital, length of last admission, years since last admission, length of all CPN contact and number of study drop-outs. In the control group, the mean number of psychiatric hospital admissions was higher (4.5 vs 2.7), and this difference approached significance ($t = -1.99$, $p = 0.06$). The mean length of 'prior CPN contact' (defined as the length of time the CPN had been involved with the families at the commencement of the study) was significantly higher in the control group (1.78 years vs 0.3 years, $t = -3.03$, $p = 0.005$). This latter finding is to some extent an artefact of the design of the study, inasmuch as CPNs in the experimental group found it harder to recruit families for active treatment that met the study criteria, and so had to obtain them from sources other than their own caseloads. In these circumstances, prior contact with the families was inevitably lower.

On examination of the clinical outcome data collected at baseline (Table 3.2 and Figure 3.3), no significant differences between the client groups were established in relation to: the frequency and severity of depression, hallucinations, delusions, anxiety, inappropriate affect, incoherence of speech and poverty of speech.

In addition, there was no observable difference in the level of the client's overall social adjustment. However, the patients in the experimental group were rated as being significantly more retarded ($Z = -1.97$, $p = 0.04$).

1. The KGV (Krawiecka, Goldberg and Vaughan, 1977): all eight sub-scales were used which measure both the frequency and severity of the positive and negative symptoms of schizophrenia
2. Diary records of face-to-face contact between patients and relatives
3. The Social Adjustment Schedule (SAS) reported by Birchwood (1983): seven key areas of social functioning are rated from which a global mean score may be derived
4. The General Health Questionnaire (GHQ) – the Likert-scored 28 item version was used to assess minor psychiatric morbidity in the relative (Goldberg and Hillier, 1978)
5. The Knowledge About Schizophrenia Inventory (KASI) which assesses the key relative's functional knowledge of schizophrenia. Six sub-scales are used from which a global score may be derived (Barrowclough and Tarrier, 1987b)
6. The Consumer Perceptions of Services Questionnaire, or CPQ (Spaniol, Jung, Zipple, *et al.* 1987) taps relatives' perceptions of the quality of service provision. The measure of 'working alliance' was adapted from this instrument
7. The standardized dose of haloperidol equivalents was obtained using a formula reported by Suy, Woestenborghs and Heykants (1982)

Figure 3.3 Summary of outcome measures used in the study.

Table 3.2 Target symptoms of schizophrenia (KGV ratings)

Symptom	*Median*	*Z score*	*P value*
Depression			
Control - pre	1		
Control - post	1	−1.18	NS
Control - FU	1	−0.40	NS
Experimental - pre	1		
Experimental - post	1	−1.83	0.06
Experimental - FU	0	−2.19	0.02
Hallucinations			
Control - pre	0		
Control - post	1	−0.36	NS
Control - FU	1	−0.73	NS
Experimental -pre	0		
Experimental - post	0	−0.8	NS
Experimental - FU	0	−0.94	NS
Delusions			
Control - pre	2		
Control - post	1	−2.02	0.04
Control - FU	0	−1.8	0.06
Experimental - pre	2		
Experimental - post	1	−2.19	0.02
Experimental - FU	1	−1.8	0.96
Anxiety			
Control - pre	1		
Control - post	1	−0.84	NS
Control - FU	1	−1.5	NS
Experimental - pre	1		
Experimental - post	1	−1.4	NS
Experimental - FU	1	−2.2	0.02
Inappropriate affect			
Control - pre	0		
Control - post	1	−0.8	NS
Control - FU	0	−0.47	NS
Experimental - pre	1		
Experimental - post	1	−1.77	NS
Experimental - FU	0	−1.58	NS
Retardation			
Control - pre	0		
Control - post	0	−0.9	NS
Control - FU	0	−0.67	NS

Table 3.2 (continued)

Symptom	*Median*	*Z score*	*P value*
Experimental - pre	1		
Experimental - post	0	−1.94	0.05
Experimental - FU	0	−2.02	0.04
Incoherence of speech			
Control - pre	0		
Control - post	0	−0.8	NS
Control - FU	0	−0.36	NS
Experimental - pre	0		
Experimental - post	0	−1.46	NS
Experimental - FU	0	−1.34	NS
Poverty of speech			
Control - pre	0		
Control - post	0	−0.33	NS
Control - FU	0	−0.4	NS
Experimental - pre	0		
Experimental - post	0	−0.91	NS
Experimental - FU	0	−1.57	NS

FU = Follow-up
NS = Not significant

It should also be noted that mean standardized monthly neuroleptic drug dose, pre-intervention, did not differ significantly between the groups.

The analysis of the characteristics of the two relative groups demonstrated no significant differences in terms of: the carer's age; the carer's estimate of their own minor psychiatric morbidity; the carer's independently assessed level of knowledge about schizophrenia; and the great majority (18 out of 19, or 95%) of the measures used to assess the relative's consumer satisfaction. The one consumer satisfaction item which differed significantly at baseline was 'understanding given by professionals': 90% in the control group were satisfied with this item compared with 22.7% in the experimental group ($Z= -3.33$, $p=0.0008$). In summary, the groups were well matched and randomization is unlikely to have produced closer matching, as one would have expected one out of 20 differences in the two samples to have arisen simply by chance.

Outcome measures employed

Families were recruited initially to the study over a one-month period before formal teaching on the first experimental course began ('pre-intervention'). The course then ran over a six-month period at which point all the measures were repeated ('post-intervention'). Families were followed up for six months, and measures were again repeated ('follow-up'). The full battery of assessments used are outlined in Figure 3.3.

Intervention groups

Families in the control group (n = 13) received the following interventions: routine visits to administer depot medication; the monitoring of the patient's mental state; and the provision of support to relatives. The only difference was that the control CPNs were taught to administer the outcome measures. For ethical reasons, the control CPNs were instructed to respond (in whatever way that they saw fit) to new information that they might obtain using these new assessment tools.

The experimental group was taught to deliver psychosocial intervention to the families, which is described more fully elsewhere in this chapter (see Introduction and also Appendix).

Analyses

The distribution of all the variables was examined and found to be normally distributed only in the following cases:

1. The level of neuroleptic medication prescribed.
2. The proxy measure used to gauge the extent to which the CPN had formed a 'working alliance' with the family.

It was therefore decided to use non-parametric tests to analyse the bulk of the data (the two variables above notwithstanding, which were analysed using a repeated measures analysis of variance). Mann-Whitney U tests were used to examine differences *between* groups pre-intervention. Wilcoxon sign rank tests were employed to assess differences *within* groups, that is, 'pre' to 'post' and 'pre' to 'follow-up'.

RESULTS

The clients

a) Symptom scores. No significant differences within groups were observed in four of the eight subscales of the KGV (Krawiecka, Goldberg, Vaughan assessment scale). However, as Table 3.2 indicates, depression, anxiety and retardation improved significantly to one year follow-up in the experimental group, whereas delusions improved significantly post-intervention in both groups, and approached significant improvement in both groups to follow-up.

b) Prescribed neuroleptic drugs. One client (experimental group) was not prescribed neuroleptic drugs for the period of the trial. The prescribed dose for the remaining clients (n=29) was converted to mean monthly haloperidol equivalents using a formula described by Suy, Woestenborghs and Heykants (1982).There was a trend for mean dose to reduce in the experimental group, but this was not significant (Figure 3.4).

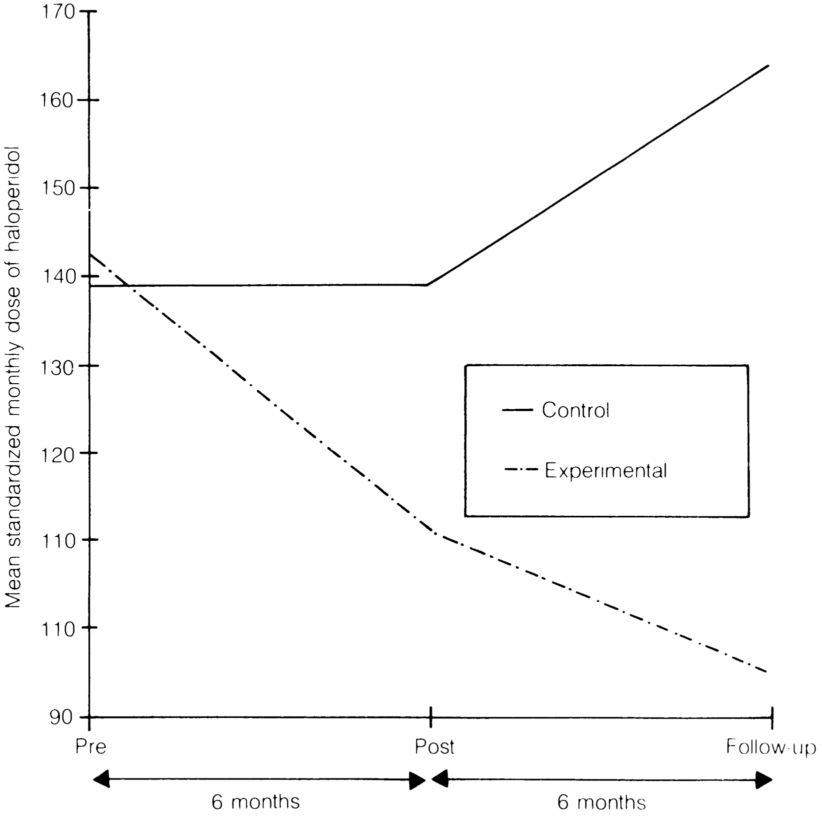

Figure 3.4 Mean standardized monthly dose of haloperidol by group.

c) Admissions to psychiatric hospitals. There was one admission to a psychiatric hospital from each group. The admission in the experimental group was for 28 days and in the control group for one day.

d) Social adjustment. Social adjustment scores improved in the experimental group both post-intervention (Z= −2.68, p=0.007) and at follow-up (Z= −2.17, p=0.02). However, in the control group no significant change was observed (Figure 3.5).

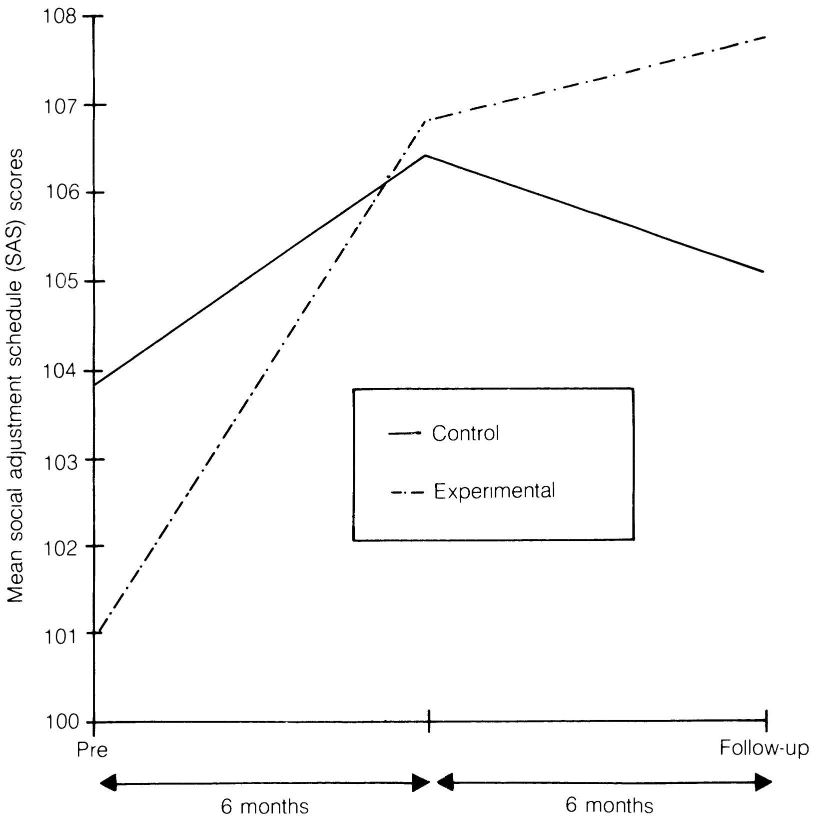

Figure 3.5 Mean social adjustment schedule scores by group.

e) Weekly face-to-face contact hours. There were only two cells (both in the experimental group) which were large enough to analyse using a Wilcoxon sign rank test, that is, patients living with mothers (n=14) and clients living with fathers (n=9). Face-to-face contact hours with mothers reduced significantly pre-post and pre- to follow-up (58.4 hours to 43.7 hours, Z= −2.2, p=0.02; and 58.4 hours to 35.4 hours, Z= −2.66, p=0.007). Face-to-face contact hours with fathers did not decrease significantly pre-post or pre- to follow-up (31.7 hours to 30.6 hours, and 31.7 hours to 24.0 hours, respectively).

The relatives

a) Minor psychiatric morbidity. There was no significant change in the general health questionnaire (GHQ) score of relatives in the control group either from pre- to post-measurement or pre- to follow-up. However, although the differences between the groups at baseline were not significant, relatives in the experimental group reported significant improvement in their own mental health status both post-intervention (Z= −1.96, p=0.05) and to follow-up (Z= −2.4, p=0.01). This information is presented graphically in Figure 3.6.

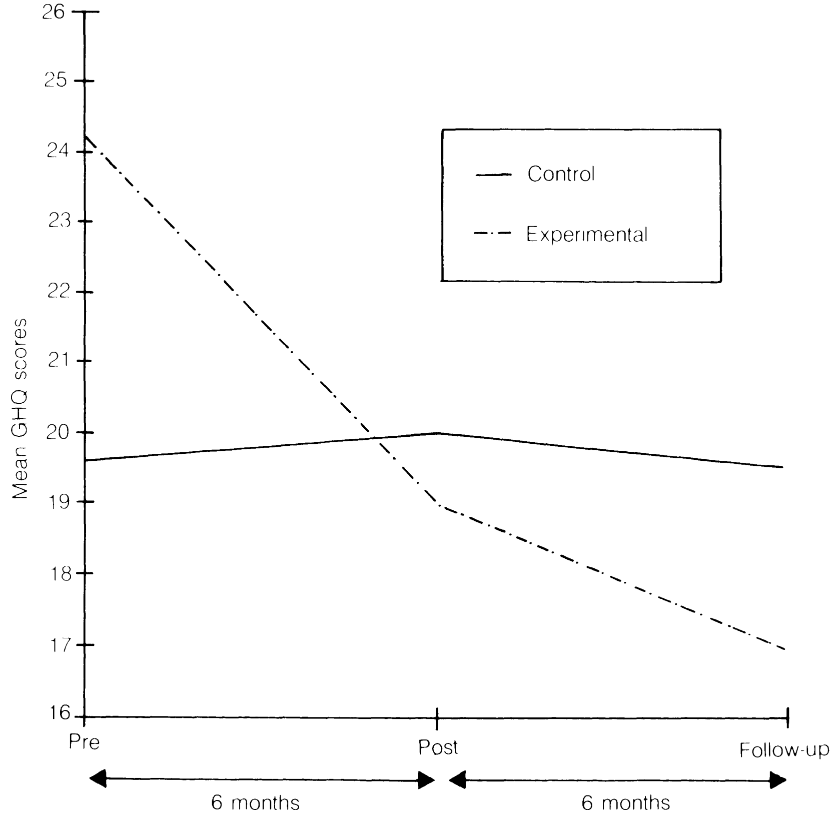

Figure 3.6 Mean general health questionnaire scores by group.

b) Knowledge about schizophrenia inventory (KASI). The median KASI sub-scale and global knowledge scores for relatives by measurement period are given in Table 3.3. Within-group analysis of the control group revealed no significant change either from baseline to post-test or baseline to follow-up. In the experimental group the global KASI score increased significantly

Table 3.3 Median KASI scores by group and measurement period

KASI section	*Median*	*Range*	*Z score*	*P value*
Diagnosis				
Experimental - pre	3	1-3		
Experimental - post	3	2-4	−2.02	0.02*
Experimental - FU	3	3-3	−1.6	0.05%
Control - pre	3	1-4		
Control - post	3	1-3	−0.8	NS
Control - FU	3	2-3	0.0	NS
Symptomatology				
Experimental - pre	3	1-3		
Experimental - post	3	1-4	−1.15	NS
Experimental - FU	3	2-4	−1.96	0.02*
Control - pre	2	1-4		
Control - post	2.5	1-3	−0.33	NS
Control - FU	3.0	1-4	−0.73	NS
Aetiology				
Experimental -pre	3	1-4		
Experimental - post	2	2-4	−0.40	NS
Experimental - FU	3	2-4	−1.61	0.05*
Control - pre	2	1-3		
Control - post	2	1-3	−0.9	NS
Control - FU	2	1-4	0.0	NS
Medication				
Experimental - pre	3	1-3		
Experimental - post	3	1-4	−1.15	NS
Experimental - FU	4	3-4	−2.2	0.01**
Control - pre	2.5	1-4		
Control - post	4	1-4	−1.26	NS
Control - FU	3	2-4	−1.15	NS
Prognosis				
Experimental - pre	2	1-4		
Experimental - post	3	1-4	−2.11	0.02*
Experimental - FU	3	1-4	−1.42	NS
Control - pre	2.5	1-3		
Control - post	1	1-4	−0.36	NS
Control - FU	2.5	1-3	0.0	NS
Management				
Experimental - pre	3	1-3		
Experimental - post	3	1-4	−0.63	NS
Experimental - FU	3	1-4	−1.18	NS

Table 3.3 (continued)

KASI section	*Median*	*Range*	*Z score*	*P value*
Control - pre	2	1-3		
Control - post	1.5	1-3	−0.84	NS
Control - FU	2	1-3	0.0	NS
Global KASI score				
Experimental - pre	14.0			
Experimental - post	18.5	−1.77	0.04*	
Experimental - FU	19.0	−2.53	0.005***	
Control - pre	14.0			
Control - post	13.0	−0.28	NS	
Control - FU	15.0	−0.70	NS	

* = Significant p<0.05
** = Significant p<0.01
*** = Significant p<0.005
FU = Follow-up
NS = Not significant

from the pre-intervention baseline both post-test (median 14.0 vs 18.5, Z= −1.77, p=0.04) and at one year follow-up (median 14.0 vs 19.0, Z= −2.53, p=0.005). On the KASI sub-scales there were also significant increases in knowledge to one year follow-up in the following areas: diagnosis, aetiology, symptomatology and medication.

c) Global aspects of consumer satisfaction. No global measure of consumer satisfaction improved in the control group. In the experimental group, however, relatives were more satisfied with 'the frequency of service contact' (Z= −1.72, p=0.01) and 'understanding given by professionals' (Z= −3.17, p=0.001); the item 'overall satisfaction with services' approached significant improvement to follow-up (Z= −1.82, p=0.06).

d) Specific aspects of consumer satisfaction. No specific measure of consumer satisfaction improved in the control group, although a significant *decrease* in satisfaction with 'emotional support' given was observed (Z= −2.02, p=0.04). The following specific measures of consumer satisfaction improved to follow-up in the experimental group: 'practical advice given' (Z= −2.36, p=0.02); 'information given about the illness' (Z= −2.52, p=0.01); 'emotional support' (Z= −2.03, p=0.01); 'service co-ordination' (Z= −2.02, p=0.04); and the percentage satisfied with 'the professional's attitude to the family' changed from 71% (a high baseline) to 100%, an improvement which approached significance (Z= −1.8, p=0.06).

e) Extent of working alliance established with the family by the CPN (mean scores by group for this item are given in Table 3.4). Analysis of variance demonstrates a significant experimental group effect (F=10.15, p=0.004), with mean scores increasing from 2.5 (pre-intervention) to 5.5 (post-intervention) and 6.2 (follow-up). There is also a significant 'time period' effect (F=14.34, p=0.000) and a highly significant interaction, that is, group × measurement period (F=10.85, p=0.000).

Table 3.4 Mean 'working alliance' scores by group

Group	*Pre*		*Post*		*Follow-up*	
	Mean	*sd*	*Mean*	*sd*	*Mean*	*sd*
Control	3.1	1.4	3.5	1.8	3.4	1.4
Experimental	2.5	2.0	5.5	1.7	6.2	1.0
Total	2.8	1.8	4.7	2.0	5.1	1.8

sd = standard deviation.

DISCUSSION

In the design of the field trial it proved impossible to assign clients and their families at random to the control and experimental group. Therfore, strict study inclusion criteria were devised in an effort to minimize any possible between-group variation. Although only small differences were detected in the CPN, client and relative samples (and these were no more than one would have expected by chance), the results should be interpreted cautiously. A suspicion will remain that, perhaps, *unmeasured differences* exist, and it might be that the observed changes within groups are a function of some other competing hypothesis. The design of the research study reported here is, as discussed by Campbell and Stanley (1963), *quasi-experimental.*

Unlike previous psychosocial intervention studies the 'expressed emotion' (EE) status of relatives has not been measured before hospital discharge with subsequent attempts made to reduce a high EE rating to a low one (Hogarty, Anderson, Reiss *et al.*, 1986; Leff *et al.* 1982; Tarrier, Barrowclough, Vaughn, *et al.*, 1988). This study focuses on a group of patients with a diagnosis of schizophrenia, with multiple psychiatric hospital admissions (x=3.5), who have been maintained in the community for lengthy periods (x=2.4 years) by a combination of unstructured family support, drug therapy and CPN visits. Therefore, the overall objective in this study was closer to that of Falloon, Boyd, McGill, *et al.* (1985), that is, to improve the quality of life for such families and enhance their ability to solve problems. However, despite recent findings to the contrary (Parker, Johnston and Hayward, 1988; Stirling, Tantam, Thomas, *et al.*, 1991), we suspect that 'family atmosphere' is one of a number of predictors of relapse in schizophrenia but that there are other more generalized environmental stressors which can also be important. For example, the client's social functioning, employment status and housing (Falloon and Shanahan, 1990).

There is evidence to suggest that it may be erroneous to focus active intervention on *only* those groups defined as high in EE. As Tarrier *et al.* (1988) remark, low EE families are not free from problems and 'if they do not receive any specialist intervention, these relatives may well develop critical and hostile attitudes'. Furthermore, Hogarty *et al.* (1986), in their study of psychosocial intervention, have commented that 'considerable relapse' was observed in 'low EE female subjects'. Lastly, Smith and Birchwood (1990), in considering a service model for families caring for a relative with schizophrenia, argue that 'the constraints of high EE were ... too great to adopt it as the *primary* entry criterion to a service'.

The target symptoms of schizophrenia which improved *only* in the experimental group were anxiety, depression and retardation. Social anxiety is common in schizophrenia and is usually associated with social skills deficits; however, a more generalized anxiety may accompany the prodomal signs of the illness and be related to the intensity and frequency of hallucinations and delusions. Lazarus (1966) demonstrated that giving information allows an anxiety-inducing stimulus to be reappraised and increases the likelihood that effective coping ensues. This is one aspect of the rationale for the health education component of psychosocial intervention, as an understanding of the illness should increase effectiveness in dealing with the stress associated with it (Falloon, Boyd and McGill, 1984). We believe that the reduction in anxiety observed in these clients is one consequence of the family education programmes conducted by the CPNs.

Depression and retardation are also common features of schizophrenia. Indeed, between 25 and 50% of patients may suffer depression during the acute phase of schizophrenia; in fact, a small proportion commit suicide (Donlon, Rada and Arora, 1976). It should also be acknowledged that it can be difficult to distinguish between depressive symptoms *per se* and the negative symptoms found in schizophrenia (Kulhara, Avasthi, Chadda, *et al.*, 1989). In this study there was a strong tendency for neuroleptic drug dose to decrease in the experimental group, which may help to explain the reduction in the severity of depression and retardation. However, drug reduction itself in this group may have been possible only because social intervention, particularly the management of family stress, began to replace the buffer effect of phenothiazine medication (Hogarty, 1984).

The great proportion of clients in this sample led impoverished social lives; the majority were unemployed, had no qualifications, and two-thirds lived in a parental home and were economically dependent upon parents. The baseline social adjustment score for the whole group was very similar to the standardized mean score (and distribution) reported by Birchwood (1983) in a large sample of clients with schizophrenia living in the community. Creer and Wing (1975) reported that the most common problems cited by carers were social withdrawal, underactivity, lack of conversation and leisure interests, little contribution to domestic chores and the absence of any social interaction outside of the house. These restricted behaviours, of course, limit not only the lives of patients but also impinge on carers, often leading to the complete withdrawal of relatives themselves from any kind of meaningful social life (Cohen and Sokolovsky, 1978). Clearly, then, caring for a relative with schizophrenia at home causes social problems for the whole family, a finding corroborated by this study.

During our first experimental course in psychosocial intervention, the CPNs were taught: first, through the education programmes, to teach families that social withdrawal may well be an attempt by the client to self-regulate environmental stress; second, to develop social and vocational programmes for the client based on their pre-morbid strengths; third, to set the carers themselves social goals which achieved the second aim of reducing client/mother weekly face-to-face contact (Vaughn and Leff, 1976). The use of these strategies seems to have been successful, as highly significant increases in clients' social functioning were observed post-intervention ($Z = -2.68$, $p = 0.007$) and to six-month follow-up ($Z = -2.17$, $p = 0.02$). No such changes were found in the control group. Falloon *et al.* (1984) observe that 'it is evident that in a good family milieu the social outcome is improved . . . it seems probable that a greater degree of acceptance of the patient's illness with more supportive understanding relationships may mediate this effect'. The outcome of the CPN's intervention, reported here, would reinforce this view.

The needs of relatives have now been well studied and shown to include information and education about the illness for both moral (Atkinson, 1989) and practical reasons (Tarrier and Barrowclough, 1987a and b), advice on difficult clinical management problems such as socially embarrassing behaviour or violence (Creer and Wing, 1975), to feel part of a working partnershiip with the professional (Spaniol, Zipple and Fitzgerald, 1984) and relief from their own tension and anxiety (Hatfield, 1979).

The results outlined in Table 3.3 show that the CPNs trained in psychosocial intervention were superior to control CPNs in providing relatives with knowledge about schizophrenia to one-year follow-up. The education programme is a crucial aspect of the intervention, overall, and provides the cornerstone for all other therapeutic strategies designed to reduce the stress experienced by families. It has been suggested (Berkowitz, Sharit and Leff, 1990) that the more a carer believes that a relative with schizophrenia is suffering from a genuine illness, the more likely it becomes that chronic domestic stress will reduce. A number of different educational approaches have been used by investigators in this field and are reviewed helpfully by Barrowclough and Tarrier (1987a and b). As Barrowclough and Tarrier point out, however, most of these methods are based on a 'deficit' model of education and have serious shortcomings. CPNs in this study were taught to teach families using the 'interaction' model which assumes that behaviour change is more likely to occur following information-giving if an understanding is obtained about the reasons for people's beliefs about illness rather than by focusing on pathology in general (for a fuller discussion of these issues, see Brooker, Barrowclough and Tarrier, 1992).

Global changes in the minor psychiatric morbidity experienced by relatives were examined using the 28-item version of the GHQ. Gibbons, Horn and Powell (1984) had previously used this instrument in a study of the relatives of all patients with schizophrenia within the catchment area of the Southampton health authority. They established that 32% of the carers were experiencing definable psychological distress, that is, a score of 5+. However, even higher levels of distress have been reported (Scottish Schizophrenia Research Group, 1985), where it was established that 75% of carers experiencing the first admission of a relative had a minor mood disturbance reaching case level.

Only a small proportion in the experimental group, 23.5% ($n=4$), and in the control group, 30.8% ($n=4$), had experienced only one admission to a psychiatric hospital, so we would not have expected to find such high GHQ scores in our sample. This was the case. It is important to note, though, that significant decreases were obtained for the Likert-scored GHQ, in the experimental group, both post-intervention ($Z= -1.96$, $p=0.05$) and at one-year follow-up ($Z= -2.4$, $p=0.01$). On the other hand, the GHQ scores of relatives in the control group did not improve significantly throughout the year of the trial.

There is a growing awareness of the need to provide mental health services which satisfy consumers, although the measurement of such a construct is potentially problematic (Lebow, 1982). For example, Falloon *et al.* (1984) report that patient and family member's ratings of 'family' and 'individual' treatment conditions were both equally as high in their family intervention outcome study – although outcome was far superior in the 'family' group. This finding may say less about the relative efficacy of the two treatment conditions than it does about consumers' tendencies to positively connote *any* service received.

But evidence has started to accumulate which suggests that the relatives of clients with serious mental illness are far from happy with community mental health service provision. Creer and Wing (1975) demonstrated that only 25% of carers were satisfied with the service they received, and this is very similar to a figure of 26% obtained by Holden and Lewine (1982) for a similar sample. A common problem cited in Creer and Wing's study was the fact that 'relatives said they had been left entirely without help when the patient first came out of hospital . . . and they were left to sink or swim or to find out by trial and error how best to cope with the illness'.

A more recent postal survey conducted with members of the National Schizophrenia Fellowship suggests that little has changed (National Schizophrenia Fellowship, 1990). Although this study did not obtain a representative sample (it obtained only a 10% response rate from all members), it does convey an important flavour of the negative ways in which carers can view the contribution of the CPN to community mental health services. For example, only 3% of the carers and 34% of the sufferers were in contact with a CPN. Further, a global rating of the quality of support offered by all services showed that CPNs were ranked fourth behind the police, GPs and psychiatrists. Consumers are dissatisfied with services because they are often neglected as partners in the care of their relative, they receive little information about schizophrenia, and they lack emotional support and practical help. In this study, experimental group relatives' evaluations of services improved significantly in all of these areas, whereas control group relatives' scores remained unchanged. Indeed, control group relatives' estimates of the 'emotional support' offered by CPNs deteriorated significantly.

Training CPNs to undertake psychosocial intervention with families will unquestionably alter the traditional role of the CPN in the care of clients with schizophrenia. For example, in this study, there were significant increases in the proportion of the working week spent with families by the experimental CPNs; increases in the percentage of CPN caseloads for people with a diagnosis of schizophrenia; an improvement in relationships with consumer groups, day-centres and in-patient units, and an extension of the CPN role in relation to the minimum effective dose of neuroleptic drugs required by clients (Brooker and Butterworth, 1991). Interestingly, local psychiatrists (those working with the experimental group CPNs) were not very supportive about such changes in role, although such a change of direction in CPN practice is often advocated (Goldberg, 1985; Tyrer, Hawksworth, Hobbs, *et al.*, 1990; Wooff *et al.*, 1988).

However, significant and lasting improvements in the community care of people with a diagnosis of schizophrenia (and other such serious mental ilnesses) are more likely to occur with a change in the ethos of a whole multidisciplinary team rather than, as here, a handful of geographically disparate individual nurses. Recent guidance has been forthcoming on this issue from the Department of Health (1990). The care programme approach applies to all those discharged from in-patient units from 1 April, 1991. It indicts implicitly the erstwhile discharge procedures of some psychiatric hospitals where after-care has been unsatisfacory, and requires that key workers are identified and care programmes negotiated by all professional staff, the client and the carers (where appropriate). Although key workers can be drawn theoretically from any discipline, it seems likely (and desirable) that CPNs will often be identified to occupy these positions. As White and Brooker (1991) have suggested, CPNs might well be required to reorientate their current working practices and realign themselves to closer working relationships with psychiatrists. Thus, the case for training in psychosocial intervention strategies may well become very strong indeed over the next few years or so.

CONCLUSION

The 1990 quinquennial national survey of CPNs (White, 1991) underlines the very strong suggestion that CPNs are less likely to be working with people with a diagnosis of schizophrenia than they were ten years ago. Clearly however, CPNs still work with sufferers from schizophrenia but, as the literature suggests, in a way that could be much improved.

This report of a pilot study demonstrates that CPNs can be trained to work systematically with a family using psychosocial intervention strategies and thus improve the quality of life experienced by both clients and carers. If the main study is able to replicate some of these early findings with an improved design, we can begin to feel confident that a theoretical framework exists which can guide CPNs (and other mental health professionals) in their work with families. This may help to reverse the trend which has seen CPNs retreating from the care of those with, arguably, the most serious mental illness of them all.

APPENDIX - FAMILY VIGNETTES

Family 1

Mr R was referred to the community mental health team by a psychiatrist, and this was when the CPN first became involved. He was referred because the doctor felt that Mr R's wife was being 'over critical' of his behaviour.

Mr R was first diagnosed as suffering from schizophrenia in 1982 at the age of 33. He has been married to his wife for 17 years and they have two daughters, aged 14 and 4. Since 1982 he has been admitted to a psychiatric hospital on three occasions. Between admissions he takes his neuroleptic medication regularly, and his main support comes from his wife and elderly parents.

He was a full-time crane driver until his first admission, but he has not worked since. The CPN's assessment of the domestic situation, which involved all the family, revealed that Mr R's wife and eldest daughter were very concerned about his apparent apathy and laziness around the house. Common complaints were that Mr R 'never got up until lunchtime', 'kept himself to himself', 'never did any housework' and 'lounged around in front of the telly all afternoon'. One consequence of these behaviours was that both daughters were too embarrassed to bring any friends back to the house.

The CPN discovered that Mr R had been prescribed flupenthixol 10 mg monthly just before the last admission and that during his stay on the ward this had been increased to 40 mg weekly. On discharge the dose was still 20 mg weekly, that is, eight times more than at admission. The prescribing psychiatrist agreed to halve the amount of Mr R's medication to 10 mg weekly which had a rapid effect.

The whole family now began to engage enthusiastically in intervention. They were all given information about schizophrenia which helped them to understand Mr R's previous behaviour. As Mrs R had mentioned that her husband had a sexual problem which was a focus of stress between them she was also told, in some depth, about the side-effects of neuroleptic medication which enabled her to appreciate some of her husband's problems in obtaining an erection.

With a structured programme of social goal setting, Mr R began to increase his social behaviour both with the family and on his own. For example, he has become very involved with voluntary work and church activities. This is reflected in an increase in his social adjustment schedule (SAS) score from 115 pre-intervention to 127 at 12-month follow-up. His wife's GHQ-28 (Likert scored) score decreased from 40 to 3 over the same one-year period. At one-year follow-up, his symptoms of schizophrenia were almost non-apparent and he was taking a maintenance dose of four units of haloperidol equivalents per month.

Family 2

Peter was first diagnosed as being schizophrenic nine years ago at the age of 18 when he was admitted to a psychiatric hospital for the only time. He lives at home with his parents and has an older sister who lives nearby. His brother died from Hodgkin's disease when he was 17 years old and when Peter was 14 years old.

Peter has been on a regularly reviewed maintenance dose of neuroleptic medication for nine years. However, he still experiences both tactile and auditory hallucinations and frequent delusions.

At assessment it became clear that Peter's symptoms became more problematic in certain circumstances. The intensity of his delusions was related to guilt about masturbating (he was a Catholic). This, at a time when masturbation was becoming more painful due to increases in his medication. Peter believed that this increase in uncomfortable sensation was God punishing him for his sin: 'If I can't control my wicked urges, God has to do it for me'. This state of affairs was extended as Peter believed that by thought transference he should (and could) stop other people masturbating. During intervention the brand of drug was changed, erection became possible again and this, combined with individual health education about the side-effects of drugs, led to Peter feeling less guilty about masturbation and, in turn, less deluded.

It also became clear that Peter lacked confidence and skills in social situations when an increase in anxiety was clearly linked to worsening of his tactile hallucinations. Thus, Peter went out only infrequently and always with his parents.

Family interviews revealed that Peter's parents held negative views about his abilities and of his future in general. His mother, for example, stated, 'What will happen to him when we die – he can't look after himself?' Peter, on the other hand, craved independence and did possess a number of skills; he had a driving licence for both a car and a motorbike and he was an able cook. A series of factors prevented him from making more use of these skills; his parents were overprotective, he lacked self-confidence and his medication did little to control the positive symptoms of schizophrenia, while leaving him sedated.

Peter's mother suffered from arthritis (itself stress related) and often referred to this fact: 'If I felt better, I could do more for him.' The family were helped to deal with the stress in their lives in different ways. Peter, for example, was given a structured programme of graded *in vivo* exposure to social situations. As a consequence, he started attending a day unit and National Schizophrenia Fellowship centre four days a week, and playing sport regularly (SAS score improved from 100, pre-intervention, to 122 at one-year follow-up). His father was encouraged to take him to the pub with him when his mother needed time alone. His mother's Likert scored GHQ-28 decreased from 37, pre-intervention, to 4 at one-year follow-up, largely because, in her words, 'I think now much more about what he can do rather than what he can't.'

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CHAPTER FOUR

Client/CPN contact during the administration of depot medications: implications for practice

Gordon Turner

INTRODUCTION

The findings and discussion presented in this chapter are extracted from a larger study and, consequently, only a small part of the data collected can be included. The content will deal with issues related to administration of depot neuroleptic drugs, and to data describing the standard and content of observed nurse and client contacts involving the administration of depot drugs. While drug-related issues might be seen by some as being more the province of the medical profession, the rationale and usage of depot drugs do have important impact on the workload, and therefore the clinical practice, of nurses. The data reported here focuses on the nature of the nursing involvement in the administration of depot neuroleptic drugs.

It is hoped that this subject will be of particular relevance to practising CPNs, many of whom will have personal experience of, and may be currently involved in, the administration of depot drugs. These findings may also be of interest to medical practitioners and, hopefully, all those involved in the provision of community services, especially those services related to mental health care.

The data reported in this paper are extracted from a thesis to be submitted to the University of Edinburgh. The study was supported by the award of a Nursing Research Training Fellowship by the Scottish Home and Health Department. Opinions expressed are those of the author and do not necessarily represent the views of the funding body.

The findings here are, of course, specific to the study area but, as will be shown, the variations in practice across a single health board do raise issues which should be of interest to all practising CPNs and their managers.

BACKGROUND

Schizophrenia and chemotherapy

In general terms, it can be reasonably assumed that clients receiving depot drugs will have been diagnosed medically as having a major mental health disorder of the type encompassed by the term schizophrenia.

Within the mental illness services the care of the schizophrenic client has been described as 'the heartland of psychiatry and the core of its clinical practice' (Kendall, 1983). Although the assessment of active 'symptoms' is important, particularly in younger people, some clients will, eventually, present with a more chronic condition in which the acute symptoms are minimal, but where social functioning is grossly impaired. This 'defect state' is described by Kendall (1983):

> He becomes apathetic, no longer strives, no longer cares. At the same time, and perhaps fundamentally for the same reason, he loses interest in other people and his capacity to form enduring emotional relationships is reduced . . . It is this apathy and emotional blunting which make schizophrenia the terrible illness it is, because they are permanent changes in the personality which handicap the subject in every sphere.

Among such persons, then, it is probable that some will have been ill for many years and will have accrued considerable personal and social handicaps.

Neuroleptic, or anti-psychotic, drugs are closely associated with the management of schizophrenia. When first introduced in the 1950s they were available only as short-acting oral drugs and, as a consequence, compliance with oral drugs quickly proved to be a major obstacle to treatment.

Given the known efficacy of neuroleptic drugs in reducing relapse rates (Leff and Wing, 1971; Pasamanick, Scarpitti, Lefton, *et al.* 1969), compliance is obviously a key factor in effective clinical management, at least from the 'symptom control' point of view. The requirement for clients to take tablets at intervals throughout the day has obvious implications, given the potentially insightless nature of the client with schizophrenia.

By the mid-1960s neuroleptic drugs became available in depot format, which allowed administration by deep intramuscular injections to occur, for most, at intervals of between one and four weeks. This change in the mode of drug administration improved treatment by reducing the risk of noncompliance (Eberhard and Hellbom, 1986), as clients have to be seen regularly by a health care professional in order to receive an injection. These drugs proved to hold so many advantages that by the 1980s Eberhard and Hellbom (1986) viewed that neuroleptic drugs, particularly in the depot form, had become 'the mainstay in the treatment of chronic schizophrenia'.

However, one area of concern regarding some neuroleptic drugs, and depot types especially, are the side-effects. Of these, the most important are the three types of movement disorder: dystonia, producing involuntary muscle contractions; akathisia, which commonly presents as a discomfort in the arms and legs resulting in marked restlessness; and tardive dyskinesia, which is characterized by movements of the mouth and tongue, and may be both irreversible and resistant to treatment. The incidence of tardive dyskinesia is common and has been found to affect between 27% and 31% of schizophrenic clients (Robinson and McCreadie, 1986).

A number of studies have indicated that the administration of depot drugs to schizophrenic clients living in the community is extensive (Cheadle, Freeman and Korer, 1978; Freeman and Alpert, 1986; McCreadie, Robinson and Wilson, 1984). In a group of 44 out-patients described by Turner (1984), depot drugs had been a component of treatment for an average of 7.5 years, with injections being administered, on average, every 2.3 weeks. Surveys of prescribing practice (Clark and Holden, 1987; Holloway, 1988) confirm the popularity of depot drugs in the treatment of clients with schizophrenia.

The management of clients with schizophrenia living in the community is a key challenge for mental health services in view of the move to discharge a greater proportion of such clients into the community. The use of depot drugs will place certain demands upon the health services, but will also provide an opportunity for frequent assessment, ensuring that drug treatment, social factors and the personal circumstances of each client can be monitored regularly, possibly over long periods of time for a population with major mental health care needs.

Failure to fully utilize this contact might not only prejudice the abilities of such clients to remain in the community but might also indicate an unacceptable standard of nursing intervention.

Nursing involvement in depot administration

The nature of the nursing input to the care of such clients is of particular importance, since most will be seen regularly by nurses to receive their injection. For many clients this will represent their most frequent contact with health services. However, there is evidence to suggest that the opportunities afforded by the depot injection event are not always being fully utilized.

The nursing role in relation to depot administration has not been defined specifically, although some researchers have commented on the practices involved. Thomson (1982) found that nurses gave depot administration a low priority, while Turner (1984) found that depot administration to out-patients occurred informally, and was not recognized by the hospital concerned as requiring any particular facilities.

In one study it was found that 41% of all nursing contacts with clients with schizophrenia occurred at depot clinics, but that these contacts accounted for only 4% of the nurses' working time, with an average contact duration lasting only three minutes (Sladden, 1979). Thomson (1982) also raises the topic of brevity, describing a situation where injections were given to different clients, each in separate locations, within a relatively short period of time. Hunter (1978), in a study of the provision of care to clients with schizophrenia, commented that:

> Disappointment was expressed by some of the patients and caregivers about changes they had experienced starting with the patient being given Moditen [a depot drug] injections. A number said this was associated with the stopping of conversation with the nurse, and they missed this.

Wooff, Goldberg and Fryers (1988) contrasted the activities of CPNs and social workers and found that the mean duration of contacts with clients with schizophrenia was substantially shorter for the CPN group, and that drugs were administered in 80% of CPN contacts. It was suggested that the main thrust of CPN involvement was related to the administration of drugs to the exclusion of other types of nursing activity, concluding that:

> The CPNs' emphasis on the administration of drug in their interactions with their schizophrenic clients confirmed the observer's subjective impressions of shortcomings in arrangements for the long-term care of these clients and their families. The observer noted that in the 'injection clinics' questions about symptoms were often made in the language and tone associated with an ordinary social enquiry; and a tendency to avoid upsetting clients and to reassure them, rather than discuss strategies for dealing with problems, was observed.
>
> (Wooff *et al.*, 1988)

This evidence raises important questions for research into the activities of nurses and the ways in which they exploit the contact required by depot drug administration.

It would appear that some nurses might see their role mainly as that of 'injection givers', since the duration of some contacts suggests that it is unlikely that any other nursing interventions could occur with any consistency. This would contrast sharply with any aims to provide a more comprehensive service, thereby maximizing the potential for clients to enjoy meaningful community living for as long as is possible.

Therefore, in view of the frequency and potential value of the depot injection contacts and the previous evidence regarding the involvement of nurses, a study was undertaken to describe in some detail nursing activity during these contacts in order to identify the extent to which nurses constructively utilized this important therapeutic opportunity.

RESEARCH METHODS

In order to obtain information regarding current standards of nursing care (care) during the administration of depot drugs to out-patients, a survey of nurse/client contacts, in the various settings involved, formed the main thrust of the study. Data on care was collected using an instrument constructed specifically for this purpose, and involved the use of both non-participant observation of nurse/client contacts and subsequent discussion about the contact with the nurse concerned.

The use of non-participant observation, involving the presence of the researcher during the contact, did not prove problematic, because in the study area the presence of learner nurses during such contacts was common practice, so that clients were well used to the presence of a second person.

Waltz, Strickland and Lenz (1986) identify two principal approaches to measuring standards of care; the 'norm referenced' and the 'criterion referenced'. Norm referenced measurement involves comparing the performance of a subject with the known performance of others, while criterion referenced measurement is used to determine whether or not a subject has exhibited a predetermined set of behaviours.

Since a previously established 'norm referenced' nursing care standard for depot administration was not available, a 'criterion referenced' instrument (Waltz *et al.*, 1986) was developed to measure standards of nursing care. This instrument (index) represents for the purposes of the study a standard of nursing care against which the nursing contacts observed could be compared, thereby revealing the patterns of, and any difference in, nursing practice. The selection of criteria for inclusion in the index was undertaken by obtaining a consensus of expert opinion, and also taking into to account prescriptive nursing interventions contained in the literature (Boettcher and Alderson, 1983; Irons, 1978). Individuals having relevant knowledge and experience of depot drug administration were identified to provide this expert opinion and were asked to identify the range of nursing interventions which they considered common to the administration of a depot drug in typical circumstances.

The 22 criteria identified by these experts, and subsequently included in the index, are those which, in the view of these experts, a nurse administering depot drug to a number of clients would find relevant. As one expert commented, these criteria should be in every nurse's 'armoury' of possible interventions when dealing with clients receiving depot drugs.

From the index an observation schedule and scoring system were developed. It was also anticipated that during observation the researcher might not correctly identify some interventions, due primarily to lack of familiarity with nurse and client. Therefore after each contact, and after the client had left, nurses were invited to summarize their concerns during the contact about the client or any other related circumstances. Where this discussion indicated that an index item had been a factor in the nurse's actions but had not been identified by the researcher during observation, a score was awarded. For each contact the time duration to the nearest minute was documented, as was whether the client was part of the formal caseload of the nurse concerned.

From the pilot study some important assumptions were made regarding the standard of nursing care, in view of the practicalities of observation and ethical issues:

1. The prescribed dose of drug was administered by the nurse.
2. The injection would be administered in the most appropriate injection site, which was commonly an alternative site to the last site used. Again, the main study confirmed this with frequent references to 'which side today?'.
3. Immediately before the injection was given the nurse would ascertain that the proposed injection site was in a fit state to receive it.

Therefore, in view of these assumptions, for each observation a minimum index score of four could be achieved simply by a nurse giving an injection; the injection being a pre-requisite for inclusion in the study. Each injection was therefore presumed to be of the correct drug and dose, and was given into the most appropriate injection site after examination by the nurse. Field notes were used to document the pattern of the contacts, in particular the flow and content of conversation, any non-verbal interventions, or any other events of note (such as telephone interruptions).

Non-parametric (or 'distribution-free') statistical tests were used to analyse the data. The results were considered statistically significant, and the null hypothesis rejected, at the $p = 0.05$ level or less. While the majority of tables show mean values to summarize data, readers should note that the statistical techniques used are not those which involved the comparison of means.

SETTINGS, NURSES AND MANAGERIAL SECTORS

The study took place within the psychiatric services of a single health board and were encompassed by a single overall management structure within the health board. This structure was further subdivided into four 'managerial sectors', each having local management, but reporting to the unit general manager. From within the main study area, settings involved in the administration of depot drug to out-patients were identified at the conclusion of access negotiations, with data being collected from all those nurses who agreed to participate in the study.

During the main study 202 contacts between nurses and clients were observed, all involving the administration of a depot drug injections. These contacts were obtained in 16 different settings, and involved 17 nurses. Three types of settings and three types of nurses could be defined from the data collected, and proved valuable in exploring the patterns of care given across the different setting and nurse types, and the four managerial sectors.

Types of setting

Each of the 16 settings can be considered as being one of the three distinct types; hospital clinic, CPN office and health centre.

Hospital clinics (setting type 1). The two hospital clinics were situated in a large mental illness hospital and large acute general hospital, in the grounds of which a mental illness unit is based, which is managed from the mental illness hospital. The larger of the two hospital clinics, set in the acute hospital grounds, was well equipped and more spacious than the other hospital clinic, which took place in a small 'treatment room' within the out-patient complex. In both clinics, concurrent consultant clinics also took place.

CPN offices (setting type 2). The term 'CPN office' is not used within the study area, but is used here to identify those locations in the community used by CPNs for depot administration, other than multi-purpose local health centres. The six settings of this type appeared to be used primarily as bases for community nurses and health visitors. In some of these settings the room in which depot injections were given tended to be rather spartan, compared with health centres, and often had numerous posters targeted at pregnancy or child care issues.

In the CPN office settings there were usually no reception staff, and some nurses reported that telephone facilities could be problematic. Where screens were available they tended to be of the portable variety.

Health centres (setting type 3). Eight of the 16 settings studied were contained within local health centres. These settings all had reception staff, with consequent good communications, and more comfortable waiting areas. The rooms used all had fitted screens and, from the range of posters on display, were again most often used for nursing mothers and children.

Although hospital consultant staff were not available here, some nurses did appear to have a good relationship with some GPs based in the health centre, some of whom referred clients to the CPN concerned.

Types of nurse (CPN)

Nurses participating in the study were considered as belonging to one of three types of CPN, irrespective of their clinical grade. All nurses held the appropriate registered mental nurse (RMN) qualification.

CPN1. These nurses were employed as part of the community psychiatric nursing service, but had not obtained post-basic qualification in this specialty.

CPN2. These nurses were also employed as part of the community psychiatric nursing service but had obtained post-basic qualification in this speciality.

CPN3. These nurses, while having links with the community psychiatric nursing service, did not hold post-basic qualification in this specialty and were primarily hospital based. In this sample both the nurses in this type were based in the two hospital clinics.

Of the 17 nurses, 10 were CPNs with post-basic experience (CPN2). The five remaining CPN department-attached nurses had no post-basic qualification (CPN1), although some were awaiting confirmation of acceptance for post-basic training at the time of observation, with the remaining two nurses being hospital clinic based (CPN3).

Managerial sectors

As noted earlier, and while all the settings studied form part of a single managerial structure, there is a sub-structure of four managerial sectors, related primarily to the geography of the study area. Each of the managerial sectors contains a large mental illness hospital, which in some cases involves related, smaller, satellite hospitals. In each case the CPN department containing the responsible manager was located in the major hospital. Some CPNs may have a local base, where they maybe wholly or partly based, but continue to report to a manager located in the main hospital.

Managerial sector 1. The setting used in the pilot study was from managerial sector 1, which reduced the potential number of main study observations from this sector. The pilot setting was the only clinic based in a local health centre within this area. Both the settings in the main study were CPN offices.

Managerial sector 2. Both the settings in managerial sector 2 were the only two hospital clinics in the sample. Setting 2 also functioned as a clinic dealing with the administration other drugs; this being the responsibility of the same nurse.

A health centre setting involved in depot administration in this managerial sector was not studied; the nurse concerned declining to participate.

Managerial sector 3. The clinics in managerial sector 3 were all located in local population centres. Of the four settings studied, two were based in local health centres and the remaining two in CPN offices. Facilities in both the health centre settings were good, while in one of the CPN offices the accommodation appeared to be particularly unsuitable.

Managerial sector 4. Managerial sector 4 accounted for eight of the 16 settings; and for six of the eight health centre-based settings, with the remaining two settings here being in CPN offices. The health centre accommodation, again like elsewhere, was noticeably better than other types. In one setting the nurse concerned was in the habit of playing music during contacts with clients.

Before leaving the issue of the various types of settings, it is worth noting specifically that data presented regarding hospital clinics (setting type 1), non-CPN attached nurses (CPN3) and managerial sector 2 will be identical since all the data regarding these types arise from the same observations.

APPOINTMENT ARRANGEMENTS, RECORDS AND CLIENTS

Appointment arrangements

The appointment arrangements were broadly similar in all 17 settings. The use of appointment cards was common, although there were occasions where the nurse had 'run out' of cards. Interestingly, the majority of these cards are supplied by depot manufacturers, with the names of particular drugs prominent on the card. While not a specific item of data, it is worth noting that there were several occasions when clients were given an appointment card (since these appeared to be regularly mislaid by clients) where the 'logo' on the card was not that of the drug prescribed.

On one of these occasions a nurse had to spend some time reassuring a client that their prescribed drug had not been changed, because the nurse had given the client an appointment card with the 'logo' of another drug (the nurse having none available for the prescribed drug).

In all cases clients could expect to see a particular nurse. In a number of cases nurses did inform clients that they would be unavailable to give the next injection, and usually said which nurse would be in attendance instead. During contacts where the nurse was meeting the client for the first time, the nurses always introduced themselves by name before administering the injection. The use of specific appointment times was observed, primarily in those settings with managerial sector 4, where the setting caseload numbers tended to be smaller. In practice these timings appeared flexible, and on occasions there would be a gap between the departure of one client and the arrival of the next. It was apparent that in these settings a queue of clients awaiting injection rarely developed.

Records

The use of records proved to be more problematic in terms of categorization. Apart from prescription and drug recording sheets, both of which are mandatory and identical in all settings, the most common record (other that the appointment card) was the diary. In the diary nurses would 'tick off' each client as they attended and, at the same time as amending the appointment card, would record the client's name on the next due date. Commonly, nurses would note here which injection site they would use next time.

The term 'care plan' proved problematic to interpret in that some of the nurses who stated they used care plans did not have them available, or appeared to be referring to their personal written notes or a Kardex type of format. Shortly after completion of the data collection a new standardized care plan was to be introduced; unfortunately, these were not available during data collection.

The most important type of record, in view of later findings, operating solely in the managerial sector 4 settings, was a computer-based record system, containing information specifically in relation to depot drug clients. This involved nurses completing a pro-forma, recording primarily drug-related information, and involved the assessment of drug side-effects using examination techniques. These pro-formas were then returned and the information added to the patient's record; for forthcoming injections, nurses would receive a report on the client's depot history and any significant drug-related issues.

Although primarily related to the assessment of side-effects, which CPNs are obviously well placed to do given their frequency of contact with clients, and containing no singularly nursing components, the actions taken by the observed nurses in relation to this information system did prove an important factor in the variation of observed care scores. However, this system is used only in relation to clients referred by hospital consultants, and is not used for clients referred to the same CPNs by general practitioners (GPs). Consequently, the assessment of side-effects by the same nurses for GP referrals was less thorough in the absence of the requirement to complete the pro-forma.

Clients

Since the focus of study was the observation of nurse and client contacts, only a limited amount of information regarding clients was collected.

Gender. Of the 202 contacts, 123 (60.89%) involved male clients and 79 (39.11%) were female. The predominance of contacts involving male clients was repeated across the various types of settings and nurses, and managerial sectors, with no statistically significant differences being revealed.

Age range. The mean age range of all clients was 43.18 years, and ranged from 18 to 70 years. For male clients the mean age was 41.22 years, while for female clients the mean age was 46.23 years. In both cases the range of ages was similar - 20 to 70 years for males and 18 to 69 for females.

Frequency of injections

In Table 4.1 the frequency of contacts in relation to the injection intervals is shown. This indicates that of the 202 contacts, 16 (7.92%) were weekly administrations, 103 (50.99%) were two-weekly, 33 (16.34%) were three-weekly, and 50 (24.75%) were four-weekly or more infrequent. Over half of all contacts involved fortnightly drug administrations, with a mean injection frequency across the whole sample of 2.56 weeks.

Table 4.1 Injection frequency of interactions by types

Injection frequency	*Sex*		*Sectors*				*Nurses*			*Settings*		
	M	*F*	*1*	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Weekly	11	5	7	0	5	4	11	5	0	0	9	7
Two-weekly	64	39	20	17	31	35	32	54	17	17	41	45
Three-weekly	18	15	5	5	9	14	8	20	5	5	13	15
Four weeks +	30	20	5	9	12	24	9	32	9	9	12	29

Table 4.2 shows the mean injection frequencies across the gender of clients, the various types of settings and nurses, and managerial sectors. In terms of these various types, there were no significant differences in the pattern of frequencies of depot drug administration across the gender of clients, settings or managerial sectors. There was, however, a significant difference in the frequencies across the types of nurse (p=<0.05).

Table 4.2 Mean injection frequencies by types

Settings	*Mean*	*Managerial sectors*	*Mean*	*Nurses*	*Mean*	*Gender*	*Mean*
1	2.74	1	2.22	CPN1	2.25	Male	2.56
2	2.39	2	2.74	CPN2	2.75	Female	2.66
3	2.72	3	2.52	CPN3	2.74	–	–
–	–	4	2.78	–	–	–	–

As Table 4.2 shows, the mean injection frequency of contacts is lowest, at 2.25 weeks, for CPN1 nurses (CPN-based nurses with no post-basic training), while for the other types of CPN the means are almost identical.

The results in Tables 4.1 and 4.2 show that CPN1 nurses accounted for most of the weekly injections, while having proportionately fewer contacts involving injection intervals greater than fortnightly than either of the other types of nurse. For example, 18.33% of CPN1 contacts were weekly drug administrations, which contrasts with only 4.5% for CPN2 nurses, and none for the CPN3 nurses. Therefore, it does appear that those clients requiring the most frequent contacts, and who therefore may be the most chronically unwell, tend to be seen by the non-post-basic trained CPN1 nurses, while their post-basic trained CPN2 colleagues tend to see clients with less frequent injection intervals.

Living alone

Since an aim of this study was to explore the extent to which nurses utilized the contact with clients afforded by the administration of depot drugs, it was considered of value to identify the extent to which this contact might be important to clients themselves; in particular those clients who lived alone and for whom the contact with nurses might be especially relevant.

Of the 202 contacts, 74 (36.63%) involved clients living alone, with there being no significant difference among males and females. Analysis also revealed that the standards of nursing care were not significantly different, as measured using the index, between clients living alone and those living with others. However, the difference in the duration of contact times between clients who live alone and those who live with others was statistically significant ($p = < 0.05$), with those living alone tending to experience briefer contacts, with mean contact times of 4.01 minutes for those living alone and 5.30 minutes for those living with others.

This suggests that the standard of nursing care observed was not influenced by whether or not the patient lived alone, although it might be argued that clients living alone might have a greater need for nursing intervention. While significant, the shorter mean contact time for those living alone does not necessarily imply that the contacts were being less fully utilized, since the standard of nursing care was not found to be significantly different than for those clients living with others. A possible explanation for the difference in contact time durations, although supporting data is not available, is that nurses may more often make additional home visits for clients living alone.

Community support

In order to further explore the potential importance of depot attendance to clients, each was asked to identify their most important source of community support. The responses from the 202 contacts show that family supports are the most common; parent or sibling 112 (55.45%), spouse, children or other relatives 37 (18.32%), friends or care staff 52 (25.74%), no response 1 (0.50%).

In relation to gender, the most important community supports identified by clients were significantly different ($p = < 0.01$). Seventy-nine of the 123 males (64.23%) identified parents or siblings as being the most important community support, compared with 33 of the 79 females (41.77%). Females, however, more often identified a spouse, child or other relative than did males; 25 of 79 females (31.65%) and 12 of 123 males (9.76%). Similar proportions of each sex identified friends or care staff as community supports.

The difference in important community supports was also significant between clients who lived alone and those who lived with others ($p = < 0.01$). Eighty-seven of the 128 (67.97%) clients living with others identified parents or siblings, compared with 25 of the 74 (33.78%) clients who lived alone. Similar proportions identified spouses, children or other relatives, while 37 of the 74 (50.00%) clients living alone identified friends or care staff, compared with 15 of the 128 (11.72%) clients living with others.

The data suggest that those clients who lived alone had less reliance on family supports, possibly because such supports were less available to them. Clients who lived with others indicated that they were predominantly supported by their families, with whom many of the clients presumably lived.

There are, then, significant differences in terms of the sources of community support experienced by clients, of which nurses should obviously be aware in relation to individual clients. The finding that the standard of nursing care was not significantly different between these two groups, and is at least no worse for clients living alone, is encouraging.

STANDARDS OF NURSING CARE

Within the scope of this chapter, it is not possible to present in detail all of the data regarding standards of care, particularly by describing the findings regarding each of the index criteria. Since analysis has revealed that the observed standard of care and the duration of contacts (time) are significantly correlated, the data presented will include the mean values of care and time across the various types within the sample (settings, nurses and managerial sectors), with only occasional reference to specific index criteria of particular interest. These mean scores are used to illustrate differences and similarities, and readers are reminded that the statistical tests used are not those based on comparisons of these means.

Table 4.3 shows the frequency and percentage of observations for each care and time score. It can be seen that 45 (22.28%) of the 202 observations achieved a care score of only four, the minimum score as described earlier. For these contacts it can be assumed the nursing activities observed related only to drug administration, and that no other type of nursing intervention was evident.

Table 4.3 Frequency of care and time scores

Care score	*Contacts*	*%*	*Time score*	*Contacts*	*%*
4	45	22.28	1	23	11.39
5	31	15.35	2	43	21.29
6	35	17.33	3	31	15.35
7	26	12.87	4	21	10.40
8	14	6.93	5	21	10.40
9	8	3.96	6	12	5.94
10	3	1.49	7	5	2.48
11	12	5.94	8	14	6.93
12	3	1.49	9	9	4.46
13	9	4.46	10	8	3.96
14	8	3.96	11	6	2.97
15	4	1.98	12	1	0.50
16	2	0.99	13	4	1.98
17	2	0.99	14	1	0.50
			15	1	0.50
			19	1	0.50
			23	1	0.50
Mean care = 7.25			Mean time = 4.81		

n = 202

Of these 45 minimum standard observations, 30 occurred in managerial sector 3, with 26 of the 45 being attributed to nurses with post-basic training (CPN2). During these minimal contacts, not only was no attempt made to assess side-effects or oral drug compliance, but no assessment of issues such as the client's sleep pattern, diet, personal hygiene or daily activities was attempted. The finding that over 20% of the nursing contacts observed had no obvious nursing attributes other than the giving of an injection is of obvious concern. Similarly, that almost half of the contacts observed lasted for four minutes or less, with 23 lasting for only one minute, is of equal concern since with such short durations the capacity for any meaningful nursing assessment or intervention to occur must be constrained.

This confirms the findings of both Sladden (1979) and Thomson (1982), in that some of the contacts in this sample were similarly brief. In relation to the standard of nursing care observed, the data does indicate more specific issues of concern, of which the following are illustrations.

Compliance with oral medications

In 105 (54.88%) of the 202 observations nurses failed to address the issue of oral drug compliance, where this was relevant in that clients were receiving some form of oral drug. It was apparent, however, that some nurses, because of prescribing practices, might not even have been aware that their clients were receiving oral drugs. This appeared to be because, for some clients, oral drugs and depot drugs might be prescribed separately by the GP and consultant involved. As a result, nurses may have had a record of only the depot drug regime which they themselves administered since this would involve prescription and drug-recording documentation. However, the nurses may have had no formal information regarding any concurrent oral drug prescribing, usually carried out by GPs. The dosage of oral drugs for some clients would normally be amended when the client saw the GP so that, unless advised by the GP, nurses might have no knowledge of such changes when the client next attended. The field notes do show occasions where the client was able to inform the nurse about oral drug changes, sometimes in response to the nurse asking about the outcome of their GP appointment. Indeed, the field notes also show that nurses often asked when clients had last seen, or were next due to see, either their GP or consultant.

Since many of the drugs taken by clients were of the type prescribed to deal with drug side-effects, then the failure of some nurses to routinely monitor oral drug compliance during depot contacts is of concern. The issues of prescribing arrangements, communication between some nurses and medical staff, and perhaps the level of awareness among nurses of the value of monitoring oral drug compliance during these frequent depot contacts, all appear relevant to this finding.

Other nursing interventions

The research instrument developed (index) was used to record any nursing interventions occurring during each observation. During the main study, over 1200 separate nursing interventions were recorded, of which 606 consisted of the three interventions assumed to occur in each contact, resulting from the administration of an injection. The remaining interventions describe the nursing care observed other than the actual administration of an injection.

For example, in respect of the daily living activities, nurses enquired about sleep patterns during 31 (14.42%) contacts, the client's daily activities in 54 (25.12%) contacts and diet in 22 (10.23%) contacts. In view of the probable needs of such clients, and in terms of the standard of nursing care, the frequency of enquiries on these matters is a cause for concern.

Since all of the clients involved received depot neuroleptic drugs, the monitoring of drug side-effects is an important issue. Given the frequency of contacts, nurses are well placed to meet this need. That oral movement was assessed in only 36 (16.74%) contacts, and tremor in 43 (20.00%) contacts is also of concern, particularly in view of the issues such as tardive dyskinesia. All 36 assessments of oral movement occurred in managerial sector 4, as did almost all attempts to monitor drug side-effects. This probably relates to the demands of the unique computer-based record system used there.

Mean care and time scores

Some indication of the differences within the sample in terms of the standard of nursing care and the duration of contacts (time) is illustrated by showing the respective mean scores.

Table 4.4 shows the care and time means, calculated from all 202 observations, for each setting type. The health centres (setting type 3) are seen to produce the highest means of both care and time, with the hospital clinics (setting type 1) producing the lowest. The differences in contact times shown in Table 4.4 are not statistically significant. The differences in the standard of care across types of setting is significant, however ($p=<0.01$), confirming

Table 4.4 Mean care and time by type of setting

Settings	*Mean care*	*Mean time*
1	5.74	3.39
2	6.24	4.69
3	8.52	5.36

n=202

that observed standards of care were better in health centres (setting type 3), compared with either hospital clinics or CPN offices.

Table 4.5 Mean care and time by type of nurse

Nurses	*Mean care*	*Mean time*
1	7.58	4.93
2	7.49	5.14
3	5.74	3.39

n=202

Table 4.5 shows the care and time means by type of nurse, again calculated from all 202 observations. The hospital clinic nurses produce the lowest means of care and time. The means of the two CPN-based groups indicate similarity, and differences between the two CPN-based types were not statistically significant for either care or time scores. In effect the CPN-based nurses with no post-basic training performed as well as CPN-based nurses who had undergone post-basic training, in terms of nursing interventions observed.

Table 4.6 Mean care and time by managerial sector

Managerial sector	*Mean care*	*Mean time*
1	6.35	5.14
2	5.74	3.39
3	4.86	2.35
4	10.05	7.05

n=202

Table 4.6, like Tables 4.3 and 4.4, shows the means of care and time across all 202 observations, but by managerial sector. Analysis shows that the differences in both care and time scores across the managerial sectors are statistically significant ($p=<0.01$). Managerial sector 4 attains the highest means of both care and time, which is not surprising given that this sector contains six of the eight health centres in which greater care and time scores were obtained.

Interestingly, the lowest mean values of care and time are found in managerial sector 3, which would be expected since 30 of the 45 minimum care standard contacts occurred in this sector. Three of the four nurses observed in managerial sector 3 were CPNs with post-basic training (CPN2).

Caseloads

A possible explanation for the relative performance of sectors, aside from the information system in managerial sector 4 which contributes to care scores there, are the caseload sizes involved, as shown in Table 4.7.

Table 4.7 Nurse/setting case loads by managerial sector

Managerial sector	*Mean nurse caseload*	*Mean setting caseload*
1	52.67	33.81
2	207.00	204.65
3	75.75	46.50
4	53.17	20.49

n=202

The large caseload means shown in managerial sector 2 are due to both settings there being hospital clinics, so that the caseload includes clients who do not receive depot drugs. For the remaining three sectors, the setting caseload means shown are comprised solely of depot clients. Managerial sector 3, which had the lowest mean values of both care and time, shows the largest means in terms of both nurse and setting caseload sizes.

Analysis shows that the size of the nurses' personal caseload is not correlated with the care and time scores observed during depot-related contacts. Many nurses conducting depot 'sessions' also administered depot injections to clients on the caseloads of other nurses, and no correlation with care and time results even when including these other 'informal' clients. However, analysis does reveal a significant inverse correlation between setting caseload sizes and both care and time scores ($p = < 0.01$), suggesting that it is more the demands made on individual settings, in terms of the volume of clients attending during 'sessions', rather than the overall workload of individual nurses, which influenced the standard of nursing care observed in depot settings.

The combination of having more depot settings for an approximately similar population, lower setting and personal caseloads, and the unique information system in managerial sector 4, appears to give nurses based there a considerable advantage in terms of standards of nursing care practised as compared with their collegues in the other sectors.

NURSE/CLIENT CONTACTS

Detailed field notes were compiled for each contact. These field notes described the nature and content of the contact, with particular emphasis on the social and conversational aspects of the contacts: for example, the modes of address used between nurse and client, and conversation topics describing both the manner in which the index issues were dealt with, and the more socially orientated conversation topics.

The field notes were later coded, again by experts, in order to describe the nature of each contact by the allocation of a series of categories. These categories, being descriptive, carry no numerical value. Raters were instructed to consider the description of each contact from the field notes, and to identify which of the following categories adequately described an aspect of the contact. Such a contact could be described in terms of one or all the categories noted below, since they are not mutually exclusive.

The categories used to classify contacts are as follows:

1. Basic. The contact description contains elements primarily related to the administration of the depot injection. Every contact is therefore basic in that an injection is given as a pre-requisite for inclusion in the study.
2. Social. The contact description contains elements of personal social intercourse; such as the use of forenames, or non-clinical conversation topics.
3. Structured. The contact description contains elements which indicate that the nurse used the contact to explore certain issues and/or gather any relevant information.
4 Directive. The contact description indicates that the nurse initiated or reviewed some form of nursing intervention, gave specific direction to the client or took some other form of action in response to particular circumstances.

Social contacts

Only seven of the 202 contacts were considered to have no social components and, as such, it can reasonably be assumed that virtually all the nurse/client contacts at least dealt with the practicalities of depot administration in a socially appropriate manner.

Structured contacts

Of the 202 observed contacts, 136 (67.33%) were considered to be structured, where nurses explored relevant issues in a systematic manner.

As Table 4.8 shows, the majority of structured contacts (52.21%) occurred in managerial sector 4, where 71 of the 77 contacts were structured (92.21%). This is not surprising given that this sector has demonstrated greater

greater care and time scores. Since the remaining sectors reveal similar proportions of structured contacts, the statistically significant ($p = < 0.01$) difference in the frequency of structured contacts across managerial sectors further reinforces that better standards of care were observed in managerial sector 4.

Table 4.8 Frequency of structured contacts

	Sector				*Nurse*			*Setting*		
	1	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Unstructured	17	15	28	6	21	30	15	15	25	26
Structured	20	16	29	71	39	81	16	16	50	70

n=202

Across the types of nurse, those attached to a CPN department showed the largest proportions of structured contacts, 72.97% among post-basic trained CPNs (CPN2) and 65.00% among non-post-basic trained CPNs (CPN1), compared with 51.61% for the hospital clinic nurses (CPN3). These differences, however, are not statistically significant. The proportion of structured contacts in health centres and CPN offices are similar, 72.92% and 66.67% respectively, compared with the 51.61% in hospital clinics.

Directive contacts

Of the 202 contacts, only 41 (20.30%) were considered to be directive, where there was evidence of the nurse initiating or reviewing nursing interventions.

Table 4.9 Frequency of directive contacts

	Sector				*Nurse*			*Setting*		
	1	*2*	*3*	*4*	*1*	*2*	*3*	*1*	*2*	*3*
Not directive	32	24	54	51	53	84	24	24	66	71
Directive	5	7	3	26	7	27	7	7	9	25

n=202

Table 4.9 shows that 26 of the 41 directive contacts occurred in managerial sector 4, where one-third of all contacts were directive. Again this could be expected in this sector given the care and time score findings. Among the remaining sectors the proportions of directive contacts are more variable.

Particularly notable was managerial sector 3, which had significantly lower care and time scores, and where only three of 57 contacts were directive. In managerial sector 1, five of 37 contacts were directive, while in managerial sector 2 the proportion was seven in 31 contacts. It is worth noting that neither of the nurses in managerial sector 2, which had proportionately more directive contacts than either managerial sectors 1 or 3, had post-basic CPN training. The differences in frequencies of directive contacts is significant only across managerial sectors ($p=<0.01$), which again relates to the performance of managerial sector 4.

In terms of care and time, Table 4.10 shows the mean scores in relation to the frequencies of the three contact types. Those contacts designated as not meeting the criteria concerned produced lower means of care and time than those that did. These differences in care and time scores are not significant in relation to social contacts, but are significant in both structured and directive contacts ($p=<0.01$). Therefore, contacts designated as being structured or directive did involve longer durations, and tended to involve a greater range of nursing interventions, and were most often a feature in managerial sector 4.

Table 4.10 Mean care and time scores by contact type

	Not social	*Social*	*Unstructured*	*Structured*	*Not directive*	*Directive*
Mean care	6.29	7.28	5.42	8.13	6.66	9.56
Mean time	3.71	4.85	2.76	5.81	4.11	7.59

n=202

The Appendix to this chapter includes the actual field notes of seven contacts, including the relevant contact classification, time duration and care score. These field notes show the contrasting content of contacts, ranging from one of the seven contacts classified only as basic, lasting only one minute and barely recognizable as being nursing, to the more comprehensive structured and directive contacts.

CONCLUSIONS

Within the confines of this chapter it has been possible only to present a small proportion of all the data collected, and even then to summarize using only means. The background information suggested that nurses might not fully utilize the contact inherent in depot drug administration, and the findings from this study confirm that this is indeed the case for some nurses. However, the data presented here, along with the information contained in the field notes, also shows that some nurses do make more effective use of these contacts.

The absence of a significant difference between the performance of the CPN-based nurses with post-basic training and those without was surprising. It is suggested that it is the situational factors within some managerial sectors (such as the numbers of settings, setting caseload sizes and the consequent demands on nurses conducting depot clinics) which accounts partly for the absence of evidence that post-basic trained CPNs displayed a higher standard of nursing care; otherwise, the value of post-basic training would become questionable.

The most striking feature in the findings is the variation in scores, and therefore related nursing practices, across this sample. Although all the sample data is contained within a single mental health service, the key variation appears to occur across the four managerial sectors which make up this service.

The performance of managerial sector 4, by comparison with the other sectors, is outstanding. This sector contains more settings, and six of the eight health centre settings in which both care and time scores were greatest, had smaller setting caseloads, while structured and directive contacts were more common here. An important issue which also appears to have contributed to the performance of managerial sector 4 was the presence of the unique computerized information system, the nursing requirements of which contributed to the measurement of nursing care, although the same nurses when dealing with clients not involved with the system did not perform the same interventions as frequently.

The performance of managerial sector 3, which involved three post-basic trained CPNs, was the most disappointing. However, in managerial sector 3 the setting caseload sizes, in view of the significant correlation with care, and personal caseload sizes appear to place higher workload demands on these nurses.

The numbers of settings and the size of setting caseloads do, therefore, appear important, since there are obvious consequences for the workload demands made of nurses during depot injection 'sessions'. The impressions of the researcher are that in the larger caseload settings there was more of a 'production line' approach, however unpalatable this may be, where queueing was common, and where nurses had a limited time to administer the number of injections required. This contrasts with other settings, particularly in managerial sector 4, where the caseload size and scheduling arrangements were conducive to longer and more comprehensive contacts, as the care and time scores and the incidence of structured and directive contacts confirm.

That some nurses administered injections to clients outwith their caseload, as was the case in 45 of the 202 contacts, may appear undesirable, although the data collected shows that these 'informal' contacts did not involve a reduced standard of nursing care. This is probably explained by the predominance of these contacts in managerial sector 4, where prevailing characteristics allow routine standards of care to be significantly better in any event. There were, however, a number of contacts where the nurse administering the injection either suggested that the client contact their 'own' CPN regarding an issue, or stated that they intended to refer the issue to another CPN.

While it might be argued that dealing separately with the physical injection process allows additional contacts with the client to be used for other issues, this practice has implications for continuity since clients might not feel able to wait to see their 'own' CPN, or might have little control over their difficulties or their understanding of them. To use the depot contact solely to give an injection appears wasteful since, if used more constructively, some additional contacts might be avoided or, if required, their content might be planned more carefully. That nurses might deliberately not assess or explore important issues during an injection contact because a further contact (possibly involving another nurse) would occur in any event, does not appear to represent good nursing practice.

The demands on nurses conducting depot clinics is also related to the prescribing and working arrangements of medical staff, both hospital consultants and general practitioners, where their differing demands and practices will have important effects on the work of the nursing staff involved. This is most marked regarding the prescribing of depot and concurrent oral drugs, where the depot drugs are often prescribed by consultants but concurrent oral drugs are managed typically by general practitioners. It was apparent during observations, and was indeed reported by some nurses, that they were often informed of drug changes by the clients themselves, before being formally advised by medical staff. This is reinforced by the finding that monitoring oral drug compliance with oral drugs was often overlooked by nurses.

There are clearly nursing implications arising from medical prescribing practices, along with any administrative issues regarding the supplying of these drugs to nurses. For some clients the separation of depot and oral prescribing may have consequences in terms of the effective communication of drug changes, the monitoring of oral drug compliance during depot contacts and the standard of nursing care practised.

In relation to the different types of setting, hospital clinics were the less effective than either health centres or CPN offices. However, the working arrangements of these settings, particularly because of the presence of consultant staff, are probably important local factors in the volume of clients attending. The situation here is convenient in some respects; clients could be seen quickly by medical staff, and nurses could obtain prompt advice in situations of concern. This, however, does involve some dependence on a major hospital site, and also involves substantial travelling for some clients in view of the location of these settings in relation to some population centres. The health centres demonstrated the best standard of nursing care. However, it is the location of most of these settings within managerial sector 4, with its unique information system and where better standards of care were routinely achieved, which is the probable cause of this finding.

Given that all of the settings studied relate to a single managerial structure, and the observations were of a relatively homogeneous group of clients and nurses, the variations in standards of care and nursing practice are of obvious interest and concern. The findings from this study indicate that a review would be justified of issues such as the number, location and caseload size of depot settings, communication with medical staff, the nursing implications of prescribing practices and the quality of information available to nurses – if only to raise the standard to that observed in managerial sector 4.

However, if this standard were to be attained across the main study area, the data collected shows that some important and relevant clinical issues are not assessed regularly, even in managerial sector 4. A considerable degree of both professional and managerial commitment would be required to review and, where appropriate, change aspects of depot drug administration arrangements.

Of equal concern is the need to establish an awareness of the potential benefits of more fully, and consistently, utilizing the opportunity afforded by these frequent depot contacts. Within this sample the differences in organizational arrangements and nursing practices observed suggests that a common view of this important event, even with a single management structure, had not been established. Such an awareness should not just be confined to, or expected of, the individual nurses concerned, but should also be an essential responsibility of organizations providing comprehensive and effective mental health care to the population at large.

As noted in the background information, the clients of this type of service do have major mental health care problems and related social and personal needs, which they might not fully appreciate or in some cases be able to articulate. The data shows that a number of clients do value contact with care staff, particularly those who live alone, which for depot drug receivers will most often involve nurses.

The evidence from this study confirms that some nursing contacts related to depot drug administration did involve an acceptable, and at times excellent, standard of nursing care, particularly in managerial sector 4. However, it is the overall variation in the observed standards of care across this single mental health care service organization, albeit with local managerial levels, and the inconsistencies of nursing practice in terms of the range of interventions observed, which are the particularly important findings.

Some clients clearly did not receive an acceptable standard of nursing care, in view of the brevity of their contacts with nurses which, in some cases, involved few recognizable nursing components other than the administration of an injection. For these clients, if the minimum care standard contacts observed represented their only regular nursing contact, then the nursing contribution to their care in the community must be considered unacceptable, and might not accord with the term 'nursing' at all.

Post script

Since this paper was written it has been confirmed that the information system in managerial sector 4 is no longer operational. The nurses, however, report that they continue to monitor drug side-effects using the same techniques, although the information is no longer recorded and disseminated as before.

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APPENDIX

Contact 1

Type – basic; setting – health centre; time duration – one minute; care score – 4.

Contact description. Neither nurse nor client use any form of address during the contact. As the client enters the nurse says, 'Where do you want it today?'; the client smiles but does not respond. The nurse, looking at her diary says, 'Left this time', and administers the injection, stating, 'That's it'.

Both exchange goodbyes and the client leaves; the nurse follows to the door and shouts, 'Next'.

Nurse's comment. No comment made.

Contact 2

Type – basic, social; setting – CPN office; time duration – five minutes; care score – 6.

Contact description. Nurse uses client's forename. Client uses no form of address in conversation with the nurse.

Client informs the nurse that she had seen her consultant and that the frequency of her injections was amended to fortnightly. The nurse comments that he had not been told of this yet but would, 'Take your word for it'.

Client comments that this had been the first time she saw her consultant, rather than her GP, for 18 months. The nurse comments it was 'about time' her drug was reviewed.

After the injection both briefly discuss the weather and exchange goodbyes.

Nurse's comments. Is glad client has seen the consultant, since he had been pressing for a drug review and general practitioners were reluctant to alter depot prescriptions. Notes that this particular consultant prefers clients to contact him directly, rather than be referred by a CPN.

Contact 3

Type – basic, social; setting – hospital clinic; time duration – three minutes; care score – 5.

Contact description. Nurse uses client's forename. Client uses no form of address in conversation with the nurse.

Nurse asks about holiday plans and client responds that he has made no holiday arrangements, but volunteers that his mother is 'just back'. Both then discuss holiday matters, such as hotels, in more detail.

Both then discuss local car parking problems and, after the injection, exchange goodbyes.

Nurse's comment. No comment made.

Contact 4

Type – basic, social, structured; setting – health centre; time duration – nine minutes; care score – 11.

Contact description. Both nurse and client use forenames when addressing each other. The client has hearing problems and the nurse speaks more loudly than usual, and appears to deliberately maintain eye contact with the client whenever speaking.

The client comments that she has not seen her consultant for some time and that a recent appointment was cancelled at short notice. The nurse explains that he knows that Dr X is 'very busy', and had to rearrange a number of appointments. He reassures the client that a new appointment will be made soon; the client appears satisfied and this topic ends.

The nurse commences a series of procedures to test for drug side-effects. For each procedure the client asks, 'What is that one for?', and the nurse gives an explanation for each procedure. The client comments that she has been feeling drowsy; the nurse asks for details about how often and what times of day this is most apparent. The client is unable to be specific and the nurse suggests that she mentions this to the consultant when she sees him.

The client asks if the injection can be given in the right buttock; the nurse checks the prescription sheet and says 'Happy to oblige'.

Both exchange goodbyes and the client leaves.

Nurse's comments. Will check that a new consultant appointment has been made and, if not, will arrange it himself since the client is obviously concerned.

Contact 5

Type – basic, social, structured; setting – health centre; time duration – four minutes; care score – 9.

Contact description. The nurse uses client's forename, and also calls him 'love'. Client uses no form of address in conversation with the nurse.

The nurse asks, 'How are you?', to which the client replies that he is 'fine'.

The client volunteers that he is to see his consultant again soon and is hoping that a reduction in drug will be considered. The nurse responds that she is sure the consultant will consider this option since the client is 'doing so well'.

The nurse asked about the client's social life: the client tells the nurse that he went to see a film called *Ghost*, which he enjoyed.

The nurse then asks if the client had seen the disablement resettlement officer at the local Jobcentre. The client informs that he had not, but he intended to. The nurse responds, 'You should; you might have hidden talents': both laugh.

The nurse asks if the clients had experienced any 'troublesome thoughts' recently; the client responds that he had not.

After the injection is given both exchange goodbyes and the client leaves.

Nurse's comments. No particular concerns today. Is on depot drug after a 'first episode' illness, is now well but a little overprotected by his family. Encouraged to see him getting out to the cinema.

Contact 6

Type – basic, social, structured, directive; setting – health centre; time duration – eight minutes; care score – 11.

Contact description. Both nurse and client use forenames when addressing each other. Client has arrived in a wet state, having walked for two miles in heavy rain.

The subject of Invalidity Benefit is raised, and the client informs the nurse that her telephone and electricity supply have been disconnected due to non-payment. The nurse advises the client to contact her social worker and Citizen's Advice Bureau as soon as possible to discuss finances.

The client reports occasional daytime drowsiness but that it is not a problem. The nurse notes this and advises that client to inform her if the drowsiness worsens.

After the injection the nurse asks the client to participate in 'tests for side-effects'. This involves standing and walking: holding the arms outstretched while the nurse observes for tremor, dropping the arm from horizontal, shoulder manipulations by the nurse and tongue protrusion while the nurse observes for movement.

Afterwards both exchange goodbyes and the client leaves.

Nurse's comments. Financial problems are not unusual. Will contact the social worker after the clinic has ended, and will make a home visit as soon as possible.

Contact 7

Type – basic, social, structured, directive; setting – CPN office; time duration – 11 minutes; care score – 8.

Contact description. Nurse uses client's forename. Client uses no form of address. First contact between client and this nurse.

Client states that she 'hasn't been good' for the past week. She saw her consultant yesterday and reports not informing him of having suicidal thoughts, in case she was readmitted to hospital. The nurse asks what is meant by 'not feeling good', and the client describes hearing voices telling her to 'run into the traffic'.

The nurse suggests that it would be advisable to inform the consultant of her feelings and asks her approval to telephone him; the nurse advises that he would be unhappy if she were to leave before he has spoken to the consultant. The client agrees to the nurse telephoning. Before leaving the room the nurse asks about the client's appetite and sleep pattern.

The nurse returns after three minutes and tells the client that she can go home and that an appointment had been made for her to see the consultant again tomorrow.

The injection is given, both exchanging goodbyes, with the nurse telling the client to 'take care till then'.

Nurse's comments. The suicidal thoughts are of concern but since this was the first contact he has with this client he is happy to follow the consultant's advice. He will make a particular effort to 'get to know her as quickly as possible'.

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CHAPTER FIVE

Human immunodeficiency virus (HIV) disease and drug misuse - research issues for CPNs

Jean Faugier

INTRODUCTION

Human immunodeficiency virus (HIV) disease poses a range of practice issues for CPNs and there is a growing body of research which, while not addressing the direct involvement of CPNs with those individuals with HIV disease, nevertheless begins to inform our approach to the prevention and care issues in the community.

There are, of course, the obvious effects of HIV disease, presenting as they do a great complexity and diversity of emotional and psychological problems which affect every aspect of a person's life. Such stresses can, in turn, further diminish the immune response, often leaving the individual caught in a vicious circle of stress and illness. The CPN has a role to play in providing essential emotional and psychological support and assessment for all those people and their loved ones who are affected by HIV disease. Diagnosis with a life-threatening disease of the nature of HIV will produce a myriad of responses, ranging from a positive approach to despair and hopelessness.

HIV also has the ability to strip away people's anonymity, thereby identifying them as a member of a socially stigmatized minority. This may frequently happen before the individuals concerned or their loved ones have had time to come to terms with their feelings about the situation.

Many CPNs will no doubt feel quite comfortable with a support and treatment role directed at psychological stresses, or in fact discrete examples of anxiety and depression. However, one of the major challenges of HIV disease lies in the prevention work with hard-to-reach groups in our society. In particular, the work of CPNs in relation to HIV will demand a consideration of the health care needs of largely unpopular and disenfranchised groups who rarely use health care in the accepted fashion, if at all.

While we are not currently in a position to cure those affected by HIV disease, nor do we yet have a vaccine, our biggest hope of minimizing the effects of this virus lies in prevention. The prevention message holds true for everyone. The manner of HIV disease transmission demands, nonetheless, that we target and work with certain groups in our society who may have special needs in respect of HIV prevention. Before we can effectively achieve this, we need research information on the current risk and health care behaviour of these particular individuals. The world has now been confronted with the tragedy of HIV disease for well over a decade; during that time, many researchers have had to develop new and innovative methods of obtaining data relating to the behaviour of what is in effect a previously unknown quantity. Perhaps the most challenging groups for researchers in this regard are injecting drug users and prostitutes. Both of these groups of people are difficult to access for research purposes primarily because they are marginalized by the rest of society; they break the law and often have much to hide and fear from those representing authority.

In order to target effectively health promotion and health care towards these individuals, we must first of all have some idea of their risk behaviour. This not inconsiderable challenge is the one which, along with colleagues in Manchester, the present writer has been attempting to meet for the past five years; what follows is a report of some of our work.

BACKGROUND

All national and international estimates of HIV transmission outside Africa and Asia place injecting drug misuse and its associated behaviour as the most reliable source of transmission. Injected use of illegal drugs such as heroin and cocaine now represents an epidemic in the majority of the Western world, along with very worrying increases in what previously constituted Eastern Europe. In the United Kingdom, the North West of England represents an area in which illegal drug use is a very substantial problem, officially reflected in Home Office statistics and unofficially in the day-to-day experience of treatment agencies and the criminal justice system. The major cities of the area, Manchester and Liverpool, carry the brunt of the effects of drug use in the area. Media exposés of Liverpool's drug problem are too numerous to mention, and Manchester's drug industry recently hit the headlines with the dramatic rise in drug-related shootings and gang warfare in the city streets. Throughout the North West, there is rarely, if ever, a shortage of illicit drugs such as heroin and cocaine on the streets.

In response to the evident problem of drug use in the North West, the regional health authorities have been successful in attracting funding for the establishment of a whole range of services for the prevention of drug misuse. The 'jewel in the crown' of this service provision is frequently thought to be the extensive network of community drug teams in which the most commonly employed professional workers are CPNs. These services have attracted considerable extra funding arising from the Advisory Council on the Misuse of Drugs' reports, (1988, 1991), which recognized the need for drug services to make major changes in their treatment strategies in order to meet the challenge of HIV disease. These issues are particularly pertinent in the North West Region which has the highest number of AIDS cases outside the Thames Health Regions. These cases are at the moment drawn predominantly from the gay population, but the number of injecting drug users presenting with HIV disease is increasing constantly, in line with national and European trends.

This background to the problems faced in the North West of England led the Economic and Social Research Council to commission a major research study by Klee, Faugier, Hayes *et al.* (1990), into the risk behaviour of injecting drug users in the North West, with a view to gaining some insight into the possible areas for prevention input. Interviews were conducted with 303 injecting drug users in the first phase of the project between May and December 1988. Ages ranged between 16 and 45 years, with 48% being under the age of 25; a quarter of those interviewed (76) were women. The drug of preference for the majority was heroin (75%), with 13% injecting amphetamine sulphate, 9% methodone and 3% a variety of prescribed drugs acquired illicitly. Despite distinct preference for a particular drug, the majority (90%) were polydrug users.

In order to ensure that the study described not just the behaviour of those users in touch with treatment agencies, 'snowballing techniques' were used to gather 40% (n=97) through outreach work. This is a well-established methodology in which one contact in a non-random population leads to others, often forming a group or 'snowball' of respondents gleaned from that initial source. In our particualr work, we found this use of what could be termed 'key informants' in particular locations very important in gaining access to groups of injectors who had no contact with treatment agencies. The remainder of the sample (60%, n=206) were in treatment; 60 in-patients in residential units, 112 users attending community drug teams and clinics, 20 users contacted through the probation service and 14 respondents from needle exchange schemes.

SHARING INJECTING EQUIPMENT

In relation to the continued transmission of HIV among injecting drug users, it is clearly important to have some idea of the extent of sharing behaviour and of the major social and interpersonal influences on such high-risk activity. Addressing issues such as sexual and needle-sharing activity in relation to HIV disease demands a methodology which takes into consideration the fact that respondents will be reluctant to admit to such socially disapproved behaviour. In order to collect data which would be reliable, the research team opted for a methodololgy in which data was collected by tape-recorded, semi-structured interviews of approximately 60 to 90 minutes' duration. Considered wisdom in relation to self-reported data holds that reliability can be increased by the establishment of a non-judgemental rapport with respondents. Experience from this and other projects suggests that this is most essential when attempting to elicit data which cannot be generalized to the entire population. Potentially, all sexually active adults can be responsible for the transmission of HIV, but only injecting drug users can be held responsible in direct personal terms for the continued transmission of HIV from the sharing of injecting equipment. That is why the collection of this data demanded a sensitive and skilful approach in interviewing techniques.

The term 'sharing' implicitly covers two aspects of joint use of equipment which are quite different in terms of motivation and personal risk. One entails giving used needles and syringes to others with the knowledge that they will also use them. The other involves receiving them. This distinction is desirable since users are generally more willing to give than to receive. Some respondents reported that they would never consider using a syringe used previously by another person, but had no such qualms about passing their used equipment to others. Illicit drug use tends to be a social activity due to the constraints of access to supplies and the nature of other social arrangements such as housing. It was not surprising, therefore, to find that 60% of the sample regularly injected in the company of other drug users, which undoubtedly increases the opportunities for the sharing of injecting equipment.

It is important also to recognize that 'sharing' is not always as volitional as the term perhaps implies. The frequently reported scenario of a group of users under the influence of heroin getting equipment mixed up, or simply being too intoxicated to bother finding out whose syringe they were using, is testimony to this. Figure 5.1 shows the extent to which respondents had shared injecting equipment in the six months before the interview.

When asked about any changes in sharing behaviour brought about by the threat of HIV, 63% of the sample reported that they shared less than before. However, these figures, in line with other UK data (for example, Power, 1988; Stimson, Aldrit, Dolan, *et al.*, 1988), give scant room for optimism. It is essential, then, to have a better understanding of those variables which could be identified as possible predictors of increased sharing. The study identified four major predictors, all of which have considerable significance for the work of CPNs, both specialist and generic.

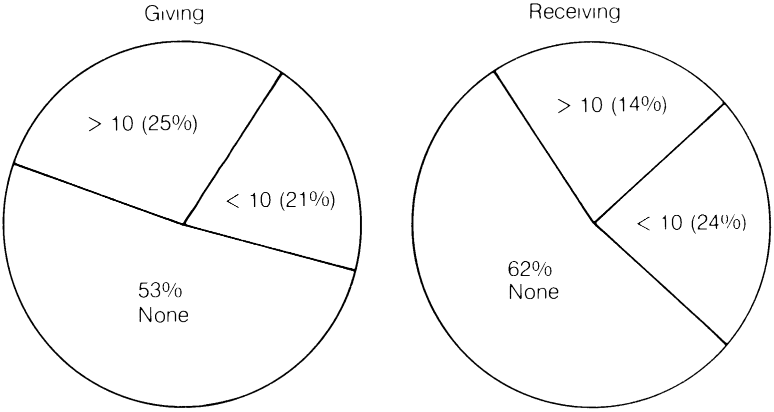

Figure 5.1 Number of occasions respondents reported sharing injecting equipment in the six months before interview.

Homelessness

Although many long-term mentally ill individuals, notably male schizophrenics and alcoholics, have long been associated with periods of homelessness, CPNs are not normally greatly involved with homeless people. And yet, changes in the social structure of our society, long-term youth unemployment, changes in local taxation on families with young adults at home, shortages of readily available rented accommodation and the sale of council house stocks have all combined with the increasing availability of illicit drugs to create a fast-growing pool of homeless young drug users. Thirty-five respondents in the above-mentioned study were homeless and, as Table 5.1 indicates, homelessness was associated with a whole range of behaviours which placed the individual at increased risk of HIV disease: notably, daily use of illegal drugs; not having access to methadone maintenance; recent involvement in crime; disorganization of daily life with little time or energy to seek help; and poor knowledge of drug-related health problems. Most importantly, homelessness was seen to be associated with a high incidence of giving and receiving injecting equipment.

Research evidence from the United States (Hartgers, 1989) shows that homeles drug injectors are more likely to be seropositive for HIV antibodies than those injectors who are not homeless. Furthermore, Marmor, Sanchez and Krasinski (1987) found that frequency of drug use was also linked to seropositivity; those with a higher daily habit who need to inject most often are more likely to share injecting equipment with someone infected with the virus. The implications of these figures mean that both specialist and generic CPNs will have little influence on reducing or preventing user

Table 5.1 Variables associated with homelessness in respondents

	Percentage homeless (n=35)	*Percentage not homeless (n=268)*
Drug amount – more than 1 g a day	60	34
Frequency of use – daily	94	77
Recency of crime – less than six months	91	66
Treatment – on maintenance	3	30
Organization – disorganized	39	21
Knowledge of drug problems – expert	26	50
Giving equipment – more than 50 times in last six months	21	9
Receiving equipment – more than 50 times in last six months	15	2

involvement in high-risk activities unless they can make significant changes in their social conditions.

Knowledge of drug-related health problems

Respondents were asked about the health problems associated with drug use and, on the basis of their responses, were allocated to categories of 'expert' (16%), 'good' (32%), 'fair' (40%) and 'poor' (12%). Somewhat predictably, older respondents were more expert. Expertness was related significantly to all sharing behaviour, most notably the number of times respondents gave and received used equipment in the last six months. The greater the degree of knowledge of health-related problems, which in a high percentage of older respondents was based on personal experience, the less respondents were likely to share injecting equipment. Rather depressingly, simply having information is not so effective in changing behaviour; knowledge of acquired immune deficiency syndrome (AIDS) in the sample was very high, with 93% of the sample rated as 'good' or above, but it did not exert any positive influence and was not associated significantly with sharing behaviour. This is in line with American data reported by Freidman, Des Jarlais and Southern (1987).

Those with injecting partners

Respondents with injecting partners were more likely than those with a non-injecting partner, or no partner, to give and receive injecting equipment. They were also more likely than other groups to give and receive more frequently. However, the enhanced rates of sharing do not arise wholly from these personal partner relationships. Only nine (14%) of the 63 respondents with injecting partners gave exclusively to those partners, the rest included friends and associates among those to whom they gave syringes. This figure increased (n=22, 35%) when looking at those who received used injecting equipment exclusively from their partner, although the majority were also receiving used equipment from others. A relationship with an injector seems to provide little protection from HIV in restricting those with whom a user will share.

When drug users present to CPNs either in specialist drug services or in generic teams, there is frequently a concentration on the presenting client and their behaviour, with insufficient acknowledgement of the influence of a relationship outside of the treatment setting. Data from the study presented here would suggest that any therapeutic intervention should always take on board the issue of partners in prevention and treatment strategies.

Crime

A section of the interview on criminal activity yielded data on the nature, extent and recency of crime and imprisonment. CPNs are working increasingly in settings in which contact with all aspects of the criminal justice system is a part of their work. More and more CPNs are moving into the area of criminal justice work as a major part of their activity as evidence becomes available of the increasing use of prisons and courts as a way of dealing with mental health problems. The necessity to fund a drug habit frequently lands drug users in court for a range of other criminal behaviours. The most popular methods of obtaining money for drugs among the sample reported here were shoplifting (32%), dealing in drugs (23%) and chequebook and credit card fraud (16%). A majority of respondents (88%) had been engaged in some form of illegal activity, ranging from aggravated burglary to minor drug dealing. Those involved in criminal activity in the six months before the interview were more likely to be sharing syringes. Drugs were used in prison by 58% of those imprisoned and, of those, 25% (n=26) had injected with equipment provided by others.

In a survey of a representative sample of sentenced adult and young adult offenders in the prison system in 1991, Maden, Swinton and Gunn (1991) of the Institute of Psychiatry, have estimated that as many as 11% of men and 23% of women in the sentenced populations are drug dependent. The recent report to the Home Office by the Advisory Council on the Misuse of Drugs (1991) would suggest that the problem is likely to be higher in the remand population. Additionally, this report argues that changes are needed in the present system which will enable more drug users to be identified in the courts and diverted from custody when appropriate. This move towards treatment orders in the community will in the first instance make increasing demands on the probation service, but will also require essential inter-agency co-operation, not least from those CPNs working as specialists in the field and those working in diversion from custody and court referral schemes. CPNs working more closely with the criminal justice system could be an essential element in encouraging more drug users to identify themselves when charged with drug-related crimes, and gain access to the wide range of treatment options available.

PROSTITUTION, HIV AND DRUG MISUSE

It is the nature of research that the collection of data for one study will almost always raise other important questions for future work. In the process of analysis of data for the study reported so far in this chapter, a small group of female drug users (n=20) was identified who raised their funds for drugs by means of prostitution. Evidence gleaned from this small group supported the anecdotal evidence that those women engaged in prostitution represented evidence of more chaotic behaviour which raises the likelihood of risk activity associated with HIV transmission. Anecdotal evidence is also quoted widely to support the commonly held view that drug-using prostitutes are more likely to accept money for sex without the use of a condom than are non-drug-using prostitutes.

In an attempt to take this investigation further, a proposal was submitted by the author to the Department of Health, and the research was commissioned in May 1990.

General aim

To investigate the drug-related, sexual and health care behaviour of drug--using prostitutes in the Greater Manchester area in order to assess their potential for acquiring or transmitting HIV.

Specific objectives

To examine to what extent drug-using prostitutes engage in sexual activities which place them at high risk of contracting or transmitting the HIV virus, for example, unprotected penetrative intercourse, unprotected oral intercourse and anal intercourse.

To examine the extent to which safer sex guidelines and risk-reduction strategies are being adhered to by prostitutes as well as by their clients and partners.

To determine the level of knowledge of HIV- and AIDS-related risk behaviour among drug-using prostitutes.

To ascertain to what extent the health care needs of both drug-using and non-drug-using prostitutes are being met by existing services.

Definitions

The definition of prostitution employed for the purpose of the project is the exchange of sexual services for money or other items of monetary value such as drugs. The sample includes those currently involved in such behaviour or those who have done so not more than six months before the interview date.

Definitions of drug use are interpreted as the regular use of mind-altering substances. This excludes recreational use of alcohol and cannabis, and means that 'regular use' is interpreted as daily use in the majority of cases.

Background - prostitution in Manchester

The city of Manchester has a well-developed sex industry, the most overt expression of which is the highly visible and problematic street prostitution. There are three main areas of the city which serve as red light areas.

Central Manchester. This is near an area called Picadilly which was, for a long time, run down and composed mainly of warehouses and a few rather dubious public houses. In recent years, however, it has witnessed a dramatic revival, becoming the centre of what is known as Manchester's 'Gay Village'. Gay businessmen are investing considerable money in the area in the form of clubs, restaurants and coffee houses and this, together with more substantial developments such as the transformation of many of the old warehouses into exclusive executive flats, is changing the appearance and nature of this part of town. Before these developments, the female and male prostitutes had, for years, used this area as their beat, with its convenient side streets and nearby hotels. This attracted other crime to the area, and there was an increase in attacks on the person, muggings and robberies. In particular, it has served to create what the police describe as the almost perfect crime; the prostitute and her client in a car in a secluded place are easy pickings for groups of males wielding baseball bats. It is apparently common for a man to be frogmarched from the car to the nearest cash dispenser and told to withdraw as much as possible on his cashcard. In fear of his life, and more importantly his reputation, marriage and perhaps job, most men do not inform the police.

Due to the rise in crime in the area and the pressure arising from its changing nature, the police frequently mount major operations to clear prostitution from the streets. This involves intensive and severe policing and is currently making life very difficult for those who work the streets.

Whalley Range. This is the traditional red light district of South Manchester and seems to have been so for many years. It is, however, a very mixed area with a lot of high quality Victorian houses attracting residential family accommodation as well as bedsits and multiple occupancy dwellings. It is also very popular with students as it is near to the University and the city centre. Moreover, it has a fairly significant Asian and black population. Prostitution is apparent in the area both day and night. However, it is more widespread and more discrete than in the city centre. Local residents complain regularly to the police about the problems of kerb crawling and there is the occasional crackdown.

Cheetham Hill. Situated in the north of the city, just on the outskirts of the city centre, this was formerly the area of Manchester occupied by Jewish immigrants who built up the rag trade. It now houses mainly Asian-owned retail interests. The housing is generally poor quality and the population tends to be mainly white working class along with poorer, more recent Asian immigrants. It is an extremely delapidated area with a high crime rate and one of the poorest health records in the country.

In addition to the visible street prostitution, there are also a number of 'saunas' and 'massage parlours' advertised in local papers and contact magazines. Higher class escort agencies, too, are in operation within the city and seem to have contacts in the more prestigious hotels.

All three areas are policed by different divisions within the Greater Manchester police force. As such, there is little if any co-ordination of policing effort; the motto seems to be very much 'as long as it's not on my patch'.

Prostitution is also evident in other towns within the Greater Manchester area. Bolton has a small but well-developed street scene, as do Blackburn and Rochdale. In other towns such a Wigan, evidence to date would suggest a less well-developed scene, with women working mainly from home.

THE PILOT AND DEVELOPMENT OF CONTACTS

In the early stages of the project, it was important to make the necessary contacts and develop good will so as to ensure access to a sample of population that was difficult to reach. In this respect, early contact with the police to gain their support and ensure that they were kept informed of the work has proved very useful. In order to help the team make contacts at Court, the vice squad of A Division arranged for all soliciting charges to be heard on the same day. This proved to be extremely successful in that it enabled the team to build rapport with the women working in the city centre.

While the research team already had excellent working relationships with drug services throughout the region, it was necessary to submit the research protocol to a number of ethical committees in order to enable services to co-operate by referring respondents to the study. The bureaucratic machinations of such committees can be extremely time consuming. However, all necessary ethical permission was obtained and the project was able to access respondents from drug treatment services. This was essential in order to gain a sample of those in touch with services and those who are not.

Respondents were also contacted via direct outreach while working on the streets. This was more possible during the day, as the women were less distracted by the surrounding animation and there was less risk of the researchers receiving unwanted attention. However, it became apparent almost immediately that it would be absolutely impossible to collect any meaningful data in the street, or indeed in the courts, as the women are simply too busy or too distracted.

Pilot interviews were conducted with 20 women either in their own homes or in the University of Manchester. These were essentially unstructured interviews aimed at exploring the issues and helping to identify the variables to be operationalized in the research instrument. The interviews were taped and analysed, some fully transcribed in order to identify the major themes emerging. During this period, the instrument was being refined and added to at every stage.

In addition to the interviews, researchers spent time with the women both in court and on the streets in order to establish a presence and build credibility in the eyes of a group with an understandable lack of trust.

In-depth interviews were conducted with 12 of the pilot sample, four of whom were non-drug users. From these tapes and from the interests expressed by the Department of Health, it was possible to produce the variables which were operationalized in the semi-structured interviews.

METHODOLOGY

Initially, it was intended to pursue a mixed methodology, utilizing a structured questionnaire and support from unstructured interviews. Following the pilot stage of the project, however, it became clear that the use of structured questionnaires would have little advantage and, moreover, would fail to elicit data of sufficient reliability. The data collection method of a face-to-face interview was important in achieving a number of the research aims. Interview techniques were favoured for this study because of the level of co-operation which was needed from the respondents. It is essential when collecting data of such a sensitive nature that rapport is established between respondent and researcher if that data is to be reliable. Experience in the pilot of trying the two methodological approaches confirmed that, without the establishment of rapport and the opportunity for sensitive probing in an interview situation, the women would be more likely to give a knee-jerk reaction to questions about condom use and sexual activities.

It also became apparent during this stage that very strong group norms exist on the street among these women, and the wish to keep secret the fact that they may be breaking any of the unwritten rules of conduct would influence responses. In addition, drug users and prostitutes are engaged in illegal activities and are not readily trusting of those outsiders who express interest in their activities. It was necessary to spend a considerable amount of time and energy establishing research credibility and trustworthiness. Alternative methodological approaches, such as self-administered or fieldwork-administered questionnaries, would have been inappropriate, as they would certainly not glean the wealth of qualitative data which the interview approach has achieved.

SAMPLING

The precise numbers of prostitutes working in the Greater Manchester area was unknown. Hence it is was necessary to employ non-random methods of sampling in order to contact respondents. One method used previously to good effect and which was employed on this project is known as 'snowballing'. This involves making initial contacts with respondents and then using the respondents themselves to provide access through personal introduction and recommendation to their colleagues and friends. The sample was gleaned from a number of sources, such as magistrates' courts, contact with the drug misuse services, contact with prisons and police and by direct approaches to the women while working on the streets.

The variables were used in a semi-structured fashion to decide upon the questions for the interview, which lasted on average 40 minutes. In an interview situation, a trained interviewer could bring about an accepting atmosphere which is conducive to honest self-reporting. Evasion and non-informative responses could be handled by gentle probing and the sensitive handling of potentially threatening questions.

The interviews were conducted either in the client's home or in some other suitable location. A few respondents have had to return to the University of Manchester because they had no suitable home or are too frightened of their partner. They were taped with their fully informed consent, and then coded carefully on to an answer frame. Using this methodology with a large team of researchers could, of course, bring problems of interviewer interpretation. With only one principal researcher working with an associate, it has been possible to check interpretations at all stages of the coding. Variables were then assigned a numerical value which allows for quantitative analysis.

FINDINGS

Findings from these data, which are still undergoing analyses, would suggest that these women are failing to access necessary care, and are not being offered a sufficiently comprehensive service when in contact with drug services. Additionally, the drug-using group present findings which suggest that they are at greater risk of HIV infection from both sharing equipment and prostitution.

The drug users represent a younger and more damaged and unsettled group. This was particularly demonstrated by the tendency for many more of them to have been in care as children (55%), as opposed to 24% for non-drug users. (n=100 and 50, respectively). Equally, a small but significant percentage of drug-using prostitutes were more likely to be living in temporary accommodation; 4% in squats, 9% were homeless and 7% in other transitory arrangements. Similarly, of those with children, the non-drug users were more likely than drug users to be caring for their offspring themselves; of those with children (n=48 for drug-using prostitutes; 36 for non-drug users), only 18% of drug users as opposed to 58% of non-drug users were managing to provide care for their children themselves.

Data collection was focused mainly on high-risk activity in respect of HIV disease and use of relevant health care services. Drug-using prostitutes were

Table 5.2 Days per week worked as prostitute

Days	*Drug users*	*Non-drug users*
1	1(1%)	1(2%)
2-3	9(9%)	23(46%)
4-5	15(15%)	14(28%)
6	13(13%)	-
7	62(62%)	12(24%)
Total	100(100%)	50(100%)

Table 5.3 Number of clients per day/night

Clients	*Drug users*	*Non-drug users*
3	13(13%)	8(16%)
4–5	45(45%)	24(48%)
6+	42(42%)	18(36%)
Total	100(100%)	50(100%)

Note: The figures for non-drug users are inflated by women working in saunas who work longer hours and see more clients; a comparison of street workers reveals only a more marked tendecy for drug users to work longer hours and to service more clients per night/day.

found to be working more frequently than non-drug users and to be seeing more punters per shift (Tables 5.2 and 5.3).

The majority of respondents, both drug users and non-drug users, used condoms all of the time for sex with clients. However, a significant group (33% of drug users and 12% of non-drug users) did not do so all of the time. Of particular concern is the fact that 20% of drug users reported dispensing with condoms when offered more money to do so, while this figure was only 8% for non-drug users and included two prostitutes who had learning difficulties. Condom use with regular sexual partners outside of prostitution was almost non-existent: only 2% of drug users and 1% of non-drug users did so all of the time. The inability of prostitutes to use condoms with regular sexual partners has been identified by other researchers (Kinnell, 1989; Plant, 1990) as representing a sociological distancing of personal relationships from those of a commercial nature by the absence of equipment used at work. Many of the women in the present study cited this as a reason for their inability to use condoms, but a larger percentage cited as a more compelling reason their partners' complete unwillingness to even consider using condoms.

Health care needs

As might be expected, this group of respondents exhibited a wide range of unmet health care needs. Drug users were less likely to seek routine or specific care than non-drug users. Only 73% of drug-using prostitutes had a general practitioner as opposed to 90% of non-drug users. Seventy-six per cent of drug users, as opposed to 46% of non-users, reported not attending for regular genitourinary clinic checks. If those reporting a last check taking place about a year ago are included, the figure rises to 92% of drug users not having what might be described as regular checks for sexually transmitted diseases. Of those reporting ever having had a diagnosed sexually transmitted disease, 48% were drug-using prostitutes and 36% were non-drug-using prostitutes.

Additionally, drug users were more likely than non-drug users to get pregnant; 77% of drug-using prostitutes had one or more pregnancies, as opposed to 41% of non-drug users.

Failure of services

Data collected for this study seem to indicate that attempts to attract female drug users into increased contact with drug misuse services is having limited success. Even when they are in touch with services (and, of course, this would mean predominantly specialized CPNs for many of these respondents), there is little evidence of this having much effect.

Even though the whole emphasis of treatment for chaotic drug users had moved from detoxification to a more liberal regime of maintenance prescribing, there was little evidence in the Manchester area that this was convincing these chaotic women either to make contact with services, or to stay in touch with treatment agencies. Many had not gained access to a maintenance prescription, with only 17% of the sample reporting that they were currently receiving such help.

Of those in contact with a drug team in the community, the drug team (including nursing staff) was not establishing in most cases that the woman worked as a prostitute. In all, 52% of the sample had contact with a drug team at some stage in their careers; of these, only 10% reported that the drug team gave them advice on safer sex. This would support the findings of Stimson *et al.* (1988) on the work of syringe exchange schemes, in which they found a failure of drug workers to talk about sexual matters. The dangers of unprotected sexual activity are generally recognized by drug users and those who advise them, but the evidence is that the sharing of equipment has priority from workers, who seem to find drug misuse easier to address than sexual issues as these may raise fears which have greater relevance to themselves. This failure to address sexual issues with a group of women who are earning their drug funds by working as prostitutes, and the additional failure to establish the nature of the work the women are undertaking, represents a very important opportunity missed in the health promotional work of drug services.

Female drug users who prostitute represent a minority, but a rapidly growing one, of those women involved in drug misuse. CPNs working with these women need to be aware of the lifestyle of the clients they are meeting in order to help, advise and refer appropriately. Findings from the study reported briefly here would suggest that, at times, these women are being treated for their drug misuse in isolation from other pressing health care needs.

Accessing this information sensitively and in a manner which builds rapport and trust with an extremely abused group of women means that skills in assessment and interviewing should be re-emphasized. It also means that CPNs must be more willing to see past the presenting drug problem to the wider health issues which have a role in the prevention of HIV disease.

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This chapter is dedicated to the life and work of Shane Christopher Snape, 1959–1992. Royalties have been donated in his memory to the Bethaney Trust Respite Centre for people with AIDS.

CHAPTER SIX

A review of a psychological intervention for depression in elderly people

Colin Hughes

INTRODUCTION

Psychiatric services specifically for the elderly in the United Kingdom began to develop in the 1960s and early 1970s. The most significant factor in this development was the increasing pressure on the health and social services arising from the size of the elderly population, and from the increasing proportion of the very old within this (Arie and Isaacs, 1978).

Community psychiatric nursing (CPN) services for the elderly began with the establishment of the first CPN service in the United Kingdom in 1954 at Warlingham Park Hospital, Croydon (May and Moore, 1963). Two 'out-patient nurses' were seconded to 'extra-mural' duties in the borough:

> The help given by the service is freely acknowledged by the psychiatrists who use it, particularly for geriatric patients. The acute pressure on these beds can often be alleviated by regular home visits which relieve the anxiety of relatives and encourage them to accept responsibility – even if only temporarily – for elderly people.
>
> (May and Moore, 1963)

Few other CPN services were established until a period of rapid development in the 1970s, during which time specialist CPN services for the elderly also began to develop (Simmons and Brooker, 1986). A 1985 national survey (Community Psychiatric Nurses Association, 1985) obtained data on the structure of CPN services, and 86.5% of health districts in the United Kingdom supplied information on a CPN workforce of 2758; 505 (18%) worked exclusively with the elderly. More recently, White (1990) has estimated the total CPN workforce in the United Kingdom to be 4990. Of the 3181 individual CPNs who responded to a survey questionnaire, 796 (25%) reported 'working intentionally and predominantly', that is, were specializing with the elderly. This remains the largest area of specialist work. However, the majority of CPNs have a 'generic' caseload, but it has been reported that the elderly might also make up a significant proportion of this (House of Commons, Second Report from the Social Services Committee, 1985).

Developments in psychiatric services for the elderly were mainly as a response to the problems caused by the illnesses causing dementia. Much invaluable work of many CPNs working with the elderly (specialist and generic) will undoubtedly be in relation to these illnesses. However, epidemiological studies indicate that depression, not dementia, is the commonest psychiatric disorder in the elderly (Sharma and Copeland, 1989). In their review of such studies, Brayne and Ames (1988) conclude:

> The prevalence of severe depressive conditions is probably of the order of 1% to 3%. Significant depressions which interfere with functioning are often reported at rates exceeding 10% and mild symptoms of depression afflict up to a third of those over 65.
>
> (Brayne and Ames, 1988)

In relation to dementia, Brayne and Ames (1988) state:

> Taking all the prevalence figures into account there seems to be a rough consensus that dementia occurs in about 5% of the population aged over 65 . . .
>
> (Brayne and Ames, 1988)

Given their numbers, therefore, elderly people with depression should also be an important client group for the CPN. This paper is concerned with this client group and more specifically with one psychological intervention, cognitive therapy.

Depression is said to be the most treatable of the psychiatric disorders in the elderly (Pitt, 1982). Despite this, follow-up studies (Baldwin and Jolley, 1986; Murphy, 1983) suggest that its prognosis can be poor in many elderly people. Studies published to date relate to in-patients or out-patients treated principally with the 'traditional' treatments of antidepressant medication and/or electroconvulsive therapy (Ames and Allen, 1991).

Recent studies point to a scenario in which at least three-quarters of patients initially recover or improve significantly (Baldwin, 1988). Nonetheless, there is a marked tendency for relapse, incomplete recovery, or indeed for patients to remain ill. For instance, Burvill, Hall, Stampfer *et al.* (1991) describe the one-year outcome of 103 elderly patients suffering from major depression. All but five were treated as in-patients, and all by physical treatments; 35% had 'psychotic depression'. At one year 47% were well, 18% had relapsed, 13% had made an incomplete recovery, 11% had been continuously ill and 11% had died. Only 32% had remained well throughout the year.

Little can be said about the prognosis of depression in elderly people treated by their general practitioners (GPs) as either the work has not been done or has not yet been reported. A recent report of the follow-up of a community sample of depressed elderly detected in an epidemiological survey only hints at the answer. Ames and Allen (1991) report a personal communication of Dewey: after three years, only one-third of a Liverpool sample of depressed elderly in the community showed evidence of recovery.

Considering, therefore, the significant proportions of elderly who appear to suffer relapses, have incomplete recoveries or who remain ill, there is scope for considering the usefulness (or otherwise) of therapies other than antidepressant medication and electroconvulsive therapy. This is certainly the case in relation to the hospital treatment of depression (as an in-patient or out-patient) but also to its treatment in the primary health care setting.

One possible alternative, or adjunct, for many patients in either setting might be cognitive therapy as described by Beck, Rush, Shaw *et al.* (1979). It has a number of aspects which would seem to make it particularly relevant: the approach is clearly set out in one book specifically for the treatment of depression (Beck *et al.*, 1979); outcome studies indicate its efficacy with samples of younger adults suffering from non-psychotic unipolar depression treated as out-patients (Blackburn and Davidson, 1990; Williams, 1992); it has a behavioural component which is relevant as inactivity is a common complication of depression in the elderly; it has a cognitive component which could give a different and helpful approach to the counselling intervention; it is a problem-solving approach in the 'here and now' rather than a therapy concentrating on, say, early childhood experiences of perhaps 60 or 70 years ago; it is a relatively short-term therapy (15 to 25 weekly sessions) making therapist time available to more people; and, importantly, it is a therapy that is offered by CPNs (White, 1990). Importantly, because CPNs working with the elderly are likely to be in positions to assist in the treatment of elderly clients whose medical responsibility remains with the GP in the primary health care setting, and in the treatment of clients being treated by a psychiatrist as an out-patient. Residual difficulties which might remain following in-patient treatment (and often do) might also be treated psychologically by the CPN. CPNs might also intervene in this manner to detect early signs of relapse following successful initial treatment.

This paper reflects a concern of the present writer that elderly people, being a devalued group in society, are in danger of not being offered the more 'valued' interventions for mental health problems.

AIM OF THE STUDY

The aim of this study, then, is to examine whether the literature suggests that Beck's cognitive therapy is an intervention helpful to depressed elderly people, and, if so, to consider the issues which are raised and adaptations suggested in its use with this client group. For convenience in writing, when cognitive therapy is referred to, the present writer is referring to cognitive therapy as described by Beck *et al.* (1979).

It would have been a purely arbitrary decision to define the elderly as being men and women of a certain age and over. To do so might have excluded important documentary information relevant to this area of study which is as yet poorly documented. The literature search found journal articles on 'geriatric depression' and 'depressed elders' with samples which included subjects as young (or old) as 55 years of age. So as to gain at least an initial overview of this area of study, the present paper therefore includes any documentary information which is considered by its author or authors to relate to the 'elderly', 'depressed elders' and so on. 'Helpful' is defined as achieving recovery from depression or significantly reducing symptoms.

It is beyond the scope of this study to give an account of the cognitive theory and therapy of depression. The reader is referred to Beck *et al.* (1979), Blackburn and Davidson (1990) and Williams (1992) for this. However, some clarification of terms will be helpful. Beck's cognitive therapy involves both cognitive techniques (aimed at modifying thinking) and behavioural techniques (aimed initially at changing overt behaviour, but also aimed at eliciting and modifying thoughts), the therapy's rationale being based on Beck's cognitive theory of depression. A therapist might use only cognitive techniques or only behavioural techniques, but could still be said to be conducting Beck's cognitive therapy so long as the theory base was that of Beck. In some of the studies reviewed here, the approach is said to be that of Beck but it appears that only the cognitive techniques were used.

METHOD

Literature search

The method consisted of a library-based literature search (Studolski, 1984). This was chosen in preference to a computer-based search as the present study builds on an earlier one by the present writer (Hughes, 1991). The time scale covered in the search was from 1980 (a year after the publication of Beck *et al.*'s book, *Cognitive Therapy of Depression*) to mid-1991. Keywords were 'cognitive therapy' and 'psychotherapy'. Only documentary information published in English was accepted. The search was conducted from the Mary Badland Library at the Collegiate Crescent site of Sheffield City Polytechnic, Sheffield. It held the necessary bibliographic tools, that is, the indexes, abstracts and bibliographies, which are the keys to journal literature (Treece and Treece, 1986).

In order to gain access to the psychological, psychiatric and nursing literature, the following titles were consulted.

Psychological Abstracts. This was used as it abstracts from around 1000 journals and other serial publications likely to publish articles relevant to psychology and behaviour. Publications are scanned regularly and systematically for their content, and articles are specifically and individually selected for inclusion in *Psychological Abstracts* on the basis of their relevance to psychology (American Psychological Association, 1989). The presence of a serial title in the coverage list does not imply, therefore, that all articles contained in issues of that serial will subsequently appear in *Psychological Abstracts.* Subject heading for the search was 'cognitive therapy', this heading first appearing in 1982.

International Nursing Index. This was used because over 270 nursing journals from all over the world are indexed, as well as nursing articles in the 2700 allied health and biomedical journals indexed for *Index Medicus* (American Journal of Nursing Company, 1991). The *International Nursing Index* is considered essential to the majority of literature searches in the field of nursing (Studolski, 1984). It is of note, however, that the *Community Psychiatric Nursing Journal* is not in its current coverage list. Subject headings for the search were, 'psychotherapy', 'psychotherapy, brief', 'psychotherapy, group' and 'psychotherapy, multiple' up to and including the 1989 cumulation (there being no heading of 'cognitive therapy'); and 'cognitive therapy' in volume 26, number 1, 1991, where it first appears.

Nursing Bibliography. This was used as a possible other source of nursing literature. It presents a selection of the material received in the Royal College of Nursing Library each month and comprises books, theses, reports, pamphlets and articles published in the English language (Royal College of Nursing Library, 1990). British nursing literature is included, as is other material if it is relevant to nursing in the United Kingdom. Subject heading of the search was 'psychotherapy' in the absence of one of 'cognitive therapy'. Importantly for a literature search on CPN matters, *Nursing Bibliography* has indexed the *Community Psychiatric Nursing Journal* since 1983, although up to 1984 it went under the title of the *Community Psychiatric Nurses Association Journal.*

New issues of the following journals were scanned as they were considered especially important in this area of study since they had already furnished a number of relevant articles in the search using the bibliographic tools: *Journal of Consulting and Clinical Psychology; Journal of the American Geriatrics Society*; *Cognitive Therapy and Research*; and *Community Psychiatric Nursing Journal.*

Literature review

It will be seen that many of the findings of the literature search are from experimental research into the efficacy of various psychotherapies with the elderly. It is beyond the scope of this paper to present a detailed critique of those studies. This paper's aim is to see if cognitive therapy appears to have been 'helpful' (as per the statement of aim of the study above), that is, to have achieved recovery or significantly reduced symptoms. Its aim is not to examine whether cognitive therapy has been shown to 'work' in the strict sense that it has been shown to be efficacious after so-called 'non-specific factors' in treatment are controlled for.

FINDINGS

The findings are presented in three parts:

1. Outcome studies.
2. Case histories.
3. Issues and adaptations.

Two commonly used instruments for measuring the severity of depression are the Hamilton Rating Scale for Depression (Hamilton, 1967) and the Beck Depression Inventory (Beck, Ward, Mendelson *et al.*, 1961). They will be referred to here as the HRSD and the BDI, respectively.

Outcome studies

In all of the outcome studies presented here treatment was given on an out-patient basis, and the patients had non-psychotic unipolar depression of mild to moderate severity.

Individual cognitive therapy. The first papers are concerned with individual cognitive therapy. Gallagher and Thompson (1982) assigned 30 patients having major depressive disorder to: cognitive therapy (though apparently only using the cognitive techniques); behavioural therapy (though based on a rationale other than Beck's); or brief relational/insight psychotherapy. Twenty-two of the patients were either not depressed or were improved at the end of treatment. Improvement was seen equally for all treatments on the HRSD and BDI. Some difference between conditions was seen at follow-up at one year; fewer relapses occurred for the cognitive and behavioural conditions; and approximately two-thirds of those who had received these treatments were still using specific skills learned in therapy to help them cope with depressogenic situations, compared with only one-third of those having received the relational/insight treatment.

Subsequent analysis (Gallagher and Thompson, 1983) compared the relative response to treatment of patients who initially had endogenous features (including diurnal variation of mood, poor appetite and weight loss, and early morning wakening) with those with no endogenous features. Non-endogenous patients fared better at the end of 12 weeks of treatment with one-half versus four-fifths having a normal BDI. At one-year follow-up they also fared better (zero versus seven out of 15 having relapsed).

Thompson, Gallagher and Breckenridge (1987) report a larger scale replication of Gallagher and Thompson (1982). Now, 91 elderly depressed patients were distributed between the three treatment conditions. Once again, patients responded equally to the three treatment conditions so that, overall, 47 out of 91 (52%) were in remission and another 17 (18%) improved. They conclude that '. . . although older patients are sometimes reluctant to seek psychotherapy, our results suggest that it would be worthwhile to encourage them to do so if they become depressed'.

Gallagher-Thompson, Hanley-Peterson and Thompson (1990) report a two-year follow-up study of the 91 patients in the last study. Gains were maintained over time for a substantial proportion of the sample, with no significant difference between the treatment modalities in response rates at one-year or two-year follow-up. At one-year follow-up, 58% of the sample (47 out of 81 interviewed) were not depressed. At two-year follow-up, 36 of the original 47 in remission (77%) were well.

Thompson, Davies, Gallagher *et al.* (1986) reviewed the evidence for the effectiveness of cognitive therapy in adults, young and old, and their conclusion is very relevant to this study:

> Taken together, these findings support the conclusion that cognitive therapy, engaged in on a one-to-one basis, is efficacious in the treatment of clinically depressed older adults. While it is unclear whether cognitive therapy is superior or essentially equivalent to other forms of psychotherapy and/or pharmacotherapy, the evidence is accumulating that it is a useful clinical approach that holds considerable promise for the future.
>
> (Thompson *et al.*, 1986)

This is an encouraging conclusion. It should be emphasized that it appears that only the cognitive techniques of Beck's cognitive therapy were used in these studies. Strictly speaking, the conclusion relates to them only.

Group cognitive therapy. The next papers are concerned with the effect of group cognitive therapy. It appears that both the behavioural and the cognitive techniques of therapy have been used. Jarvik, Mintz, Steuer *et al.* (1982) compared two tricyclic antidepressant drugs (imipramine and doxepin) with a drug placebo (32 patients in all). In a concurrent study they compared cognitive–behavioural group therapy and psychodynamic group therapy (26 patients in all). Outcome was assessed after 26 weeks of the 36-week treatment plan, or earlier if patients had dropped out of treatment. Most patients who received group psychological therapy (of either type) showed some improvement on the HRSD, the average improvement being about 30%, with no significant difference between the two types. Three out of the 26 (12%) who received the psychological therapies had full remissions. This compared with 45% with full remissions who had received an antidepressant drug.

However, one problem was that in neither study were patients assigned to treatment conditions in a strictly random manner, thereby making any comparisons between treatments rather dubious, a limitation recognized by the researchers.

The outcome after 36 weeks of the two types of psychotherapy is reported by Steuer, Mintz, Hammen *et al.* (1984). Ten patients received cognitive–behavioural group therapy and another 10 patients received psychodynamic group therapy. Results showed statistically significant improvements for both treatment groups: 80% showed some improvement and 40% clear remission on the HRSD. The only measure which showed a difference between the groups was the BDI, but the authors suggested that patients may have 'learned' to complete this in a favourable way as a result of being in cognitive–behavioural treatment.

Taken together, these two papers (Jarvik *et al.*, 1982 and Steuer *et al.*, 1984) suggest that group cognitive therapy can be a helpful treatment for depression in the elderly, though it appears equally as helpful as psychodynamic group therapy. A proper comparison with the efficacy of antidepressant drugs is not possible. Steuer *et al.*'s (1984) tentative conclusion is that:

> . . . it might be reasonable to suspect that the therapy experience was beneficial and may provide an intervention option for older persons who are physically ill and unable to take antidepressant medications.
>
> (Steuer *et al.*, 1984)

This is important because even if cognitive therapy was somehow shown to be less effective than antidepressant drugs, in terms of numbers of patients improved or amount of improvement or some measure of quality of improvement, it still means that it might be of some help to those who could not take (or do not respond to) medication. Further research into the efficacy of cognitive therapy with those who do not respond to antidepressant medication will be needed.

Case histories

Emery (1981), in a chapter providing some general guidelines in applying cognitive therapy to the elderly, discusses aspects of several cases of patients, some of whom were depressed. He illustrates how various problems were solved. These were such as: countering a 72-year-old woman's inactivity by treating the reasons she gave for this as hypotheses to be tested by behavioural experiments; and encouraging a patient to examine the evidence for and against the belief that after 65 years of age there was nothing else to do but to wait for death.

Church and Bennett (1982) present a pilot investigation into the feasibility of using cognitive therapy in a group setting with elderly day hospital patients recovering from depression. They give brief case histories of the four group members and describe the outcome of the group therapy for each. Two members benefited much, one remained relatively unchanged, and one began to make progress towards the end of the group. Some of the techniques in the group therapy were: information giving, challenging unrealistic beliefs, problem-solving and confrontation.

Steuer and Hammen (1983) briefly describe four cases in which cognitive–behavioural group therapy was used to treat elderly depressed patients. Each case is described in two parts: behavioural activation and problem-solving; and cognitive restructuring. Techniques used in the first were assertion training, modelling and activity scheduling; and in the second, thought-catching, and identifying and challenging cognitive distortions. One patient achieved remission of symptoms, two improved significantly and the other changed little. Interestingly, they point out that the two patients who were unable to perform thought-catching also scored less on tests of cognitive functioning (they also had less education and were of a lower educational status). This is an important paper, and is discussed again later.

Thompson, Davies, Gallagher *et al.* (1986) briefly discuss four cases of elderly depressed patients who received individual cognitive therapy. They report that at the end of treatment two were no longer depressed, one was much improved and one had changed little. They describe the use of techniques of: activity scheduling, identifying and checking dysfunctional thoughts, and information giving. In relation to these four cases and other work done at their centre, they explore some factors in relation to therapeutic outcome. They stress that these are only several among many variables and that their research continues. Thompson *et al.* (1986) tentatively suggest that:

1. Patients who are less severely depressed initially, may respond better.
2. Patients with endogenous features do not respond as well as those without.
3. Patients who also have a 'personality disorder' respond less well, due to such factors as rigid thinking patterns blocking experimentation with new thoughts and behaviours, and greater likelihood of strains in the therapeutic relationship.

4. Patients with greater depths of bonds with others seem to respond better.

Further research into these variables will be very helpful in guiding the therapist in deciding which clients would benefit most from cognitive therapy.

The above case history information offers much encouragement for the use of cognitive therapy with elderly people suffering from depression.

There was no evidence in the literature that cognitive therapy is used by nurses, CPNs or otherwise, in treating this particular client group, although as noted earlier, it is an intervention used by CPNs (White, 1990).

Issues and adaptations

The literature search obtained some documentary information on issues which arise in conducting cognitive therapy with elderly people and on adaptations to be made for it to be maximally effective.

Ageism. A most important issue which is raised is that of ageism. This comprises a set of negative attitudes, practices and values which form a stereotype of the elderly, and affects the way they are treated and the way they are able to function within society (Scrutton, 1989). Emery (1981) suggests that a therapist should become aware of his/her negative stereotypes of the elderly and correct them by spending some time with elderly people who are healthy and functioning well, a remedy also proposed by Thompson *et al.* (1986). Otherwise, the therapist may have limited expectations of therapy (if the therapist believes that the elderly are not able to learn new behaviours, for example) which can be communicated directly or indirectly to the client (Thompson *et al.*, 1986). One wonders if this aspect of ageism is more pervasive among mental health workers than is recognized.

Another aspect of ageism is also raised by Emery (1981). He discusses the notion that the elderly in Western society are involved in a chronic conflict between stereotypes of the elderly as being weak and incompetent, and their own ideas of themselves as being active and competent. It is suggested that they resolve this conflict by adopting a negative concept of themselves, or by adopting a negative attitude towards those seen as being the source of this stereotype. Emery (1981) suggests that the former consequence is a 'dysfunctional theme' commonly found among the elderly, which can be questioned in cognitive therapy. The latter consequence may result in the elderly client resisting therapy as he/she might think that 'you are too young to help me'. This resistance would need to be dealt with before therapy could continue.

Interestingly, ageism in relation to psychotherapy can be traced back to Freud (1924). In discussing the contraindications of the 'analytic method of psychotherapy' in a lecture given to the College of Physicians in Vienna in 1904, he stated:

> The age of patients has this importance in determining their fitness for psychoanalytic treatment, that, on the one hand, near or above the 50s the elasticity of the mental processes, on which the treatment depends, is as a rule lacking – old people are no longer educable – and, on the other hand, the mass of material to be dealt with would prolong the duration of the treatment indefinitely.

Expectations. It is suggested that elderly people, especially, may hold certain misconceptions about both therapy and the nature of depression itself which need to be tackled for therapy to continue successfully (Emery, 1981; Steuer and Hammen, 1983; Thompson *et al.*, 1986). A client may believe that he/she is 'too old to change', or may expect to be in a passive role as a 'patient'. Elderly clients are said to often mislabel depressive symptoms such as fatigue, loss of appetite and poor concentration as signs of ageing (a view often reinforced by others, of course). Education and challenge are needed to right these misconceptions. 'Treatment socialization' is needed (Emery, 1981).

Learning and memory. Twining (1988) gives a clear account of the cognitive changes in normal ageing. In relation to learning and memory, there is evidence of some decline in memory performance. The decline is quite small in primary memory. In secondary memory, the decline is evident unless the task requires recognition, when there is little difference between young and old, as organization and retrieval seem to be the problems. Complex learning does show decline, but the important factors are speed and novelty. Indeed, a decrease in response speed is one of the most consistent findings of the effects of ageing. There is also some evidence that the style of thinking of elderly people is often more rigid, so that in problem-solving they may be slower to change a strategy that is not working; wisdom learned over many years is in conflict with new learning. Church (1983) has pointed to evidence of change in at least one aspect of abstract ability.

In any discussion of the normal ageing process, it is important to emphasize that there are marked differences between individuals. Statements, such as above, refer to the average of a whole group of elderly people. Many of a group will experience some of the changes but others will not.

The implications of such cognitive changes for conducting cognitive therapy with the elderly have been discussed by a number of writers. To aid learning, an elderly client may take notes, or a therapist write out important points during sessions. Cue cards or labels may be used for complex concepts, which could also be used in homework to aid recall. Certainly, new material should be presented at a slower pace. Major points should be repeated often, by the therapist and the client. Frequent summarization should take place (Thompson *et al.*, 1986). It is suggested that session lengths should be longer to compensate for slower responding, say 90 minutes rather than the usual 60 minutes

(Gallagher and Thompson, 1983). When sensory deficits are present (poor vision or hearing), then obvious physical adjustments such as ensuring suitable lighting and sitting closer to the client can help to compensate. All of these adaptations may be said to relate to the style of therapy.

In relation to abstract ability, it is interesting that Steuer and Hammen (1983) found that the two patients who scored lower on tests of cognitive functioning (and who had less education and lower occupational status) could not perform thought-catching, which requires the relatively abstract appreciation that thoughts may precede emotional reactions. They concluded that the behavioural aspects of cognitive therapy may be more useful for patients such as these who have difficulties in abstract thinking. Also, Church and Bennett (1982) found that they had difficulty in encouraging their patients to use dysfunctional thought sheets. They thought that the patients had difficulty in seeing the connection between using these sheets and to any benefit to themselves, and recommended caution in the use of abstract information and techniques.

Church (1983) discusses the work of Walker (1982) which shows a marked decline in one aspect of abstract ability, that of the ability to shift set, in those aged over 80 years. Ability to shift set is measured by the person's ability to classify groups of objects on different dimensions such as colour and shape. It may be then that there is a decline in abstract ability due to normal ageing in many older people, which is an extremely relevant cognitive change for cognitive therapy, but with other factors such as educational level contributing to individual differences. This tentative evidence may suggest an adaptation to the content of therapy for many elderly people. No doubt, some young adults cannot perform thought-catching either. The point is that many older people might be more likely to experience such problems, as cognitive changes due to normal ageing may also be involved. Again, it is important to be aware of the marked individual variability in normal ageing. It is inadvisable, therefore, to make hard and fast rules about the process (Woods and Britton, 1985).

Realities. Finally, consideration needs to be given to the realities of life of many elderly people. A therapist may be taxed to help patients differentiate between the hopelessness and helplessness characteristic of depression and their realistic recognition of limitations in the face of real life hardships such as poor financial and health status and loss of significant others (Steuer and Hammen, 1983). In relation to goal setting, increasing physical infirmity will make it harder to translate new or revived goals into action (Church, 1983).

Much of this involves the therapist being sensitive to the individual needs of the client at any age, but working with the elderly requires certain special sensitivities. The issue of modifications to therapy is best resolved on an individual basis (Woods and Britton, 1985).

DISCUSSION

In relation to the aim of this study, the literature does suggest that Beck's cognitive therapy is a treatment helpful to elderly people who suffer from non-psychotic unipolar depression of mild to moderate severity. Evidence comes from both quantitative research, in which cognitive therapy is shown to produce significant changes in many patients, and from the qualitative research of case histories. Further research is needed to clarify which patients are likely to benefit most.

However, there appears to be no substantial evidence that cognitive therapy is any more effective than other short-term psychotherapies, either on initial treatment or at follow-up. It does not appear to have been compared satisfactorily with a 'placebo' psychotherapy or no-treatment condition. Neither does there appear to have been a proper comparison with the efficacy of antidepressant drugs, whose own efficacy with the elderly is well documented (Peet, 1989).

However, optimism is warranted. Given the well-documented effectiveness of cognitive therapy with younger adults and the outcome and case studies presented here, it seems reasonable to use this treatment and expect it to help many clients. Overall, there are more similarities than differences between the young and old, although the differences are not necessarily negligible.

There are issues which arise in conducting cognitive therapy (and no doubt other pyschological therapies) with the elderly such as ageism and clients' expectations, which require certain special sensitivities. Also, some adaptations would appear to be needed to the style and perhaps to the content of therapy for it to be maximally effective. Many of the adaptations to style, so as to compensate for slower responding and some decline in memory, for instance, might be described as simply 'basic nursing care'. Nevertheless, 'basic nursing care' is not necessarily well undertaken, probably because it is not actually 'basic' at all. Adaptation to content (relying more on behavioural techniques) is suggested on the basis of only tentative evidence, so should not be taken as a hard and fast rule but as a special consideration to take to therapy with elderly clients.

This paper has dealt with the practical issue of whether cognitive *therapy* can help to relieve depression in elderly people. It has not been concerned with the question of by what therapeutic mechanism change is brought about, although there is research interest in the area (see Teasdale, 1985, for example). Also, whether cognitive *theory* can explain the development of most depressions in the elderly remains to be seen.

The literature search provided no evidence that CPNs working with the elderly use cognitive therapy in helping their clients with depression, although such an approach has been prescribed elsewhere (Adams, 1989). If work of this nature is being carried out, then published reports would be very useful. Of much practical value would be detailed case study reports. It is recognized that a literature search reveals only what is in the literature, not necessarily what work has been or is being carried out. If work of this nature is not being done, then this study might provide confidence for CPNs, with appropriate training and supervision, to offer this approach to selected clients.

The evidence in this paper indicates that cognitive therapy is helpful in treating elderly people who suffer from depression of mild to moderate severity. Although it can only be surmised in the absence of data published in the literature, it is likely that CPNs working with the elderly within at least some services will be referred depressed elderly people suffering from exactly this range of severity of the condition. Referrals of this nature might come, for instance, from GPs, psychiatric out-patient departments or following in-patient treatment for a more severe episode. Cognitive therapy might therefore be an intervention to be used by those CPNs.

CPNs might also consider the use of other psychological therapies for depression in the elderly. For instance, Sholomskas, Chevron, Prusoff *et al.* (1983) describe the use of interpersonal psychotherapy with this client group. Interestingly, a recent multi-centre study conducted by the National Institute of Mental Health in the United States not only confirmed the effectiveness of cognitive therapy for depression (in adult out-patients under 60 years of age), but also found no significant differences in effectiveness between cognitive therapy and interpersonal psychotherapy (Elkin, Parloff, Hadley *et al.*, 1985; Elkin, Shea, Watkins *et al.*, 1989). This provides further encouragement for considering the use of at least interpersonal psychotherapy with the elderly.

CONCLUSION

CPNs who work with elderly people have an important contribution to make to the care and treatment of those who suffer from depression. It is now recognized that depression in elderly people is common, easily missed and frequently undertreated (Baldwin, 1991). The CPN role might therefore encompass a number of areas of work including: education of other professionals in order to increase awareness and facilitate detection; screening; primary prevention; and psychological therapy.

It is suggested in this paper that CPNs who work with elderly people should consider the use of cognitive therapy, if they have not already done so, in helping their elderly clients who suffer from depression. The documentary information presented in this paper provides CPNs with the necessary research base for this aspect of their practice.

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CHAPTER SEVEN

The CPN and depression in elderly people living in the community

Anna Waterreus

INTRODUCTION

Depression is the most common psychiatric condition in elderly people; it is also the one which most often goes unrecognized and untreated. Prevalence rates of depression in elderly people living in the community range from 1% (Weissman, Myers, Tischler *et al.* 1985) to 18% (Romaniuk, McAuley and Arling, 1983), with Livingston, Hawkins, Graham *et al.* (1990) finding a rate of 15.9% in Gospel Oak, London, where the study to be outlined was undertaken. The use of differing interview schedules, definitions of 'caseness' and populations sampled are possible explanations for this wide variation in figures. When comparable populations are interviewed using standardized schedules which define caseness, cross study variation is diminished. For example, the United States/UK cross national community elderly study using the standard comprehensive assessment and referral evaluation (short-CARE) found a similar prevalence rate of approximately 13% in elderly people in New York and Greater London (Gurland, Copeland, Kuriansky *et al.*, 1983).

With a predicted change in the demographic structure resulting in increasing numbers of elderly people, it is essential to assess the services available to treat these individuals. Efficacy of different care parameters needs to be established and the most competent ways of care delivery delineated. This paper will focus on the incidence of depression in elderly people, its aetiology, diagnosis and treatment. It will outline the Gospel Oak depression study and sets out to describe specific interventions requested by a multidisciplinary team which were administered by a CPN. This CPN was acting as a case manager for an identified group of elderly people suffering from depression. This study hopes to identify whether a group of such clients can benefit from this form of intervention.

THE CAUSE OF DEPRESSION IN ELDERLY PEOPLE

The aetiology of depression can be similar for people of all ages, although there are certain factors which are more likely to be associated with depression in elderly people. Several of these are a result of increasing age itself. The death of a spouse or close other may result in loss of social contacts, it may also lead to abnormally prolonged grief reactions if adequate ongoing support is not provided. Old age has increasingly become an undervalued status and is often associated with economic hardship. These factors may contribute to a lowered self-esteem and subsequent withdrawal from activities due to financial restrictions. Limited physical activities and loss of health are consequences of degenerative diseases such as arthritis and coronary heart disease. The limits degenerative disease impose on independence may be compounded further by the existence of sensory deficits, all of which may result in the increased risk of isolation. Many elderly people are prescribed poly-pharmacological preparations to treat their physical ailments and those such as digitalis, alpha-methyldopa and some diuretics have depressive side-effects. It seems likely that one or a combination of social, physical and pharmacological factors could be implicated in the causation of depression in elderly people.

Diagnosis

As with aetiology, depressive symptoms in elderly people are similar to those experienced by other ages. Symptoms can be wide ranging from occasional episodes of misery to feelings and plans of suicide. Certain depressive features are more apparent in depressed elderly people than their younger counterparts. Examples include; an alteration in sleep pattern with early morning waking and inability to get to sleep, increased levels of anxiety, retardation and hypochondriac preoccupations (Bebington and Hill, 1985). Physical complaints such as chronic pain, headaches and/or gastrointestinal disturbances are common reasons for elderly people to frequently visit their general practitioner (GP). The coexistence of physical illness (Burn and Dearden, 1990; Wright, 1989), somatization and denial of depressive symptoms may contribute to depression being overlooked in primary care.

Both the client and GP often regard symptoms of depression as being part of the ageing process (Cohen, 1976; Epstein, 1976; Freedman, Bucci and Elkowitz, 1982) and thus they are seen as appropriate responses to inevitable adverse life events and stresses. This offers another possible explanation as to why a large proportion of depression is unrecognized in elderly people. Problems of identification are compounded by short GP consultations which may limit the GP's ability to make an accurate diagnosis.

Treatment

Elderly people are particularly high users of primary care services. Larson, Lyons, Hohmann *et al.* (1991) reported that up to 60% of this group, in the United States, receive mental health care from primary care practitioners. Elderly people suffering from depression are often not recognized by the GP for the reasons already documented; they are also less likely to be referred to psychiatric services than younger depressives (Kucharski, White and Schratz, 1979).

Pharmacological intervention such as the prescription of psychotropic medication seems to be the first line of treatment of depression in elderly people (Larson *et al.*, 1991; Shepherd, Cooper, Brown *et al.*, 1981). However, evidence from general practice suggests that prescribing rates of antidepressants are low for elderly people (Wright, 1989). These people are less likely to receive antidepressants than younger clients with similar symptoms, and may have their depression treated with benzodiazepines or sub-therapeutic doses of tricyclic antidepressants (Richter, Barsky and Hupp, 1983). For those who fail to respond to a trial of antidepressants, the possibility of noncompliance must be considered.

Pharmacological intervention alone is not the answer; a holistic approach to treatment is the ideal. Social and psychological interventions may not be implemented by GPs due to constraints of time and resources. A referral to the CPN at this point may be invaluable.

COMMUNITY CARE AND CASE MANAGEMENT

The concept of community care is not a new one, it has been an objective of government policy since the formation of the NHS in 1948. At this time official reports were published expressing the benefits of providing care for dependent groups in places other than large, longstay hospitals (Rose, Black, Davey *et al.*, 1988). Over the years community care has been criticized for being too fragmented, but this may be overcome by adopting the practice of case management in order to draw services together (Test, 1979).

Definitions of case management include distributing integrated and co-ordinated services to clients and carers, while avoiding duplicity (Clifford, Craig and Sayce, 1988; Thornicroft, 1991). Case management ensures continuity of care, which is often lacking in out-patient clinics. Continuity involves guaranteeing comprehensive co-ordinated services both longitudinally and cross-sectionally (Test, 1979). Community care endeavours to keep those accountable for services as accessible to the individual and carers as possible (Griffiths, 1988). In this study the CPN fulfilled the function of the case manager.

The 'core task' of case management as outlined by Intagliata (1982), Kanter (1989) and Renshaw (1987) appear similar to those of the nursing process; assessing needs, formulating nursing diagnoses, planning, co-ordinating and implementing care, evaluating effectiveness and revising care plans when necessary. The role of the case manager is to design the best 'package of care' for their clients (Griffiths, 1988). These packages of care or treatment plans must be comprehensive, encompassing the biological psychological and social aspects of care.

BACKGROUND TO GOSPEL OAK DEPRESSION STUDY

The Royal Free Hospital, Hampstead, North London, is the base for the Gospel Oak Elderly Depression Study and has a well-established CPN service for elderly people, but as yet no assessment has been made of its effectiveness. In 1987 a team of health professionals created a register of every person over the retirement age (that is, men over 65 and women over 60 years of age) living in Gospel Oak electoral ward. This ward (population of 6136 in 1987) has higher rates of most indices of deprivation than the national average for England and Wales. It has twice as much overcrowding, 50% more unemployment and 50% greater infant mortality than nationally expected (Hampstead Health Authority Community Health Unit, 1985). The register was established by 'door knocking' every home in the electoral ward, as health professional registers were found to be too inaccurate (Livingston *et al.*, 1990). In all, 932 elderly people were identified and 813 were subsequently interviewed using the standard comprehensive assessment and referral evaluation (short-CARE) (Gurland *et al.*, 1983) which is a semi-structured interview developed from the comprehensive assessment and referral evaluation (CARE) (Golden, Teresi and Gurland, 1984).

Aim

The aims of the Gospel Oak Depression Study were to: (1) assess the efficacy of CPN intervention with a cohort of depressed community elderly people by allocating a CPN to a random half and following them all up after a three-month period; and (2) identify exactly what interventions a CPN makes and of these interventions which are important (if any) in improving the mental state of this depressed elderly cohort.

Method

Assessment. In 1989–90 the Gospel Oak cohort of older people all living in their own homes or in one local authority home were rescreened using the same instrument as in 1987, that is, the short-CARE. Of these, 589 people were interviewed successfully, and using a cut-off score of six or more, 112 received an operational diagnosis of probable pervasive depression; this reflects depression at a level where there is a need for clinical intervention.

Diagnosis. Ninety-six of the 112 (86%) people were interviewed by the psychiatrist using comprehensive standardized interview schedules; the remaining 16 clients either died, moved away or refused interview.

Planning. 'Ideal' management plans were designed for all 96 people by a multidisciplinary team consisting of a consultant psychogeriatrician, senior registrar, CPN, psychologist, social worker and occupational therapist (on call). Regular meetings were held when plans were formulated for all new subjects and current cases were reviewed. The management plans outlined the aims and individual steps to achieve these, as well as prioritizing each intervention where necessary. Entries were made under the following headings; physical, psychological, pharmacological and social.

Intervention. The cohort was assigned randomly into either intervention by CPN for a period of three months or non-intervention. The research psychiatrist was blind to the outcome of the randomization throughout the course of the study. Each GP involved in the study was notified by letter as to which of their clients were entered into the study and the result of the allocation. They were given the opportunity to discuss the proposed management plans with the CPN, and their agreement was obtained to proceed with the planned interventions. After three months all GPs were notified about each of their client's management plans (both intervention and non-intervention groups), including details of what was achieved and, where necessary, what could be offered with regard to follow-up care (for example, referral to the regular CPN team for elderly people for continuing nursing input).

A detailed diary was kept by the CPN for each client in the intervention group. This included recording all time spent face to face with the client and time liaising with others involved in care. Entries documented the date and approximate duration of all actions and conversations between the CPN and client. They were recorded under the four individual headings as set out in the management plans.

Evaluation. After three months each subject was reinterviewed, a further short-CARE was conducted by an independent interviewer and the diaries were analyzed independently.

Selected findings

The cohort of 96 clients consisted of 85% females, 64% widowed, 21% single, 15% married and 8% divorced. Six were currently recipients of psychiatric services; three were already seeing a CPN, one each attended the local psychiatric day hospital, out-patients department and one was receiving private psychotherapy. These six all fulfilled DSM IIIR criteria (see American Psychiatric Association, 1987) for major depression, as opposed to 16 out of 22 (73%) of those also suffering major depression but who were not known to the psychiatric services. Thus, 27% of the clients with major depression were already receiving care.

Of the clients, 47 were allocated randomly to CPN intervention, of whom 43 were seen successfully. Four were not visited due to refusals, death before intervention or no visits requested by the team. Each client received on average a total of ten visits from the CPN and a mean of seven hours (range ten minutes to 12 hours 15 minutes) of CPN time over the three months. A conservative estimate of time spent travelling by the CPN to each client was a mean total time of 1.5 hours with 2.5 hours spent writing up the case notes or diary for each client.

Interventions. The interventions suggested by the team involved the CPN taking a holistic approach to care, as can be seen in Table 7.1.

Table 7.1 Seven most requested interventions by the team for the CPN cohort (n = 43), and the number and percentage of those which were unable to be implemented

Intervention requested by the team to be implemented by the CPN	*Frequency requested*		*Unable to be implemented*	
	n	*(%)*	*n*	*(%)*
1. Increase their social network	26	(60)	18	(69)
2. Trial of antidepressants	19	(44)	12	(63)
3. Discuss ongoing life problems	17	(39)	0	(0)
4. Behavioural therapy	16	(37)	0	(0)
5. Gather information from relatives	14	(32)	5	(36)
6. Discuss current relationships	13	(30)	0	(0)
7. Drug review	12	(28)	4	(33)

Most clients received some form of psychological intervention. Psychological intervention was divided into five categories: (1) 'ongoing life problems' which involved the discussion of any current issues such as housing, isolation or problems associated with reduced functioning due to physical or mental health problems; (2) 'behaviour therapy' which included cognitive therapy, behaviour modification programmes or any form of relaxation therapy; (3) 'current relationships' involved discussing problems which may exist between the client and their spouse, siblings, children or friends; (4) 'past

Table 7.2 Categories of psychological care given by the CPN to the cohort of clients (n=43), and the mean time spent by the CPN in attempting to implement each intervention

Psychological intervention⁺	*Total number of patients receiving psychological intervention**	*Mean time spent per patient (hours)*
Psychological intervention (in general)	43	6
Ongoing life problems	42	3
Behavioural therapy	33	1.5
Current relationships	40	1.5
Past relationships	24	1
Psychological assessment	3	0.5

⁺For definitions, refer to text.

*Clients may receive more than one psychological intervention.

relationships' involved bereavement counselling; and (5) 'psychological assessment' involved formally assessing clients' mental states. Psychological intervention comprised the largest component of the CPN's face-to-face time (Table 7.2). For 25 (58%) of the CPN cohort it was necessary for the CPN to liaise with other health professionals for further information, training from the psychologist on techniques such as behaviour therapy and advice and instruction on the best methods of care from members of the team.

Few difficulties were encountered while implementing the psychological component of the management plans, although at the three-month end point several interventions had not been completed due to lack of time. Difficulties were met when attempting to implement most of the other treatment requests. Client refusal to comply with the suggested treatments accounted for 50% of non-implementation. A further 25% was a result of resistance by the GP to the proposals made by the team and CPN, and 25% was as a result of a combination of lack of time in which to set in motion parts of the plan, and waiting lists to day centres and hospitals which prevented action occurring.

The most difficult interventions to implement were those of the GP prescribing a trial of antidepressants and the client's acceptance of this, and referral and attendance at a day centre. Seven (58%) of the uncompleted interventions with antidepressants and nine (47%) uncompleted interventions to increase social networks were due to client refusal. However, eight clients (31%) were referred to and attended a day centre for an average of 22 hours over the three months. Seven clients (37%) were prescribed and complied with a trial of antidepressants, which on average began at week six of the 12-week intervention period. Thirty clients (70%) received a mean total of 45 minutes' medication education on both current medication and antidepressants. Further analysis is being undertaken.

General practitioner contact. Visits to the GP by clients in the intervention period were similar in both intervention and non-intervention groups; they visited twice on average with the mean total time spent being 20 minutes during the three months. The CPN liaised with the GPs of 38 (88%) of those clients allocated to intervention, and spent a mean total time of 25 minutes with the GP per client over the three-month period.

DISCUSSION

Caseloads

The Gospel Oak Depression Study was designed as the ideal situation; the support from the team enabled the implementation of the management plans by a CPN for a total of 43 clients, a caseload of no more than 15 clients at one time over a period of three months. Visits were prearranged and a contact telephone number provided. This was felt to help develop a rapport which enabled the nurse to establish a confiding relationship and deliver effective, continuous care. To ensure case management is effective it is essential that caseloads are of a 'manageable' size. Defining a 'manageable' or 'ideal' caseload is difficult as it depends not only on the type of client but also on their geographical spread. Intagliata (1982) stated that 20 to 30 clients was an ideal number if ongoing assessments, planning and monitoring were required. According to Harris and Bergman (1988) a ratio of more than 1:15 runs the risk of rapidly diminishing benefits. As caseloads increase in number, the potential time available to each client is reduced, as is the frequency of visits. The nurse becomes reactive rather than proactive and thus deals mainly with crises; consequently, the ability to plan ahead is severely limited. This affects the nature and quality of the nurse–client relationship.

The extent to which therapeutic intervention and support may be implemented successfully and the quality of the staff–client relationship depends upon the frequency of contact, the staff-client ratio and whether the case manager is perceived as being warm, understanding and empathic (Hawranik and Kondratuk, 1986). This staff–client relationship may be the most potent therapeutic factor (Goering, Wasylenki, Farkas, *et al.*, 1988) and 'the component through which effective care is channelled' (Thornicroft, 1991).

Client contact

Initial visits by the CPN were often difficult, as help was being offered to people who had generally not sought professional help for their depression. Consequently, much time was spent initially helping the client with practical issues, their physical problems and medication, which they appeared willing to discuss. This facilitated an otherwise ambivalent client into developing some confidence in the nurse, thus enabling the conversation to be directed towards psychosocial problems which also existed.

Support and relief was provided to help relieve the stress and strain contributing to or arising from physical or emotional disorder. The level of support required fluctuates and so the case manager is able to adjust this support accordingly. The case manager has been described as the 'human link' between the client and the system (Intagliata, 1982). In order to provide this ideal care it is essential that the case manager is aware of all resources within the immediate geographical area and how to access these services.

Difficulties

Why was client refusal to a trial of antidepressants so common? Many responses given when antidepressants were suggested was the desire not to take any addictive tablets. Clients often associated this medication with diazepam and related stories read in newspapers and seen on the television. Others denied they were depressed and stated they would have to work through any problems by themselves (a theme reiterated in Chapter 9 by a different client group). Both these scenarios resulted in many hours of education about depression and types of help available, including medication. Medication education was divided into short sessions and repeated over several visits. A sheet documenting the tablet, reason for taking it and precautions was also given.

Another point worth considering is that each client may not be agreeable to what is considered best by health professionals. Whenever possible the care plan should be negotiated with the client. Resistance to attending a day centre does not mean the client should be labelled as noncompliant and have support withdrawn. Rather, the reasons for resistance should be discussed and other possibilities considered.

Skills required

Those interventions requested of the CPN do have implications for future nursing training. It appears to suggest than CPNs must have both psychiatric and general nursing skills and be prepared to treat the whole person, and not just from the neck up! It also demonstrates the need for good communication skills which should involve regular face-to-face contact with the GP. This enables the CPN to provide feedback on the progress achieved and how success was accomplished. It can be difficult at times to organize a convenient time to meet, but it is far superior to writing a letter which may receive a brief scan due to constraints of time before being filed by the receptionists. GPs may be reassured that the attempts made by the CPN to improve a client's mental state do not appear to involve extra visits or work by the GP. In fact over the long term one would hope that those treated successfully would visit their GP less often.

According to White (1990), 35% of all CPN referrals in the UK were from GPs, which shows a 12.5% increase since 1985. He stated that the number and appropriateness of referrals from GP are dependent on both the qualities of the CPN and the relationship developed between a CPN and GP (White, 1986). Although generally satisfied with the services offered by CPNs, some dissatisfaction has been reported by GPs, mainly with communication. Briscoe and Wilkinson (1989) found the GP highlighted the lack of feedback regarding eventual outcome and plans for the long term as a concern. Bennett (1989) noted GP dissatisfaction with feedback from CPNs on changes in treatment and reduction in frequency of visits especially of chronic clients and GPs felt this 'constituted a risk to their clients'. Good two-way communication between the two disciplines may lead to a greater confidence and a better understanding by the GP of the role of the CPN.

CONCLUSIONS

During this study many interventions took some time to implement and may have been completed only in the last weeks of intervention. Consequently, the full effects of, for example, antidepressants, which take at least two weeks before having noticeable positive effects, and meeting new friends at day centres, will not have been detected at the three-month follow-up interview. Thus a longer term follow-up of this cohort is currently underway.

All elderly people suffering from depression will experience a multitude of complex and individual problems. The CPN for the elderly must be adept at perceiving the needs of their client group. As CPNs develop as a specialty and boundaries of care are extended, the overlap of roles with other professionals will become more evident. It is important for each CPN to realize his or her capabilities and accept that no one CPN individually can provide a comprehensive package of care required. As a case manager the CPN has the role of enlisting the expertise and support of other members of the multidisciplinary team, which is esential in an often demanding and stressful occupation. Specialist skills are required to undertake accurate and professional assessments, planning, intervention and evaluation with elderly people suffering from depression, and the author feels this cannot be delivered most effectively by a generic CPN.

The role of the 4990 CPNs currently practising full time in the UK (White, 1990) depends greatly on what each individual CPN perceives the role, function and extent of care they provide should be. Whenever possible, the care implemented should be based on researched knowledge. Mound, Gyulay, Khan *et al.* (1991) noted that the quality of personal commitment was possibly the most influential factor in assisting clients to meet their goals. However, further objective investigations need to be made to quantify the most effective elements of care for the elderly mentally ill.

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CHAPTER EIGHT

The CPN in primary care: a pilot study of the process of assessment

Kevin Gournay, Grant Devilly, and Charles Brooker

INTRODUCTION

Psychiatric nursing research has come a long way since Professor Annie Altschul's seminal study of interaction patterns which was published in her famous monograph *Patient–Nurse Interaction* (Altschul, 1972). However, there has been very little work carried out in the area of the process of care of clients with non-psychotic problems by community psychiatric nurses (CPNs). Other work (for example, Parnell, 1978; Sladden, 1979) has focused on the care of clients who were suffering from schizophrenia. The first study which looked at the nature of community psychiatric nursing contacts with 'neurotic' clients was that of Paykel and Griffith (1983) in the well known study at Springfield Hospital. The information from this study was derived from a record which the nurses filled in after every contact, together with material from interviews with nurses, and comments made informally in the regular meetings between the research team and the nurses. In addition, Paykel and Griffith (1983) also collected detailed case reports written by nurses on illustrative cases. The nurses completed their treatment record at each contact with the client and, in all, there were data on 349 contacts. Of these, 322 were face-to-face contacts rather than by telephone. Interestingly, and in marked contrast to the study reported below, contacts in this study were predominantly in the client's home (93.5%). Paykel and Griffith (1983) categorized the various verbal interactions and the most commonly discussed areas were symptoms of current illness, the nature of the illness and its prognosis, social life and hobbies, interpersonal relationships, employment, family problems with spouse, parents and children, and physical health (Paykel and Griffith, 1983, p. 76). The authors found that the most commonly employed interventions were those of the offering of support and reassurance by the CPN, allowing the client to ventilate their feelings, enhancement of self-awareness by encouraging the client to examine the nature of his or her behaviour, attempts to establish factual information around important issues and the giving of information, explanations, instructions or practical advice. Paykel and Griffith (1983) also found that nurses tended to offer psychodynamic explanations for clients' behaviour and symptoms. This strategy increased from 41% of the contacts in the first six months, to 61% of the contacts in the last six months of the 18-month study. Their conclusions, therefore, were that the interactions by the nurse were not simply supportive. However, the study design and method complicate these findings. It should be remembered that before allocation to a community psychiatric nurse, the clients in this study had received psychiatric treatment. It seems a pity that this important study was not followed up by further research, and given the considerable expansion of community psychiatric nursing, it is surprising that there has been little interest shown in the nature of the nurse–client interaction in this area. This paucity of research is in contrast to large amounts of process research carried out in psychiatry and clinical psychology. Reference to any standard text (such as Garfield and Bergin, 1986), will show that research endeavour is intense in these professions.

The pilot study reported below examines the process of community psychiatric nursing with neurotic clients in primary health care. As indicated, it was hoped at the beginning of the study that these methods could be used as a basis for process studies in other areas of psychiatric nursing.

Setting of process study

This study of process was but one aspect of a major study carried out between 1988 and 1991, which was funded by the Department of Health (Gournay and Brooking, 1992). The main study looked at the treatment by CPNs and GPs of clients with non-psychotic problems in primary health care. It was carried out in Barnet and Parkside Health Authorities. In total, 274 clients were recruited from six general practices and health centres across the two health authorities, and these practices covered a wide range of socioeconomic conditions. In total, 48 GPs worked in these practices and, of these, 36 GPs referred to the study.

Before the main part of the enquiry (see below) a pilot study was carried out to test the measures used. Forty-three clients were referred to this pilot study and 32 clients participated. Following this piloting and some minor amendments to the measures and method, 231 clients were referred to the controlled study and eventually 177 underwent initial assessment. Criteria for entry into the study were that the clients were aged between 18 and 70 years, were suffering from non-psychotic problems and had not received previous in-patient psychiatric care. Initial assessment was carried out by one of two research assistants employed by the research grant. This assessment consisted of the use of a number of measures of psychiatric status, symptoms and economic and social function. Following this assessment, clients were randomly assigned (by a process of minimization (Taves, 1974)) to one of three conditions. These conditions were:

1. CPN intervention. In this condition, CPNs were instructed to proceed as normal and to treat clients as they saw fit.
2. Continuing general practitioner (GP) care. In this condition, GPs were instructed to continue treating clients as they would do if no CPN was available.
3. Delayed CPN intervention. In this condition, clients were assigned to a CPN but were put on a 12-week waiting list before CPN intervention. Immediately before the CPN intervened at 12 weeks, a further assessment was made by the research assistant, with a repetition of the measures.

Assessments were repeated on all clients by the research assistants at 24 weeks. The clients who took part in the study suffered from a range of mental health problems which probably represent the range of difficulties seen and treated by CPNs in primary health care. The majority of clients presented with significant levels of anxiety and depression. Apart from the standardized measures collected at assessment, the researchers also asked the client to define and rate what they saw as the main problem. The commonest category of problem presented by clients was that of relationship and family problems. The second largest group of complaints from clients was about depressive symptoms, while the third largest group of clients complained of anxiety symptoms. These three major problem categories formed the bulk of the clients' complaints, although a significant minority of clients also complained of other problems, for example, the effects of life events and life stresses, and somatic complaints, such as fatigue, aches and pains, and concern with a defined physical illness.

Apart from looking at the relative efficacy of CPN and GP interventions, the researchers also examined other aspects of the process of care by CPNs, including record keeping and letter writing. A detailed enquiry of the economic aspects of CPN treatment was also made. Results of the randomized controlled trial and these other structure, process and outcome areas are described elsewhere (Gournay and Brooking, 1992).

THE PROCESS STUDY

Subjects

Eight clients who were assigned to the CPN condition of treatment consented in writing to participate in this part of the study. These clients had all been assessed in the normal way by research assistants and their main presenting problems are shown in Table 8.1.

Table 8.1 Clients' presenting problems

1	Depression
2	Social phobia
3	Anxiety
4	Relationship difficulties
5	General anxiety disorder
6	Depression
7	Anxiety related to husband's drinking
8	Agoraphobia

Participating CPNs

Of the 11 CPNs who participated in the overall study, eight participated in this particular enquiry. As this process study was carried out in the latter part in 1990, three of the 11 CPNs had moved on from their respective health authorities, hence their non-participation. Of the eight CPNs who participated, four held an English National Board qualification in community psychiatric nursing. The average age of these nurses was 43.13 years (standard deviation 5.69, range 37 to 55 years). Their mean period of experience as community psychiatric nurses was 6.94 years (standard deviation 4.2, range one to 12 years) and their experience in primary health care settings was 4.13 years (standard deviation 3.08 years, range one to nine years).

Procedure

After the client had been referred to the study and undergone initial assessment, and when a number of measures of psychiatric status, symptoms and social and economic function were collected, clients were asked if they would participate in the process study. The explanation given to the client was that their first interview with the CPN would be videotaped and additional information would be sought from them concerning this particular interview. Clients were told that apart from this videotaping procedure, there would be no difference in the assessment and treatment they would receive.

There was no special selection of clients. When this phase of the study was started the research assistants asked all clients referred after this point for their co-operation in participating. The research assistants continued seeking co-operation until a complete data set had been collected on each of the eight CPNs. Six clients refused to co-operate in this part of the study.

After the clients' written agreement had been obtained, an immediate appointment was made with the CPN. Clients were seen within five working days and the research assistant was responsible for setting up the videotaping equipment in the health centre or surgery where the CPN normally saw the client. No interviewing took place before the videotaped assessment. When the client arrived, the research assistant started the video camera in the room and collected the client from the waiting area. The assessment interview was thus videotaped from the point at which the CPN was introduced to the client. After the interview had begun the research assistant left the room. The camera was left running for as long as the session lasted and, after the session, the research assistant collected the self-report data from the CPN and the client.

Measures

All clients entering the randomized controlled trial completed an assessment interview when various measures of psychiatric status, symptom and social and economic function were obtained. The outcome measures from that assessment which are relevant to this particular study are described below, together with the specific process study measures.

Outcome measures.

1. Standardized psychiatric interview (Goldberg, Cooper, Eastwood *et al.* 1970). This interview schedule has been used extensively as a research tool in community surveys. The interview concentrates mainly on neurotic symptoms and has high inter-rater reliability. It has been found to be generally acceptable by a wide range of clients suffering various illnesses and by 'normal' subjects. The interview yields a derived score which is a composite of client complaint and interviewer ratings. The standardized psychiatric interview also allows for making a diagnosis. There is a standard training for this interview which the research assistants and study directors received before the study took place.
2. Beck depression inventory (Beck, Warden, Mendelson *et al.*, 1961). This is a 21-item self-rating scale which allows rapid assessment of overall depressive symptomatology. Scores of 10 to 19 indicate a mild level of depression, scores of 20 to 25 indicate a moderate level of depression and a score of 26 or more indicates a severe depression (Fennell, 1989).
3. The Spielberger state trait anxiety inventory (Spielberger, Gorusch and Lushene, 1970). This questionnaire has been used extensively in research in clinical practice and yields two scores: state anxiety and trait anxiety. The state anxiety scale has been shown to be a sensitive measure of change during counselling and therapy or as a measure of experimentally induced anxiety. The trait anxiety scale is a good indicator of neurotic conditions and has been used to screen military recruits and college students for possible anxiety problems. The mean scores for this inventory for working adults are 35.72 and 35.20 for the state score for males and females, and 34.89 and 34.79 for the trait scale for males and females respectively.

This questionnaire asks you to appraise the way in which your CPN/counsellor has been treating your emotional health problem. Please answer the questions as honestly as you can by circling the point on the scale which most clearly reflects your opinions.

Part I

My CPN treating my emotional health problems:

1. Was easy to talk to

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

2. Did not make me feel relaxed

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

3. Involved me in the aims of treatment

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

4. Was someone in whom I could not confide

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

5. Helped me to manage my own problems

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

6. Was unable to show an understanding of my needs

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

7. Was good at the counselling job

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

8. Did not appear to give me enough of their time

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

9. Was a person whose abilities I am satisfied with

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

10. Was unresponsive to my needs

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

11. Displayed good listening skills

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

12. Did not give me adequate information about my condition

Strongly agree			Unsure either way			Strongly disagree
I	I	I	I	I	I	I
1	2	3	4	5	6	7

Figure 8.1 Counselling appraisal questionnaire

4. General health questionnaire (GHQ) (Goldberg, 1972). This is a very widely used questionnaire which was devised as a self-administered screening instrument to aid in the detection of minor psychiatric morbidity. The 30-item version was used in this study.
5. Life disruption rating (Marks, Connoly, Halcam *et al.*, 1977). This self-ating scale measures (on a scale of 0 to 8) the impact of the client's problem

on their work, home management, social leisure, private leisure and social relationships. The scale thus gives a possible maximum score of 40. The measures have been used extensively in clinical practice and outcome research, particularly in the work of nurse therapists (Marks, 1985).

Patient ratings.

1. Counselling appraisal questionnaire. This scale, shown in Figure 8.1, was piloted and devised by the research team specifically for use in this study. This measure has two scales, one which rates the specific intervention and the second which rates the overall service provided. For the purpose of this part of the study, only the ratings derived from the 'specific intervention' scale are reported.
2. Global rating of helpfulness. This rating, shown in Figure 8.2, asked clients to rate how helpful they saw the session overall.

Rating of CPN helpfulness

Please rate how helpful or hindering you think this session was from the client's point of view 'overall':

1. Extremely hindering
2. Greatly hindering
3. Moderately hindering
4. Slightly hindering
5. Neither helpful nor hindering
6. Slightly helpful
7. Moderately helpful
8. Greatly helpful
9. Extremely helpful

Rating of CPN attributes

Please circle the appropriate number to show how you feel about the CPN's attributes:

Today the CPN was:

Skilful	1	2	3	4	5	6	7	Unskilful
Cold	1	2	3	4	5	6	7	Warm
Trustworthy	1	2	3	4	5	6	7	Untrustworthy

Figure 8.2 Global rating of helpfulness.

Independent raters. Two raters, who were not involved in assessment of the patients, were an academic nurse researcher and a principal lecturer in psychology. They undertook various independent blind ratings on the video tapes. They completed the counselling appraisal questionnaire (see above, Figure 8.1) and a global assessment rating (see Figure 8.3).

CPN ratings. CPNs completed: (1) a global rating of their perception of the helpfulness of the session (see above); and (2) their intentions for treatment. After the session, the research assistant asked the CPN how they would now treat the client and coded the response accordingly.

Interview number ....

Please rate the extent to which the following have been achieved:

1. Did the CPN introduce herself/himself appropriately?
2. Did the CPN explain the purpose of the interview?
3. Did the CPN establish the client's main problem?
4. Did the CPN establish relevant background information?
5. Did the CPN use language that the client could understand?
6. Did the CPN discuss/describe the aims of intervention?
7. Did the CPN discuss/describe the nature of intervention?
8. At the end of the interview did the client understand what was going to happen next?

I	I	I	I	I
1	2	3	4	5
Not at all				Achieved completely

Figure 8.3 Global assessment measure.

RESULTS

Table 8.2 shows the clients' scores on the outcome measures at zero weeks (that is, just before the video-taped interview) and at 24 weeks. Pre-intervention, the standardized psychiatric interview (SPI) scores demonstrate that all clients had significant levels of minor psychiatric disturbances. A score of 13 normally indicates the cut-off for being described as a 'psychiatric case'. The Beck depression inventory scores show that four of the eight clients fell into the severely depressed category, while only one client fell into the normal range for depression scores. Likewise, the state anxiety scores at assessment were high for all but one client, and the whole group scored within the abnormal range on the general health questionnaire. Life disruption ratings also indicated a high level of disruption of various areas of life. Comparison of the score at zero weeks and 24 weeks show a mixed picture of outcome, but in order to see these results in the proper context, they need to be considered alongside other which are described below. The counselling appraisal questionnaire

Table 8.2 Scores on the outcome measures

Client number	*SPI*		*BDI*		*State anxiety*		*Trait anxiety*		*GHQ*		*Life disruption rating*	
	*0**	*24**	*0*	*24*	*0*	*24*	*0*	*24*	*0*	*24*	*0*	*24*
1	40	49	52	35	66	69	56	64	63	60	-	13
2	45	-	39	-	78	-	78	-	74	-	32	-
3	25	12	3	0	35	28	43	35	40	14	25	10
4	20	7	15	1	56	24	46	33	50	11	11	0
5	29	19	20	13	55	33	56	44	59	15	-	9
6	35	33	32	31	68	62	69	70	54	-	32	12
7	42	2	19	7	-	39	-	39	56	23	10	0
8	33	29	25	11	56	65	60	54	52	24	10	4

*0 = 1st assessment (0 weeks)
*24 = 3rd assessment (24 weeks)

SPI = Standardized psychiatric interview
BDI = Beck depression inventory
GHQ = General health questionnaire

Table 8.3 CPN, client and independent rater judgements

Client number	*ENB Cert.*	*Mean total global assessment score**	*Mean CAQ Part I (independent raters)*		*CAQ Part I (patient)*	*Client** rating of helpfulness*	*CPN** rating of helpfulness*
			Rater I	*Rater II*			
1	N	17.0	48	60	14	9	6
2	Y	25.0	33	31	19	7	7
3	N	22.5	31	36	18	7	6
4	N	30.0	33	27	20	6	6
5	Y	24.5	25	26	42	9	8
6	Y	18.5	45	59	29	7	6
7	Y	18.5	57	64	41	6	8
8	N	21.5	40	44	28	7	7

Scores range from *8 to 40
** Rating 1 to 9:
1 = Extremely hindering
5 = Neither helpful nor hindering
9 = Extremely helpful

CAQ = Counselling appraisal questionnaire

Table 8.4 Mean ratings of CPN assessment performance by independent raters

CPN	ENB Cert.	*Introduction*	*Explain purpose of interview*	*Establish main problem*	*Establish background information*	*Use language client understands*	*Discuss aims of intervention*	*Discuss nature of intervention*	*Did client understand what happens next?*
1	N	1.0	1.5	2.5	3.5	4.5	1.0	1.0	2.0
2	Y	3.0	2.0	4.0	4.5	4.5	1.5	2.0	3.5
3	N	4.0	4.0	1.0	2.5	3.5	2.5	2.5	2.5
4	N	4.0	2.5	3.0	4.0	4.0	4.0	4.0	4.5
5	Y	3.0	3.0	3.5	3.5	4.5	2.0	2.5	2.5
6	Y	2.0	1.0	2.5	4.5	4.0	1.0	1.0	2.5
7	Y	4.5	2.5	1.5	3.5	3.5	1.0	1.0	1.0
8	N	1.0	1.5	3.5	3.0	4.5	2.5	3.0	2.5
Mean		2.63	2.25	2.69	3.63	4.13	1.94	2.19	2.50

1	2	3	4	5
Not at all				Achieved completely

scores (see Table 8.3) reflect a mixture of satisfaction. The independent rater scores and the CPN ratings are also shown in Table 8.3.

The range of global assessment scores was from 17 to 30, mean 22.13. As Table 8.4 shows, mean item ratings varied from 1 to 45 (mean 2.77). Table 8.3 shows the global scores alongside the counselling appraisal questionnaire scores and CPN helpfulness scores. As the numbers involved are small, no correlation coefficients have been computed. As Table 8.4 shows, CPNs were rated most highly on using language that the client understood and in gaining background information. The lower ratings (that is, towards 'not achieved') were obtained on the items relating to discussion of the aims and nature of interventions.

As Table 8.3 shows, clients' ratings on the counselling appraisal questionnaire were (with one exception) lower than those of the independent raters (that is, client expressed higher levels of satisfaction than raters). As with the other scores, the small number of subjects limited any sophisticated statistical analysis. However, it is worth noting that the best client outcome (according to change in standardized psychiatric interview (SPI) scores) was linked to the second highest dissatisfaction rating by client (by counselling appraisal questionnaire (CAQ)), and the most satisfied client (by CAQ) had the worst outcome. With regard to helfulness ratings, these have little apparent relationship to CAQ scores.

With regard to the outcome measures, the client numbers are small and therefore caution should be exercised when considering this data. To look at the relationships between various assessments, it might be helpful to consider clients with the best and poorest outcomes. On the symptom and life disruption measures, clients 1 and 6 have the poorest outcomes, while clients 4 and 7 have the best outcomes. However, these outcomes do not seem to relate in any simple way to global assessment scores, helpfulness ratings or counselling appraisal questionnaire scores. Table 8.5 shows how information and scores from the standardized psychiatric interview (SPI) relate to the CPN's intention for treatment (as elicited immediately after the assessment interview).

Table 8.5 Intentions for treatment

*Client number**	*Standardized psychiatric interview (SPI) score*		*Presenting problem (from SPI)*	*CPN's intention for treatment*
	0 weeks	*24 weeks*		
1	40.0	49.0	Depression	Counselling
2	45.0	Dropout	Social phobia	Social skills training
3	25.0	12.0	Anxiety	Counselling
4	20.0	7.0	Relationship difficulties	Relaxation training exploration
5	29.0	19.0	General anxiety disorder	Counselling, stress management, social management
6	35.0	33.0	Depression	Diary-keeping, counselling
7	42.0	2.0	Anxiety related to husband's drinking	Bereavement counselling
8	33.0	29.0	Agoraphobia	Relaxation training

DISCUSSION

This study was conducted on a relatively small number of CPNs and therefore the findings must be treated with considerable caution. However, it is felt that the study is important because this is the first attempt to link an objective analysis of the process of CPN assessment with outcome measures. It is strongly felt that the methods could be replicated, either in whole or in part, and used in future research. The following discussion should therefore be considered in the context of the above comments.

From a diagnostic standpoint, the clients in the pilot process study were representative of the 273 clients in the overall study sample. According to the scores on the various outcome measures, all clients had significant levels of symptom and life disruption before intervention, and the depression and anxiety scores certainly indicate a considerable level of distress. Outcome was mixed, ranging from a worsening at 24 weeks to almost total recovery (according to the measures).

The CPN intentions for treatment were of considerable interest. Counselling features as the preferred intervention. This finding is somewhat in accord with Brooker's (1990) study which showed that counselling is used most often as an intervention for ENB course students. In Brooker's study, behaviour therapy and cognitive therapy were the next most preferred approaches. However, there are notable discrepancies between the treatment approaches which are indicated by the literature as the most efficacious for a particular diagnosis and the CPN's intention for treatment as elicited after the assessment interview. For example, in the case of one of the clients interviewed, it was difficult to see how relaxation training could be considered as a treatment approach as the patient was agoraphobic. The literature clearly shows (for example, Gournay, 1989; Mathews, Gelder and Johnson, 1981) that this approach is at best inappropriate. In another example the diagnosis according to the standardized psychiatric interview (SPI) was that of anxiety related to the client's husband's drinking, but the CPN's intention was to use bereavement counselling. In the event this client showed substantial improvement on the outcome measures. These examples may reflect the different approaches to formulation which exist in psychiatry and to issues of poor inter-rater agreement, but these apparent anomalies do deserve future research attention.

With one exception, the global assessment scores given an overall impression of the CPN adopting a non-focused approach to assessment (that is, a counselling style). As Table 8.4 shows, CPNs paid little attention to discussing the nature and aims of the intervention, preferring to concentrate their efforts on establishing background information. Of course, it may well be that the CPNs intended to look at these areas at a later point. One other major omission in this first assessment interview, and this perhaps reflects the client-oriented approach, was that CPNs did not inform the client just what type of intervention was intended. As a consequence of this omission, there was no opportunity for the client and the CPN to mutually negotiate the nature of the intervention or to set targets. While the lack of structure again may be linked to a 'client-centred philosophy', the observation regarding the lack of structure in the assessment interviews that were observed has major consequences for training.

Of considerable interest is the fact that in this pilot study client satisfaction scores, as measured by the counselling appraisal questionnaire (CAQ), were largely low (that is, more satisfied) but these scores have no relationship to clinical outcome. This finding was confirmed in the larger enquiry (Gournay and Brooking, 1992) and is discussed elsewhere in this book (see Chapter Nine). Client ratings of satisfaction by this questionnaire also seem to have little relationship to the ratings of the independent assessor on the global assessment scale. However, scrutiny of the individual global assessment data shows that CPNs spend considerable time establishing background information. This finding accords with data from the larger study (Gournay and Brooking, 1992) which showed that clients particularly valued the CPN's listening skills. This value attached to CPN listening skills probably, therefore, accounts for clients' high levels of satisfaction. However, the lack of any strong relationship between outcome on clinical measures and clients' satisfaction ratings in this pilot study and in the total study population (Gournay and Brooking, 1992) does confirm the proposition that satisfaction ratings *per se* should be considered only in the context of other measures.

Overall, therefore, this study shows that the CPNs studied adopt a 'client-centred' approach to treatment, and this particular counselling style, as has been argued (Brooker, 1990), constitutes the most favoured approach by CPNs working in primary health care. This has obvious implications. As White's (1990) study shows, the work of CPNs in primary health care constitutes a substantial area of activity. In that case, very large numbers of CPNs are involved in administering counselling-based treatment. However, despite enthusiastic descriptions of counselling in general practice (for example, McCleod, 1988) there is no positive evidence of its effectiveness. Indeed, the largest study so far (Ashurst and Ward, 1983), which looked at 124 clients with minor neurotic probleems within the context of a randomized controlled trial in general practice settings, demonstrated that no overall benefit for counselled clients was evident at one year after initial assessment. Furthermore, a meta analysis (Balestrieri, Williams and Wilkinson, 1988) was unable to reveal any effectiveness of counselling *per se*, and one of the authors of this study pointed out in a later paper (Wilkinson, 1989) that the general extent of the impact of counselling in general practice still remained a mystery.

The enthusiasm for counselling in community psychiatric nursing is reflected in the basic RMN syllabus (1982) which emphasizes this as a skill for all psychiatric nurses. While it is obvious that listening and other social skills are vitally important in all aspects of psychiatric nursing, the term 'counselling' has become reified and this entity has been suggested as a remedy for many health problems without any controlled evidence in support. As such, counselling has become a popular and central approach on many post-registration courses (including community psychiatric nursing). Perhaps a future and crucial task for researchers in psychiatric nursing is to dismantle the components of 'counselling' and test them experimentally in a range of situations.

Another worrying aspect of the study was the finding that in all of the assessment interviews video-taped, not one interview contained any evidence that the CPNs used standard measures of change. Furthermore, in the researchers' more considerable general contact with CPNs in the study, they cannot recall observing any attempt by CPNs to audit the interventions they used by the use of reliable measures of symptom, social function or psychiatric status. Neither could the researchers find any evidence of CPNs systematically defining problems and treatment targets. While it is probably true that the same situations prevail in the practice of many other mental health professionals, this lack of definition and measurement is considered to be most important.

By contrast, problem and target specification and routine audit form a pivotal role in the training and practice or nurse behaviour therapists attending ENB Course 650. It can be argued that although nurse behaviour therapists have a more clearly defined role than CPNs, there is no reason why such training in problem and target definition should not be incorporated into CPN training courses. More than that, perhaps the routine use of measurement should be integral to pre-registration courses. Again, this lack of definition and measurement may be much in accord with the client-oriented approach. This treatment approach would also explain the observation that CPNs did not specify for the client the type of intervention they envisaged and as a consequence, there was no opportunity for any mutual negotiation or target setting. Again, these observations have major consequences for possible future attempts to incorporate more skill training into CPN courses.

One possibility that needs to be explored is whether there might be a more effective treatment approach for some of the less specific problems in primary health care which would not (like agoraphobia) be amenable to traditional specific behavioural interventions such as exposure *in vivo*. One suggestion might be that CPNs should use an extremely time-limited problem-oriented counselling approach (for example, D'Zurilla and Goldfried, 1971). This intervention has received considerable attention recently and there is good evidence that it can be helpful in the management of personal problems and crises rather than psychiatric disorder *per se* (for example, Hawton and Kirk, 1989).

CONCLUSION

In conclusion, therefore, this pilot study has demonstrated that it is possible to measure objectively the assessment process in community psychiatric nursing in primary health care settings. Furthermore, it has been demonstrated that it is possible to link these process measures with measures of clinical outcome. The complex relationship between the various measures of process and outcome indicates that single measures of process (for example, the client's perception of a particular aspect of the psychotherapy process) cannot be considered in isolation. Rather it is suggested that batteries of process and outcome measures need to be considered in general. Additionally, this work has also confirmed that video-tape can be an extremely useful and, these days, relatively inexpensive research tool.

In the authors' opinion these results have serious implications for both the practice of community psychiatric nursing with non-psychotic clients and for the training of CPNs in general. The results indicate that the training and practice of CPNs in this area of endeavour are far from being research based.

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CHAPTER NINE

Failure and dissatisfaction

Kevin Gournay and Julia Brooking

INTRODUCTION

The title of this chapter will probably make most clinicians feel depressed. We are all too painfully aware of people who fail to respond to our efforts, people who drop out of treatment after only one or two sessions, people who refuse to participate when we offer them help or perhaps people who express discontent with the services that we have offered. However, the purpose of this chapter is to look at the areas of failure and dissatisfaction and to argue that the systematic study of these phenomena can contribute greatly to an understanding of psychiatric nursing. In turn, understanding will help to refine and improve the care and treatment that CPNs deliver.

Partly because of the reasons outlined above, it is not surprising that the areas of failure and dissatisfaction have been ignored by researchers in not only psychiatric nursing but more generally in psychology and psychiatry. Outcome research usually sets out to demonstrate the efficacy of treatment, or to explain why one treatment is better than another treatment. Furthermore, in psychiatric nursing research, positive evidence has been accumulated gradually over the years in both community psychiatric nursing and in nurse behaviour therapy to support the growth of autonomy and to assert the position that psychiatric nurses can be equal to other professional colleagues (for example, Marks, 1985; Paykel and Griffith, 1983). It is not surprising, therefore, that there has been little emphasis in psychiatric nursing research on these neglected areas of failure and dissatisfaction. However, two eminent psychologists have shown very clearly in a group of studies published in the last decade (Foa and Emmelkamp, 1983) that failures are a challenge which, if studied properly, can teach us much about the shortcomings of methods employed and so eventually lead to a refining of interventions. In order to look at some aspects of failure and dissatisfaction, this chapter concentrates on the findings of two studies recently carried out which have focused on the outcome of psychiatric nursing interventions. In doing so, the authors will attempt to answer some questions which are set out below. However, before looking at the specific issues concerning failure and dissatisfaction, it is necessary to review some of the background literature and describe in general the studies on which this chapter is based.

DISSATISFACTION

There is no systematic literature on dissatisfaction with CPNs and therefore one needs to look at the satisfaction literature for any pointers to this topic. Although there are many articles on satisfaction in the literature, the authors could find only seven rigorous attempts to look at this issue with psychiatric nurses working in the community, and one of these included a study of nurse behaviour therapists. In this study (Marks, 1985) clients expressed high levels of satisfaction with nurse therapists working in primary health care settings, but dissatisfaction with nurse therapists was not mentioned. Likewise, Hunter's (1978) study of CPNs working with patients with a diagnosis of schizophrenia, emphasized a very strong and positive view of CPN visits, and dissatisfaction barely featured. However, Pollock's studies (1986, 1987), which looked at family views of a CPN service, did emphasize areas where CPNs were not perceived as helpful and thus gave some clue to where dissatisfaction with CPN services may lie. The most widely quoted study of client satisfaction with CPNs was probably that of Paykel and Griffith (1983), which demonstrated that satisfaction with clients followed up by CPNs was significantly greater than with a group of clients followed up by psychiatrists. In particular, this study showed that nurses were rated by clients as easier to talk to, kinder, more caring, displaying more interest, being more pleasant, putting patients at their ease and being better at their jobs. However, as Paykel and Griffith point out in their monograph, only 50% of the clients who were seeing the CPN identified the nurse as the main treating agent. Therefore, the rating of satisfaction must be seen in that context rather than as a rating of the CPN of a 'principal therapist'.

In a study which is most relevant to CPNs working in primary health care settings, Illing, Drinkwater, Rogerson *et al.* (1990) surveyed client views of a CPN service and reported results which indicated high levels of satisfaction. In particular, the majority of clients reported that the CPN had helped them understand their problems and that they had provided the help they wanted. In addition, a great majority of the respondents felt that if they needed help in future, they would like to be seen by a CPN. Therefore, overall, it seemed that the clients in this study were very satisfied with the service that CPNs provided, and again dissatisfaction was barely mentioned. However, it is important to point out that the results in this study were obtained from a relatively small number of clients, that is, 31 of a total of 81 clients who were seen by a CPN associated with the practice under study. It is interesting to speculate about the possible responses of the 50 clients who did not respond to the survey.

Two recent studies give some pointers to areas of dissatisfaction. Munton (1990), admittedly looking at a fairly small sample of clients, found that the negative views by clients of CPNs focused on the structure of CPN work (for example, the limitation of hours) and concern about the lack of information, either relating to the clients' situation or with regard to the publicizing of CPN services. In another study carried out in Southwark, London, Thomas, Muijen and Brooking (1991) reported on the findings of a satisfaction survey of 83 clients of a CPN service. (These 83 comprised 69% of an overall sample.) While satisfaction levels were high with regard to some aspects of the CPN intervention (for example, 82% thought the nurse spent enough time with them), nearly all of the clients stated that they had not known what a CPN was or how a CPN could help them. In their conclusion, Thomas *et al.* (1991) cautioned that clients have no standard against which to measure quality or may have low expectations of services they are to receive.

Therefore, overall the literature shows a reasonably positive view of client satisfaction with CPNs. However, there is some indication from the above studies that there may be areas of dissatisfaction which need further exploration.

FAILURE

Before the study described below was carried out, there was only one study relating to failure in psychiatric nursing. In this, Brooker and Wiggins (1983) looked at trainee nurse therapists and discussed the reasons why three of their sample of trainees failed to make significant impact on client outcome.

The issue of treatment failure is probably the most neglected area of outcome research, and there are probably four major factors which have prevented detailed systematic research in this area.

First, there does not seem to be any universally accepted definition of what actually constitutes treatment failure, and it is only in the last eight years that workers have attempted to tackle this thorny issue. Second, precise definition of failure depends on a clear and unambiguous definition of treatment targets and the use of multiple and reliable measures of outcome. Therefore, it is only since the advent of behavioural practice, with its underpinning of objective evaluation, that such methods have been used routinely. Sadly, much of everyday psychiatric nursing practice, psychiatric and clinical psychology practice is characterized by the absence of such objective specification and evaluation. Third, the behavioural revolution of the past three decades has brought such enthusiastic optimism that any discussion of failure has been obscured. Outcome research in behaviour therapy, and nurse therapy in particular, has focused on successes and emphasizes continually the difference between outcome of behavioural and non-behavioural treatments. Therefore, the failure of behaviour therapy in general and nurse therapy in particular has been ignored as a research topic (with the exception of the study by Brooker and Wiggins (1983) referred to above). Fourth, as Foa and Emmelkamp (1983) point out, journals discourage reports of negative results. Thus studies which report the ineffectiveness of a procedure are much less likely to be published.

Foa and Emmelkamp (1983) have provided a general classification of groups of failure which is a useful division for research purposes. These groups are as follows:

1. Individuals who do not accept or refuse treatment.
2. Individuals who commence treatment, but drop out before an adequate trial of treatment has been completed.
3. Individuals who do not respond to treatment.
4. Individuals who respond to treatment but who subsequently relapse.

Before the present study described below, there were only two studies which have looked at areas which are specifically of interest to nurse therapists. The first was conducted by Emmelkamp and van der Hout (1983), who examined the reasons for non-acceptance of treatment by 25 people suffering from agoraphobia who were referred for treatment in the Netherlands. The treatment package offered to subjects consisted of an amalgam of prolonged exposure *in vivo* and cognitive therapy. Sixteen of the 25 subjects completed a questionnaire which was based on 22 factors related to non-acceptance of therapy. About half of the subjects who declined treatment reported that they were already somewhat improved, and most of the subjects gave reasons for failing to accept therapy. Some of the subjects blamed external circumstances such as problems with the time of treatment. However, two of the most important findings seemed to be the subjects were frightened of treatment and, second, that their expectations of therapy did not fit with those of the therapist. Interestingly, 13 of the 16 responders agreed with the slogan 'you have to overcome fears on your own'.

Emmelkamp and van der Hout (1983) also looked at data from a small group of eight patients who had dropped out of treatment before an adequate trial was completed, and at the data of five agoraphobics who had been categorized as treatment failures. Dropouts reported that treatment made them anxious, and five of the eight patients reported that their treatment expectations were different to those of the therapist. With regard to failure, Emmelkamp and van der Hout could find no prospective differences between this group and people who succeeded.

In the other study, Fischer, Hand and Angenendt (1987) reported on 20 agoraphobic clients, who did not complete exposure treatments. These 20 clients comprised 14 refusers of treatment and six treatment dropouts. Data included follow-up to at least one year. The main significant finding of this study was that the six dropouts showed dramatic improvement in their problem after dropping out of treatment. The authors, while cautioning against generalizing from such small numbers, suggested that improvement was attributable to clients carrying out the principles of exposure learned in the limited contact with the treatment programme. The study described below was therefore the first which provided data on failure of clients receiving exposure treatment from nurse behaviour therapists. As many CPNs are now using behaviour therapy (Brooker, 1990), research in this area has wide implications for both service and education.

THE STUDIES

The questions which are posed below and which the present authors attempt to answer are inspired by two recent studies which have involved psychiatric nurses: (1) nurse therapists and exposure treatment; and (2) the community psychiatric nurse in primary health care.

Nurse therapists and exposure treatment

This study is fully described in Gournay (1989; 1991a; 1991b). In summary, 190 clients with agoraphobia were referred to the study and, of these, 132 clients met entry criteria and were offered initial assessment. Half of the clients were assigned to exposure treatment carried out their own home setting, while the other half of the clients were assigned to exposure treatment carried out in the outpatient clinic of a district general hospital psychiatric unit. Clients were assessed using multiple and reliable measures of change, including behavioural avoidance testing and independent assessment, before treatment, after treatment and at follow-up points of three months, one year and two years. A standardized package of exposure treatment was given to all clients, and treatments were carried out by a mixture of nurse behaviour therapists and clinical psychologists (treatment consisted of six sessions of two hours each, over 21 days). Interestingly, there was no differences in clients' outcome between nurse therapists and psychologists, and no significant differences in outcome were revealed between any of the eight therapists involved. Of the 132 clients, 100 patients eventually completed a trial of treatment, while 26 dropped out, and six refused treatment. A further 14 clients who were offered hospital-based treatment, refused this offer and were subsequently offered home-based treatment. Of these, 12 subsequently accepted and completed the trial of treatment in their own homes. Of the 100 clients who completed, 19 clients met *a priori* criteria for being categorized as treatment failures, and nine clients met *a priori* criteria for being deemed treatment relapsers. Thus of the 132 clients overall, 60 fell into the four groups of failures described above.

The CPN in primary health care

This was a randomized controlled trial carried out in Barnet and Parkside Health Authorities between 1988 and 1991. The study focused on the work of 11 community psychiatric nurses working in six health centres which were situated in areas which gave a variety of socioeconomic conditions. The clients recruited for the study suffered non-psychotic problems, predominantly depression, anxiety and relationship difficulties.

In all, 231 clients were referred to the study, and 177 clients were allocated to one of three conditions, that is, continuing GP care, intervention by a CPN given immediately and, in the third condition, intervention by a CPN given after a wait of 12 weeks. All of these clients were assessed with multiple reliable measures of outcome, which included psychiatric status, symptoms and social and economic functioning, as well as completing satisfaction questionnaires. The present authors were thus able to relate satisfaction to outcome as well as looking at issues connected with treatment dropout. This study is described in detail in Gournay and Brooking (1992).

QUESTIONS

As usual, research throws up more questions than answers. However, the present authors will attempt to look at some of the issues by drawing heavily on the data from the two studies mentioned above, and will attempt to integrate the findings from studies with the background literature.

How common are treatment refusers and dropouts?

Despite a vast literature in psychological treatment and behaviour therapy in particular, there is very little data on the incidence of treatment dropouts and treatment refusers. Very simply, most studies give only the briefest mention of these categories and will only report data on people who complete treatment. In the study of community psychiatric nursing in primary health care (see above), exactly 50% of clients who started treatment with a community psychiatric nurse dropped out. In the same study, of the 23 clients who had been on a waiting list for 12 weeks, 17 clients accepted the offer of treatment and six refused this offer. Of the 17 clients who accepted the offer, nine subsequently dropped out, leaving eight clients completing an adequate trial of treatment. Thus, only one third of the original group actually saw treatment through to the end. This group of clients suffered general psychological distress and complained largely of generalized anxiety and depression. They were not offered a specific, specialized form of psychological intervention, rather counselling using a client-centred approach. By contrast, in the study of nurse therapists (Gournay, 1991a and 1991b; see above), of 132 clients offered behaviour therapy for their agoraphobia, 26 clients dropped out of treatment, six completely refused the offer of treatment and a further 14 of the remaining 100 accepted treatment only when the treatment offer was modified to accommodate the client's wishes to be seen at home.

The present authors would argue that all outcome literature should give details of the number of clients who refuse and who drop out so that the overall effectiveness of intervention can be seen in a wider context. They illustrate the point, in the study of nurse therapists referred to above, of the 100 clients who completed a trial of treatment, 19 were deemed to be treatment failures and nine were deemed to be treatment relapsers. Thus, 72 of the 100 clients were seen as treatment successes. Although this 72% figure is impressive, if one considers the complete data set and calculates a success figure based on the total sample, including dropouts and refusers, this 72% success falls to 55.6%.

Overall, therefore, the data from the present authors' two studies show that collecting information on dropout and refusal rates is an essential part of evaluating outcomes, and treatment response should be shown in the wider context.

What is the outcome of people who drop out or refuse treatment?

Again, there is very little in the way of systematic study in psychiatry and psychology generally regarding the fate of treatment dropouts and refusers. In the behaviour therapy literature there are only two systematic studies of failure (referred to above). In one of those studies (Fischer, Hand and Angenendt, 1987), the six dropouts in that study showed dramatic improvement on various measures in their problem at follow-up. However, nothing could be found in the community psychiatric nursing literature of any attempt to follow up treatment refusers or dropouts and monitor their symptom status.

In the study of nurse therapists, one of the present authors was able to follow up 13 of the 26 clients who dropped out. Table 9.1 shows that on the agoraphobic sub-scale score, which is a central measure of change, clients were improved significantly at follow-up one year after initial assessment.

This finding is in accord with Fischer, Hand and Angenendt's (1987) study and the present authors would argue, as did these authors, that continuing improvement after dropout from treatment may have been because clients continue to use principles they had learned in therapy. It is worth noting that agoraphobia has a very low rate of spontaneous remission (Marks, 1987) and therefore improvement is unlikely to have been attributable to this factor. However, in this present study of community psychiatric nurses, data (see Table 9.2) showed a similar picture, with continuing improvement in clients

Table 9.1 Pre-treatment and follow-up scores (agoraphobic sub-scale) for treatment failures and treatment drop-outs

		Agoraphobic sub-scale score	
Dropouts n = 13 (of 26 in all)	Pre-treatment	29.62 (sd 8.00)	t = 5.329 df 24
	Follow-up rating point	18.08 (sd 10.82)	p<0.001
Treatment failures n = 14 (of 19 in all)	Immediately post-treatment	20.17 (sd 6.20)	t = 0.616 df 34
	Follow-up rating point	19.33 (sd 9.71)	ns

Note: Second follow-up ratings after further professional help for three of the failure subjects were not used.

sd = standard deviation
ns = not significant
df = degrees of freedom
t = value for t-test

Table 9.2 Comparison of change scores (between 0 and 24 weeks) for groups of clients who dropped out and those who completed or continued CPN intervention

	CPN clients who	
Change in score from initial assessment to six-month follow-up	*continued or completed intervention (n = 33)*	*dropped out (n = 19)*
SPI	10.06	9.94
BDI	6.09	7.42
Y1	3.65	2.00
Y2	2.25	3.71
GHQ (Likert)	4.09	4.77
Life disruption rating	8.33	5.09

SPI = Standardized psychiatric interview score
BDI = Beck depression inventory
Y1 = State anxiety
Y2 = Trait anxiety
GHQ = General health questionnaire

who dropped out of CPN intervention, although this client population suffered from the less definable neurotic conditions which are known to be much more liable to sponataneous improvement (Mann, Jenkins and Belsey, 1981).

In this study, where CPNs administered client-orientated counselling as the main intervention, it seems unlikely that there was any carry-over effect of the intervention such as in the study with nurse therapists. However, one other explanation for the continuing improvement is that the clients in the CPN study were referred at the time of maximum severity of their difficulty and the intervention period coincided with a natural recovery process. This phenomenon has been described before in the literature (for example, Freeman and Button, 1984).

These two studies are isolated and it would therefore seem important to make routine follow-up of treatment dropouts and refusers a priority in outcome evaluations in community psychiatric nursing.

Why do people drop out or refuse treatment?

In the study of nurse therapists, a questionnaire was used (see Figure 9.1) which showed some interesting responses (see Table 9.3). The findings suggest very strongly that at least as far as the behavioural treatment of agoraphobia is concerned, CPNs need to change the way in which they assess clients

Table 9.3 Number of clients responding affirmatively to questionnaire regarding dropout from treatment

Improved since treatment/no longer troubled by phobia	4
Appointments inconvenient	4
Treatment not what was wanted	6
Medication more helpful	4
Frightened of treatment	8
Therapist did not understand	9
Did not like the therapist	2
Treatment presents difficulty for family	3
You have to overcome fears on your own	6
I will get better in time	4
Treatment will make me worse	4

Note: Total number of clients responding = 13 (of 26 in total)

Name:

Please read the statements on the left of the page and tick the response which best describes your feeling about the statement

	Not applicable	Somewhat applicable	Is very much applicable
I am improved since my last appointment			
I am no longer troubled by my fears and phobias			
The appointments were at an inconvenient time			
The treatment was not what I wanted			
Medication would be more helpful			
I was frightened of treatment			
The therapist did not understand my problem			
I did not like the therapist			
I thought that treatment would present difficulties for my family			
I was persuaded against my better judgement to seek treatment			
'You have to overcome your fears on your own'			
I will get better in time			
Treatment will make me worse			

Figure 9.1 Questionnaire given to clients who dropped out or refused treatment.

and prepare them for treatment. The fact that nine out of 13 clients felt that the therapist did not understand, and that eight of the clients were frightened of treatment, speaks for itself. These data would suggest that patients need more opportunity to feed back their feelings about treatment to the therapist in the assessment period. Furthermore, there seems to be a clear need for more preparation for treatment using techniques such as pre-therapy groups or the use of videos of treatment. The other important area defined by clients in this study was of discongruent treatment expectation, with six of the 13 clients wanting another treatment from that offered. This finding suggests that treatment expectancy should be measured routinely in the assessment period. There is currently one treatment expectancy battery which is used in contemporary practice in the United Kingdom (Caine, Smail, Wijesingheob *et al.* 1982), but some research with this battery in agoraphobic clients (Gournay, 1983, 1985) and psychiatric nurses (Gournay, 1986) indicates that one needs to be cautious about using this particular assessment method as the sole measure of expectancy.

In the present authors' study with non-psychotic clients in primary health care settings, reasons for dropping out could be tracked down by the administration of the counselling appraisal questionnaire (CAQ). An attempt was made to follow up all clients regardless of whether they had continued with the psychiatric nursing intervention or whether they had dropped out. While it was clear that clients who continued with the CPN were very satisfied with some of the counselling skills exhibited, it was clear that with those clients who dropped out, there was a great deal of dissatisfaction with the specific intervention received. It does seem likely that as the public are becoming more informed about the range of psychiatric treatment options, they are becoming more discriminating about treatments offered to them and are increasingly aware of the newer and more active cognitive behavioural treatments available. It is not surprising, therefore, that some clients rejected the offer of an intervention (that is, counselling), which only has a tenuous basis in outcome research. There were other aspects of care that also seemed to be causative of dropout. In this group of clients, the other key areas were that these clients perceived there was not enough information given about their problem and that they were not involved by the CPN in the goals of treatment.

As with the study of nurse therapists, there seems to be a clear need for both a refining of assessment skills and for the CPN to look in a more objective way at the area of clients' expectancy, that is, what treatment the clients feel will work best for them.

Who are the failures and how can they be identified?

In the nurse therapy study, the present authors looked at pre-treatment scores of clients who were treatment successes versus all of the failure groups

Table 9.4 Comparison of some pre-treatment scores of treatment responders and failures

	Phobic problem severity	*Agoraphobic sub-scale score*	*Wakefield inventory*	*Leeds inventory*	*Symptom check list*	*Marital questionnaire (subject)*	*Mean behavioural avoidance test scores*
Failure groups combined (n=51*)	5.86 (1.41) n=51	30.71 (7.20) n=51	23.23 (6.14) n=13	12.86 (3.59) n=37	24.12 (7.58) n=51	27.29 (15.71) n=24	2.07 (1.19) n=48
Treatment responders (n=81*)	5.80 (1.21) n=81	28.43 (6.99) n=81	23.59 (5.27) n=27	11.71 (4.19) n=51	23.20 (6.71) n=81	18.39 (12.98) n=38	2.22 (1.31) n=80
t	0.512 df 130	0.940 df 130	0.193 df 38	1.358 df 86	0.648 df 130	2.422 df 60	1.011 df 126
p**	ns	ns	ns	ns	ns	<0.05	ns

( ) standard deviation
* Subjects categorized as relapsers are included in the responder group
** Value for two-tailed test
ns = not significant
df = degrees of freedom
t = value for t-test

combined. On psychiatric symptom scores, very little difference could be found between the two groups of clients (see Table 9.4). However, it was found that, of the married clients, failure was associated with higher levels of marital dissatisfaction. By contrast, in the present CPN study it was found that treatment dropouts had significantly higher standardized psychiatric interview scores and tended to be slightly more depressed. Having said that, the data from both studies confirmed that it is very difficult to identify prospectively on the basis of various measures of change, any profile which is predictive of treatment dropout or treatment failure.

Because CPNs are a relatively scarce resource, it seems very important to identify which groups of clients will benefit most from their intervention. At one level it is important to identify conditions which are known to have low rates of spontaneous remission. Therefore, disorders like general anxiety and depression, which have a high rate of spontaneous remission, are not a good target for a CPN's endeavours as the CPN could well find he or she is treating patients who will get better anyway. At another level it is important to screen patients thoroughly and to look carefully at areas of both treatment expectancy and more general motivation. These screening skills are clearly difficult to acquire and there remains the problem of a lack of good clear prognostic indicators. However, the present authors would see training in screening for suitability with all the associated background knowledge as being an essential part of the CPN's repertoire. Training in screening is not a simple matter and may involve many hours of role play and video feedback before the CPN is ready to venture into the clinical area. This therefore asks the question of current CPN courses as to whether this, and other assessment and treatment skills, can be taught within current curricula.

What do satisfaction ratings tell us?

In all of the studies of satisfaction that were reviewed (see above) there was no attempt to link satisfaction to outcome. However, in the study of community psychiatric nurses in primary health care, the present authors looked specifically at this issue. As Table 9.5 shows, there were clear differences in the satisfaction ratings of clients who dropped out of intervention with the CPN, compared with those who completed.

However, it was surprising to find that when one computed correlation coefficients between satisfaction levels and clients' outcomes on the various symptom and social functioning measures, these coefficients were of a very low order. Put simply, there was no relationship between how well clients did in treatment and how satisfied they were with both the CPN intervention and the overall service that was provided.

Thus the present writers found some clients who were very satisfied who did not change over the intervention or even got worse (according to the

Table 9.5 Counselling appraisal questionnaire (evaluation of intervention): individual items

	Mean score for	
	CPN continuer/ completer (n=33)	*CPN dropout (n=20)*
CPN - easy to talk to	1.55	3.84
CPN - make you relaxed	1.65	4.00
CPN - involve you in goals of treatment	3.33	5.26
CPN - you could confide in	1.77	3.84
CPN - help you manage your problem	2.45	5.05
CPN - show an understanding of your needs	2.00	3.89
CPN - good at counselling job	2.10	4.15
CPN - give you enough time	1.70	3.52
CPN - satisfied with ability	2.32	3.94
CPN - respond to your needs	2.06	4.10
CPN - display good listening skills	1.35	3.10
CPN - give you adequate information about your problem	2.70	4.94

1 = most satisfied
7 = least satisfied

measures), while at the other extreme there were some clients who were very dissatisfied with their intervention but who showed highly signficant improvement (on all the measures of change).

Therefore, satisfaction ratings may reveal a great deal about the client's perception of the intervention received, but give little indication of how well the client will do with treatment, as measured by the various indices of change. It is therefore suggested that one needs to look at outcome from multiple perspectives, using not only satisfaction and clinical measures, but also considering whether there is objective economic improvement. This third dimension is an important (if somewhat overlooked) aspect of outcome, which was studied fully (Gournay and Brooking, 1992) but is not reported here.

CONCLUSIONS

In this chapter it has been argued that studying failure and dissatisfaction can provide some very important information about assessment and treatment. Apart from these studies there is very little research evidence concerning failure and dissatisfaction in psychiatric nursing in the community. The questions raised here are but preliminary ones. It is felt that much more enquiry needs to be launched to discover why interventions do not work and what can be done to remedy this, either by refining the treatment method or by changing or modifying the skills of the clinician.

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CHAPTER TEN

Patients' and CPNs' views of a CPN service

Ray Field

INTRODUCTION

This study sought patients' views of the service they received from a community psychiatric nursing (CPN) service. Similarly, it also sought the views of the CPNs who provided the services, regarding their own work practices. The importance of the need to assess the views of patients regarding health services was stressed as a priority by the Griffiths report (DHSS, 1983) in its call for more systematic research of consumers' demands. The district CPN service in the present study had followed the national trend of expansion and had seen the number of CPNs increase from four to 35 in the ten years up to 1990. Simmons and Brooker (1986), commenting on this national expansion of CPN services, reported that it had allowed 'a certain amount of *ad hoc* development'. The days of rapid expansion would appear to be nearing an end and a new era of evaluation of health services beginning.

Evaluation involves the use of research methods for the purpose of judging the extent to which a therapeutic programme accomplishes its goals (Milne, 1987). Weiss (cited in Milne, 1987) has noted that this involves: identifying and defining the goals of the service; measuring the amount of change that occurs and attempting to measure which change (if any) is attributable to the service. Suchman (1967) has added that evaluation research should attempt to differentiate between change that is attributable to the service or the other factors in the patient's life. Often the 'amount of change' is examined in terms of its cost-effectiveness and value for money to the purchaser of the service. In other words, are the resources and energy invested in the service benefitting the patient or not, and by how much? Was the programme goal achieved?

The philosophy of a 'market-forces' led health services has been incorporated into both the Griffiths report (DHSS, 1983) the White Paper

Caring for People (DoH, 1989a) and *Working for Patients* (DoH, 1989b). The newly created Trust hospitals and 'own budget holding' GPs may require CPN services to justify their effectiveness before they purchase (or not) the skills of their service. Justification for a service on the grounds that it has always been there and is a community service will not suffice in the future. The *Care Programme Approach* (DoH, 1990) may require CPNs to refocus their work towards people with long-term mental illnesses (White and Brooker, 1990), rather than acute primary care, as the central feature. It was against this national background of increased emphasis of the sovereignty of the patient in health care recently reiterated in *The Patients Charter* (DoH, 1991) that the present study was undertaken.

This author would argue the primacy of patients' perceptions from two perspectives, political and professional. Politically, the relevance of the patient's perspective is valuable as it represents the view of a powerless, often stigmatized group, at the mercy of an economic, cultural system which sometimes operates without much regard for their views and to whom the CPN is ultimately responsible. Professionally, the views of patients highlight the perceived aims and objectives of a profession by their assessment of the organization's performance or ability to meet their needs and by expressing a view as to the appropriateness of the agency's objectives. A profession that fails to take account of its consumer – the patient – will become introspective and may lose touch with those it seeks to serve to the point of irrelevancy.

Consumer satisfaction

The measurement of patients' satisfaction with a service is a complex area of study which should be considered in relation to patients' expectations and their perceived social and political power, together with the methodological assumptions when collecting consumer data. Lebow (1982) believed consumer satisfaction assesses: 'the extent to which treatment gratifies the wants, wishes and desires of clients for service'.

Lebow (1982) makes the point that satisfaction is a relative term and is linked to the consumers' 'desires' and 'wishes', and the extent to which these are met by the service. Clients' awareness of satisfaction and their hopes for, and grievances about, the service they have received will depend on the frame of reference in which they are conceived. Some people, over a prolonged period, may accept as 'their lot' conditions and standards of service which others would find intolerable. Creer (1975) noted that relatives of those with schizophrenia under-reported their 'subjective burden'. A further difficulty in studying expectation of service and satisfaction is that psychiatric patients may not be willing 'consumers' and may be designated by others as being in need of help; consequently, patient expectations may not coincide with those of the workers, leading to poor satisfaction rating with the service.

The majority of the literature generally agrees that the extent of the congruence between a client's expectations and those of the service/agency or worker, is an important determinant of subsequent client satisfaction. McKay, Goldberg and Fruin (1973) found that 80% of those whose expectations of a service were fulfilled were satisfied, but that 50% of those whose expectations were not fulfilled were also satisfied. Overall and Aronson (cited in Rees and Rees, 1982), suggested that the measure of satisfaction or dissatisfaction particularly among patients in receipt of mental health services can be minimal, inappropriate or unrealistic. Thus, the overall conclusion may be that patients' expressions of relative satisfaction may be a reflection of their level of expectations of a service, rather than the actual service itself (Feldman, 1966, cited in Pope, 1978).

Further problems arise in the measurement of patient satisfaction in that results may owe as much to the methods of data collection as to the actual views of patients. Two sources of sampling bias may threaten the validity of consumer research: by the method of selecting the patients and by the skew of the patients responding. Godin, Pearce and Wilson's paper (1987) is an example where only 43% of the sample of patients surveyed regarding the CPN service responded to a postal questionnaire. Further problems exist with the common finding of generally high rates of satisfaction reported in studies of consumer satisfaction. Berger (cited in Lambert, Christensen and DeJulio, 1983), in a review of consumer satisfaction studies, concluded that on average 85% of respondents were satisfied with the service they received. This lead to his hypothesis that 85% is a general baseline level of consumer satisfaction.

Community psychiatric nursing

The history and development of community psychiatric nursing will not be discussed fully here and the interested reader is directed to excellent reviews such as Sladden (1979) and Pollock (1989). An increase in the number of CPNs nationally has continued to date, with the most recent survey (White, 1990) having estimated about 5000 CPNs in post in Britain. The rapid increase and *ad hoc* development of CPN services has been influenced by several possible explanations. These include the possibility that CPNs reduce the in-patient population by preventing admission and the belief that CPNs are cheaper and more cost-effective than alternative service provision.

A review of the economic value of mental health care by the Centre for Health Economics Consortium (O'Donnell, Maynard and Wright, 1988), concluded that community care may not necessarily be the cheaper option. Whereas the rationale which contends that the CPN is best placed to prevent admission to the institutional care, the assumption is that the CPN can apply 'expert' treatment skills at the early stage of psychological disturbance in the community, thereby ameliorating the need for in-patient admission. However, several authors have questioned the role and function of CPNs at primary health care level and the ideology underpinning their practice. Sladden (1979) reaffirmed the view that CPN practice was based on a vague, haphazard application of intuitive insights and rooted in a medical frame of reference. Skidmore (1986) noted that of the CPNs' caseloads he studied, only '10% of all referrals were termed 'new', in that they have no previous psychiatric involvement'. He further noted that CPNs adopted institutional methods of care which centred only on the patient, with little evidence of the families being involved in the care of their relative. Wooff, Goldberg and Fryers's (1986) analysis of case register data concluded that CPN services in Salford were treating the 'morbidity found at primary care level, rather than reducing the demands made on the traditional service'. Following on from their previous research, Wooff *et al.* (1988a; 1988b) compared the work of CPNs and mental health social workers and concluded that CPNs' work with the 'long-term patients' with schizophrenia was based on a very medical model of care, without evidence of interventions to ameliorate the social adjustment of long-term patients and their carers. Burns, Paykel, Ezekiel, *et al.* (1991) in a follow-up study of an original cohort of neurotic patients (Paykel and Griffith, 1983) concluded that both CPN and psychiatrist care appeared to be as effective as each other when measured using clinical symptom severity and social adjustment indices. Pollock's (1989) study suggested than CPNs were 'juggling resources' and making an under-resourced system work, while at the same time creating an illusion of helping the client, but not always actually helping, which the literature suggests is poorly differentiated by clients. She considered that the CPNs placed their emphasis on 'developing relationships' which she regarded as a shift away from the medical model reported by Sladden (1979) in her study.

Consumer satisfaction and CPN services

Pollock's (1989) study reported that carers found CPNs helpful, friendly, trusting and caring. Carers who reported dissatisfaction with the service they had received mentioned that busy CPNs and male carers compared with female carers were less helpful. Munton's (1990) pilot study repeated the common finding of Hunter (1978), and Paykel and Griffith (1983) that the majority of clients are satisfied with their CPN, and particularly valued the 'interpersonal relationship with the CPN'. Illing, Drinkwater, Rogerson, *et al.* (1990) reported generally high levels of patient satisfaction with the service offered by the Newcastle CPN service. Three-quarters of the patients reported they did not know what a CPN did. The majority were pleased with the venue of the CPN service (in most cases this was the GP's surgery), which is not in keeping with the most frequently reported practice of domiciliary visits by CPNs (McFadyen, 1985; Skidmore, 1986).

The literature highlighted major areas of interest pertinent to the study of CPNs: the need to relate patients' expectations to outcomes, reported high levels of patient satisfaction, use of a medical framework and a move away from work with people with long-term mental illnesses. This lead to the establishment of a set of aims for the study.

Aims of the study

1. To find out the views of clients and CPNs about the community psychiatric nursing service. Three major components of the community psychiatric nursing service - structure, process and outcome (Donabedian, 1966) - were to be examined.
2. To examine areas of agreement or disagreement between the CPNs' views and those of their patients.
3. To identify some ways in which the service to clients may be improved.

THE STUDY

The present study was conducted in a health authority on the south coast of England with a catchment population of 178 000. The health authority's elderly population (10.5% of the total population) was considerably larger in proportion to that of the general population for England and Wales (6.6%) (Joyce, 1991). The mental health services were divided into two main sectors, namely, 'adult psychiatry' concerned with the mental health of people up to and including those aged 65 years of age, and a separate 'elderly mentally ill' (EMI) sector concerned with those over the age of 65 years. The service was organized to be coterminous with the overall structure of 'sectors' of the district psychiatric services. The CPN service comprised of eight CPNs in an 'acute' (under-65 team), and seven CPNs in an 'EMI' team (over-65 team), together with a behaviour nurse therapist. All CPNs accepted referrals from GPs, psychiatrists, health visitors, district nurses, social workers or self-referrals.

METHODOLOGY

Research design

The CPNs in the service surveyed in this study were based in a hospital and primary health care team settings. It was therefore possible to avoid sampling just a 'hospital' or a 'primary' team in one geographic setting, a point of discussion as outlined in the literature (Skidmore, 1986). Because of the lack of patient information available regarding the CPN service, this research was in the nature of an exploratory descriptive survey, using a longitudinal design. A pilot study of 15 patients referred to the CPN service for the first time was undertaken (these patients were not later included in the main study). The pilot study lead to a revision of the wording and sequence of several of the questions in the interview schedule which was devised as the research instrument. The patients in the main study were interviewed at the beginning of their contact with the CPN and six months later. Similarly, the views of the patients' respective CPNs were examined for the congruence of their perspective of the helping relationship.

The sample

Examination and analysis of the caseload of the CPN service over a one-year period indicated that certain 'sectors' had a greater number of patients referred than others. To make the sample more representative, a proportional stratified random sampling was selected to ensure representativeness of significant subgroups of the patient population. The sub-strata of patients were those over the age of 65 years referred to the EMI teams North and South, and patients from the three acute sector teams and the behaviour nurse therapist. The overall size of the sample was first determined at a practicable level of 30 patients and then broken down into sector sub-sample sizes proportional to the service as a whole. A consecutive sample from each stratum was selected to ensure minimum time lapse between the CPNs' first interview with the patient and the author's first research interview. This ensured that all patients' views were being sampled after their first CPN visit. The new referrals were allocated to their appropriate sub-sample until the sample number was achieved. The only criteria for exclusion from the study was a previous experience of the CPN service, or incapacity to participate in an interview. The latter decision was made by the author on meeting the prospective patient at the time of first interview.

Analysis

The survey's data was organized using frequency and contingency tables and analysed using non-parametric statistical tests for independent groups, to test for significant differences between observed frequencies within the data.

SELECTED FINDINGS

The characteristics of the patient sample ($n=30$) were comparable to those usually associated with psychologically distressed groups within the general population. The largest subgroup consisted of married women; they and the number of divorced, separated, widowed and single people were over-represented (compared to the general population) and would be expected in a typical population of psychiatric clients (Brown and Harris, 1978). The elderly were also represented in a greater ratio than the normal population, but proportional to the study catchment area. The community psychiatric nurses (n=11) were evenly matched in terms of sex, age and had varying levels of experience, and only three CPNs (27%) held the CPN Cert.

Initial interviews

The results indicated that 21 (70%) of the patients, before being referred to the CPN service, had had some contact with the general mental health, statutory and/or voluntary services, albeit, for some, a long time in the past. The majority of patients (57%) were referred to the service by their GP.

The results indicated that the majority of patients (60%) regarded the explanation given to them by the referer regarding their referral to the CPN service as inadequate, or lacking in any real information. Just under half (47%) of the sample expressed negative views about being referred to the service. There was no significant relationship between those patients who said they were poorly informed regarding referral and the expression of dissatisfaction at being referred. Though the small group of patients (20%) who were pleased at being referred all reported being given an enthusiastic and personal referral. The CPNs were asked to estimate their patients' reactions to being referred to the service, and in two-thirds of cases (67%) they regarded their patient as being 'pleased' or 'relieved'. The CPNs' estimation of patients' feelings on referral was compared to those actually given by the patients. The CPNs were poor at judging the patients' feelings about being referred to the service, being correct in only 30% of cases. If the patients expressed positive emotions, these were mainly in terms of being relieved that the CPN was not 'as bad as they thought', because in general they were anxious about 'seeing someone psychiatric', if indeed they knew to whom they had been referred.

A large majority (83%) of the patients were seen in their own home by the CPN, and nearly three-quarters (73%) were satisfied with the CPN's arrangements for the visit. Exactly a third of the patients made unfavourable comments about the CPN's arrangement for the visit such as; the practice of 'dropping in' without an appointment, or the CPN's poor attitude or negative comments. Almost all of the patients (90%) were satisfied with the visit frequency proposed by the CPN.

The results indicated that the most common problems reported by the patients to the CPN were 'psychological and interpersonal', with 'depression' (37%), anxiety (13%) and behavioural problems (13%) being slightly more common than physical or social problems. The results indicated that both patients and CPNs did not agree in two-thirds of cases (67%) as to the nature of the patient's problem. The CPNs tended to use more medical diagnostic terms in their problem formulation than their patient. The CPNs were most unlikely to formulate the patients' problems in social terms, unlike the patient. The CPNs 'labelled' some problems according to thier aetiology, while patients were more likely to describe their problems in terms of their effect on daily living.

The majority of the patients (86%) were motivated towards solving their problems, and regarded the CPN as having been already 'helpful' after one visit in 87% of the cases, but only one-third were optimistic that the CPN was likely to help them more. The CPNs believed their patients to be well motivated (70%) and expected to be able to help in nearly two-thirds of cases (60%). Comparison of the CPN's estimate of the patient's motivation with the patient's own reports indicated that the CPNs were more optimistic than the patient in their belief that they could help.

Most (90%) of the patients rated their CPN highly on personal helping qualities, such as being: 'understanding', 'easy to talk to', 'warm', 'friendly' and 'relaxed'. In the majority of cases (83%) the CPNs believed they had achieved high levels of rapport with their patient, and in the remaining cases attributed poor rapport to the nature of the patient's problem such as: 'confusion', 'paranoia'. A positive significant relationship was found between the CPNs' liking for the 'type' of patient and liking of the actual patient (Fisher exact test, $p=0.013$). The reasons given for liking the type of patient included the feeling of 'being able to do something' for the patient, or 'having an interest' in that type of work or patient. The types of patients most disliked by the CPNs were those who were either 'hypochondriacal' or 'couldn't cope' or with whom the CPN felt he or she was 'going to get nowhere'. This may indicate that patients who did not fit a medical model of illness, or a 'sick role' (Parsons, 1966), and those who do not demonstrate a clear wish to get well or who will not co-operate were disliked by the CPNs.

Overall, to the preclude the second round of interviews was that patients were optimistic, liked their CPNs and expected them to be able to help with their problem, yet there appeared to be only partial agreement about the nature of the problem. The question remains as to whether or not this divergence would converge with time and whether or not the patients' expectations would be met. The latter questions are examined in the next section.

Interviews with patients and CPNs six months later

Organization/structure. After six months, all but one of the patients ($n=29$) were available to be interviewed for a second time. The majority of patients

(86%) were pleased to be visited at home and were satisfied with the number of visits they received over the six-month period. Three patients were unhappy with the CPN 'dropping in' or not pre-arranging a visit. A further issue of dissatisfaction (60%) was the presence of a student nurse accompanying the CPN, particularly if the CPN arrived unannounced with the student.

Process

Patients' problems. The term 'depression' was given in the first interview by over one-third (37%) of all patients as being their main problem. In the follow-up it continued to be reported as the most common problem by almost all (35%) of the same one-third of patients who gave it as their main problem in the first interview. The second largest category, of just under a quarter (24%), were those patients who said they had no further problem. There was low level of agreement between the CPNs' and patients' views regarding the patients' problems in almost one-third (31%) of relationships. The CPNs still tended to focus on 'diagnostic' formulations of problems such as 'reactive depression' and 'paranoia', while the patients seemed more concerned with dealing with their problems. At the end of six months, those patients who had rated their CPN positively on their ability to establish rapport (friendly, relaxed, warm, understanding) continued for the most part to do so, while a quarter (24%) of the patients continued to give a more qualified response.

The helping process. The patients and CPNs had different perspectives as to what constituted help and, consequently, the actions required to bring about change. In the majority of cases (68%) the patients said they were feeling better despite the nature of their remaining problem being the same. The remainder (32%) were divided equally between being worse or being the same. That their problem remained, but was less severe, was explained by patients to be because of either:

1. Help received from the CPN, which accounted for only a quarter (26%) of clients reporting feeling better. The three main reasons were:
   (a) The helpful features of the relationship and the 'emotional relief' gained from being in contact with a warm and friendly person who could offer 'plenty of time to talk'.
   (b) The various professional roles of the CPN such as: their ability to liaise with other services and 'get things done'; being an 'outsider' to the problem.
   (c) Active interventions (doing things) by the CPNs were appreciated.

2. Help received other than from the CPN, and/or because of effort on their own part, accounted for over three-quarters of cases (84%) of those who regarded their problem as being improved. They cited such things as new relationships, a new job, medication, medical care and effort on their own part as being the main reasons. If patients considered their problem to be 'worse' or the 'same' they tended to regard this as due to the inherent nature of the problem, or to the deterioration of a relationship with their family and/or friends. The impression gained from the patients was that they had a wider social perspective than the CPN as to what their problems were and, similarly, a larger social perspective as to why their problems might not be improved.

The CPNs' main objectives for their visits were noted at initial contact to be the assessment of their patient's problem. Over the six-month period the CPNs altered their initial objective of assessment to 'ventilation of feelings' and 'to monitor' (behaviour, mood, medication) as being the most frequently mentioned objectives.

The interventions, or helping, carried out by CPNs were related to their own explanation of the nature of the problem which, in the majority of cases, was intrapersonal and, second, to their judgement of the correct technique to be used for the type of problem. In two-thirds of cases (65%) CPNs reported using 'counselling' in keeping with their belief that the problem was intrapersonal. In a small number of cases (13%), their interventions were primarily to help 'carers to cope' by giving 'support' to the carer. These cases were mainly patients over the age of 65 years.

Overall, the most frequent intervention was counselling which, as noted above, partly involved helping the patient to 'ventilate their feelings'. The CPNs reported in half of the cases (55%) that positive psychological change had occurred in their patients, the most common being a 'changed attitude' to their problem and, in a small number of cases, 'improved self-esteem' was regarded as the main improvement. A third of patients (34%) were regarded as being 'unco-operative' with the CPNs' goals and interventions. The patients' lack of co-operation, according to the CPNs, was equally divided between the following reasons:

1. Not accepting the CPN's explanation for the cause of the problem.
2. Having opposite and conflicting views as to what the CPN should be doing.
3. Being unable to respond due to mental illness.

It appeared that CPNs required certain responses from patients, or their families, for change to occur: (1) to be able to express their feelings and be willing to change as suggested by the CPN, and (2) to accept the aetiology of their problem as being psychodynamic, that is, accept the CPN's interpretation of the problem. Similarly, if the CPN regarded the patient as 'not being ill' then intervention was not warranted. The CPN adopted an 'expert orientation' (Whittington, 1977) which required that the patient accept the CPN's definition of the problem, and further required that the patient understand the psychodynamic nature of their problem for resolution to occur.

Outcome

Luker (1981) described outcome as the 'end result of the care in terms of its effect upon the client'. The outcome in the present study was evaluated from different perspectives. Regarding their initial problem, most patients (68%) felt it had improved, but had not disappeared. The CPNs were not as positive, rating the patients' problems to be better in only half of the cases (57%). The CPNs regarded the patients as having gained 'insight' and having changed their 'attitude to the problem' as the main reasons for the problem resolution. The patients believed their problems to be better because of either actions on their part and/or changes in their life. The patients were more satisfied than CPNs with the outcome. This may be due partly to the study's finding that there was poor agreement as to the nature of the problem and what constituted improvement. The patients reported less significant changes as constituting success and believed small changes in their lives had significance for their problems. Thus, the CPNs held more ambitious criteria for success for their clients. The CPNs believed the problem to be, for the most part, due to characteristics of the patient. Thus, the cause of the problem was seen as being rooted in the patient, rather than in the environment.

What was seen as being more desirable was not so much changing the situation of the patient, but helping the patient to think or to believe differently about the problem.

A further criteria of outcome in the present study was for the patients to report whether or not they would return to the same CPN for help and, second, if they would recommend their CPN to another person with similar problems. On both questions the majority (66% and 59%, respectively) answered positively. The CPNs were less optimistic, believing that only half (50%) of their patients would want to see them again.

Patients' expectations. Patients' satisfaction or dissatisfaction with outcome was compared to their initial expectations of help from the CPN. This chapter has already noted patients' low expectations of the CPN being able to affect their problem, for better or worse. This was due partly to the patients' understanding of the nature of the problem as being ongoing and therefore not within the ability of the CPN to affect it either way. The number of patients who believed the CPN was likely to help with their problem increased from under half (44%) initially to over two-thirds (67%) six months later. A significant relationship was found to exist (Fisher exact test, $p=0.007$) between those patients who expected the CPN to be able to help with their problems and their reporting of their problem as being better six months later. Initially, the majority of patients had been cautious about the CPN's ability to help, and several were quite certain that the CPN would not help them, and they retained their original belief.

CPNs' expectations. At initial interview the CPNs expected to be able to help the patient with their problem in over two-thirds of cases (70%). Six months later the CPN regarded the patient's problem as improved in over half of the same cases (58%). It must be noted that not all CPNs believed they were instrumental in the problem resolution. In six out of ten cases where the CPN originally expected a poor outcome, problems were rated six months later to be better. This suggests that, when reassessed, the CPN's initial predictions, be they pessimistic or optimistic, were rated differently six months later.

Life circumstances. A further measure of outcome was for the patients to achieve 'real' gain (Eckert *et al.*, cited in Egan, 1990), that is, improvement enough to produce an effect in everyday functioning. In the present study nearly half (48%) rated their life circumstances (general health, housing, employment, social life, personal relationships) as being the same, over a quarter thought these circumstances to have worsened (28%), and just under a quarter that they had improved (24%). When the patients' views of their life circumstances were compared with those of their CPNs, the nurses believed there to be more improvement than the patient. When those few patients (24%) who reported improvement in their life circumstances and improvement in their initial reported problem were examined, all shared some common characteristics. They all: (1) expected their problem to be better, and evaluated it as being better, six months later; (2) said they achieved good rapport with their CPN and regarded the CPN as being helpful; (3) while several differed in their emphasis regarding helpful features of the CPN 'role', all mentioned the nurse being active and 'pushing' as helpful.

DISCUSSION AND CONCLUSIONS

Several themes emerged from these data which provided some implications for present and future CPN practice. Overall, the majority of the patients rated their CPN's personal qualities highly and continued to rate the CPN's ability to establish a warm and understanding rapport six months later. However, there was a low level of agreement between the parties as to the nature of the problem and methods of resolving it.

The evidence of this study was that the CPNs were unaware of how 'strange' and unknown the CPN service might be to a patient referred to the service. Patients should, therefore, be better informed by the referrer regarding the service to which they are being referred. This is a reaffirmation of similar findings and suggestions by other consumer surveys of CPN services (Munton, 1990; Simmons, 1990). While no effect of a significant size could be found between patients' lack of information and their reported outcome, some of the strongest criticism offered by patients in the study was regarding the discovery that their visitor was a *psychiatric* nurse.

The occasion of the first meeting between CPN and patient set the tone for the rest of the relationship and should have been the time when introductions were made, and expectations and overall purpose for the relationship were discussed (Sundeen, Stuart, Rankin *et al.* 1985). It was the time when the effort of the worker should attempt an understanding the patient's world. The CPNs in the present study operated, for the most part, from within their own view of the world. They were unaware of their patients' feelings about their referral, their problem or the CPN's methods of working. From their initial orientation, the CPNs continued not to appreciate the patient's view of the encounter, and did not always make the necessary 'jump' into their patient's view. They continued to underestimate the necessary need to collaborate and clarify with the patient their view of the problem. As the patients and CPNs began the business of problem 'identification' (Peplau, 1988), there was a low level of agreement between them regarding the nature of the problem. Patients spoke of the difficulties they experienced in life: CPNs preferred to describe psychopathology. The lack of CPN awareness of their patient's view of the problem was great: disagreement as to the nature of the problem, or even whether one existed, was present in over two-thirds of cases.

It could be suggested that the very nature of psychiatric illness is such that patients may have little insight or understanding of their problem and that disagreement is a predictable part of the CPN/patient relationship. This may be true in some cases, but the evidence of this study was that CPNs did not try very hard to understand their patient's view, but rather imposed their own inflexible diagnostic model on the problem. The CPNs disagreement was based on a poor understanding of the world the patient inhabits and missed the opportunity to benefit from the patient's view. On the CPN's part, this divergence may have resulted initially from a practice ideology which regards individuals as 'patients' and the practitioner as an 'expert' who is not required to explain professional practice. Thereafter, this established a form of relationship which encouraged a degree of distance between nurse and patient.

The CPN's preoccupation with pathology and cure only increased the gap between patients' and CPNs' views. One of the difficulties of construing problems as pathology has been that it encourages the patient to be regarded as a 'passive body' (Foucault, 1973) with little control over how to get better, usually with the 'how' having been defined by the expert, who then has to channel the efforts of the patient in certain directions. In the present study, despite the lack of negotiation regarding roles and disagreement over the nature of the problem, the patient were usually willing to allow the CPN to direct the relationship, but the CPNs lost the benefit of hearing the patients' views as to how best they might be helped. In some cases, the patient's solution required less effort and time than the CPN's proposed solution. It can be argued, therefore, that CPNs must attempt to move closer to the patient's view of how best they can be helped and attempt to match their interventions to those believed by patients to be beneficial. The CPNs should also be aware that, for some patients, their role as an 'outsider' to the patient's world was in itself beneficial. This allowed some patients to feel free to express their feelings and experience emotional relief. To other patients 'just talking' was not as effective and they gained no such emotional relief. There was no evidence in the study that CPNs did other than to prescribe helping strategies *they* regarded as being appropriate and helpful. Neither was there evidence that the CPNs explained their way of working to the patients. Although the patient's formulation should always be listened to and taken seriously, it may not always have been prudent to take it at face value, and there may be occasions when it may be necessary for the CPN to decline intervention on their own terms, for legal or ethical reasons.

The results of the present study showed that the CPNs narrowly defined patients' problems as being physical or psychological, with little consideration for the social circumstances of their patients. Such a narrow focus on pathology may have provided the consultant psychiatrists with assessment information that fitted with their conceptual framework. This may have placed CPNs as a natural ally of the psychiatrists and enabled them to become 'skilled helpers' to the doctor. The Department of Health Circular (1990) maintains that all the patients who will be required to have a care programme 'will be patients of a consultant psychiatrist'. White and Brooker (1990) have suggested that the work practices implied by the Circular (DoH, 1990) may indeed bring the CPNs back into closer working relationships with psychiatrists. The evidence provided by this study has been that the CPNs practised within a medical model and were therefore already close to the theoretical framework of many psychiatrists.

The Health Circular (DoH, 1990) further required a key worker to be agreed and identified between Social Services and the relevant health authority to monitor the agreed health and social care given. In relation to the findings of the present study, two points thus emerged for further debate. First, the monitoring of social care by CPNs may require them to develop a greater understanding of their patient's social circumstances and their use of support networks to help resolve problems.

Second, the implications of the Health Circular (DoH, 1990), according to White and Brooker (1990), may require the future work of CPNs to be 'refocused towards the long-term mentally ill and away from those requiring short-term intervention'. This study showed that the majority of patients were on the CPN's caseload for less than four months, which might be considered to be short term. Thus, the CPN practice of discharging patients from their caseload because they were 'unco-operative' may be more difficult in the future if long-term support and care has been purchased from CPN services.

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Clinical audit and CPN services

Patricia Harrigan, Jan Sorensen and Steve Ryder

INTRODUCTION

Over the last 20 years community psychiatric nursing has developed rapidly, but not in a uniform pattern. Attempts have been made to find the best way of organizing community psychiatric nursing (CPN) care, but with one or two exceptions (for example, Paykel and Griffith, 1983) there have been relatively few attempts to evaluate the effectiveness of CPN care. Therefore, little is known about the cost-effectiveness of the different working practices.

When resources are scarce and the demand for care exceeds the available supply, it is important to make sure that the existing resources are used in the most cost-effective way to offer patients, their relatives and the rest of society good value for money. Economic principles suggest that resources should be allocated to services and patients in such a way that the benefit in relation to resources used is maximized (Mooney, 1986). Applying this principle in an audit process would require measurements of the effect, benefit or outcome in relation to the inputs or resources used.

The formalized clinical audit process is becoming well known in the acute health service but is less often used for the community mental health services, Pringle (1990) outlines the audit cycle as comprising the selection of an area for audit, initial data gathering on the area, definition of standards of care, a comparison of actual care against the standards, an examination of the level of performance against expectations and, finally, a change in clinical behaviour. The audit process involves searching for excellence by continually assessing treatment methods and trying to develop better methods and improve patient care. This requires the gathering of high quality data.

The most common method for monitoring community services is collecting data on inputs and process, for example, the use of CPN time and number of patient contacts. However, such data have little value for auditing the total quality of a service because they do not take into account the effect or outcome of the care. From the practitioners' point of view the existing methods of data collection do not enable them to define standards of care or undertake clinical audit.

The traditional view of clinical audit involves peer group review. This approach is followed in *Medical Audit: Working Paper 6* (Department of Health, 1989) which states that 'the quality of medical work can only be reviewed by a doctor's peers'. This principle can also be applied to other health service professionals. Therefore, the clinical audit of community psychiatric nursing services must involve the CPNs in setting standards and reviewing the outcomes of care plans for groups of patients, as a basis for improving the quality of care.

This chapter presents and discusses a framework for auditing CPN services that has been developed by York Health Economics Consortium for the Northallerton Health Authority's Department of Mental Health Services. The framework is based on the CPN's assessment of the individual patient's health status and likely changes in health status following the care. It has been piloted over a period of three months, and examples of the analyses which are possible with the pilot data base will be presented. It is not intended to give a complete report on the findings of the study, as it contains many aspects that are of local interest only.

LITERATURE REVIEW ON EFFECTS AND OUTCOMES OF CPN CARE

A literature review was undertaken to identify methods for the evaluation of CPN services and indicators for outcome. The literature on CPN services falls into two categories: first, descriptive studies of local services particularly during the 1970s and, second, evaluative studies (defined as those that seek to analyse and make comparisons) which have become more predominant in the 1980s. However, the evaluative studies have concentrated upon the efficacy of different organizational arrangements for the delivery of the service, rather than the efficacy of different treatments or interventions, that is, clinical evaluation. An examination of these evaluative studies discloses several themes, for example:

1. Comparison of CPN base-locations (Harker, Leopoldt and Robinson, 1976; Illing, Drinkwater, Rogerson *et al.*, 1990; Skidmore, 1986; Williamson, Little and Lindsay, 1981).
2. CPNs' relationships with GPs (Illing *et al.*, 1990; White, 1986).
3. Overlapping roles of CPNs and social workers (Wooff, Goldberg and Fryers, 1988; Wooff and Goldberg, 1988).
4. Surveys of satisfaction with CPN services: GP satisfaction (Bennett, 1989; Illing *et al.*, 1990); patient satisfaction (Illing *et al.*, 1990; Munton, 1990; Pollock, 1989).

None of these studies have, however, attempted to measure outcomes in terms of changes in the clinical condition of patients, and this is essential for clinical evaluation. Two studies which have attempted to measure a range of outcomes of CPN services, including clinical condition, were found:

1. The Springfield Controlled Trial (Paykel and Griffith, 1983) has been reviewed frequently. It remains the only major randomized controlled trial of CPN services. It studied the progress of chronic neurotic patients randomly assigned to either routine out-patient care by psychiatrists or to follow-up care by CPNs working within the psychiatric team. Psychiatric health status was assessed using standardized scales during the initial assessment and subsequently after six, 12 and 18 months. Social adjustment, family burden and consumer satisfaction were other measures of outcome. The two groups of patients did not differ significantly in outcomes, except for patient satisfaction where greater satisfaction with CPN care was expressed by patients.
2. A study undertaken in the Accident and Emergency Department at Leeds General Infirmary (Atha, 1990) included a range of outcome measure, and used randomization to study two groups of patients. Attenders aged 16 to 65 were screened for psychiatric morbidity, and those who were identified as having psychiatric difficulties were either referred for CPN treatment consisting of five one-hour sessions of problem-solving therapy in the patient's home or given conventional treatment. The intervention of a CPN was found to be more effective in the 'self-harm' group of patients, possibly because the type of intervention used was not sufficiently specific for the more general group of patients.

Neither of these studies attempted to measure outcomes for all categories of patient within a service, and the conclusion drawn by Brooker (1984) that 'with a few notable exceptions, the literature does nothing to dispel the uneasy notion that the efficacy of CPN services in relation to patient outcome may well be a myth' remains valid.

THEORETICAL FRAMEWORK

Economic aspects of CPN services

Since the first CPN services were established in the mid-1950s the number of districts with a CPN service has grown considerably. The national survey sponsored by the Community Psychiatric Nurses Association (CPNA) showed that by 1980 only six district health authorities had no CPN service (Simmons and Brooker, 1986). The 1985 CPNA survey showed that the ratio of

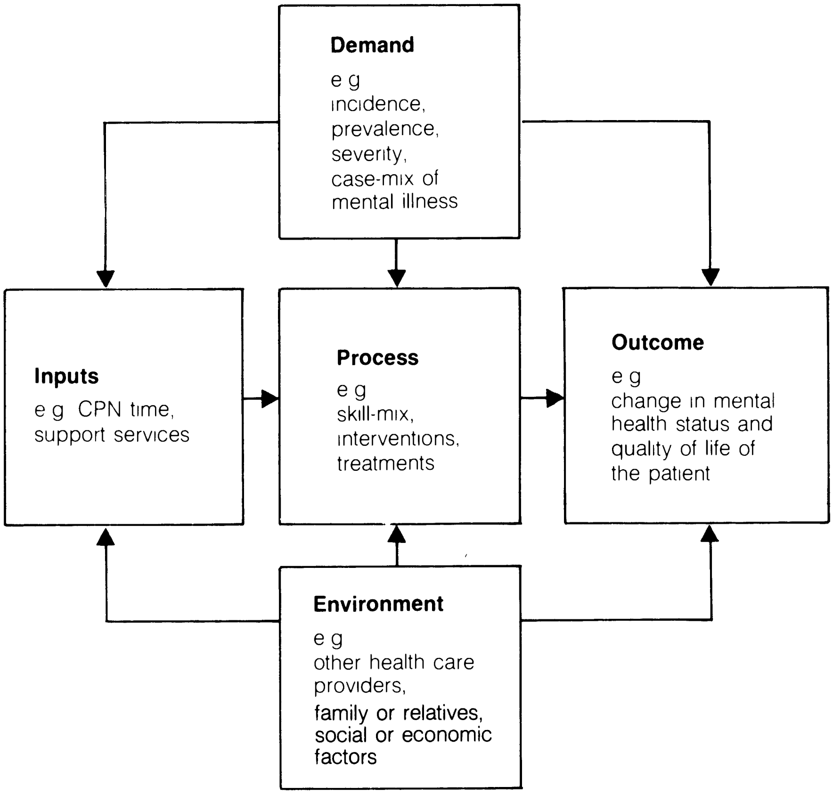


Figure 11.1 Elements in the evaluation of CPN services (adapted from Yates, 1989).

CPNs to regional populations had grown from 1:50 000 in 1980 to 1:22 100 in 1985 (Brooker, 1987).

The well-documented growth in CPN services prompts the question of whether the increased resources allocated to them has been the best use of the scarce resources available to the National Health Service. Economics is the discipline which attempts to answer questions about the allocation of scarce resources, and health economists apply the discipline of economics to the topic of health and health care (Mooney, 1986).

But before an economic evaluation can be carried out, that is the costs and benefits of the services measured and compared, a clinical evaluation is necessary to examine the efficacy or clinical effectiveness of the therapies and interventions being used. Clinical audit is therefore the key to evaluating efficiency and making decisions about the allocation of resources to different health care services.

Clinical audit can be defined as the systematic, critical analysis of the quality of care, including the use of resources (inputs), the procedures for treatment (process), and the resulting outcome and quality of life for the patient (outcomes). These three areas approximate to Donabedian's (1966) taxonomy of health care evaluation: structure, process and outcome, although 'structure' refers to the resources made available to the health care process, whereas 'inputs' implies that the resources are actually used.

Yates (1989) has suggested that these three areas must be studied in the context of the demand for particular services, which is influenced by the incidence, prevalence, and severity of mental illness in the population, and the environment in which the service is delivered. Of particular importance in community nursing services are the other health carers and community services whose presence (or absence) influences the decisions made by the CPN and the outcome for the patient. The five elements in this model – inputs, process, outcome, demand and environment – are illustrated in Figure 11.1.

Questions to be addressed

For a comprehensive clinical audit of a CPN service, the five elements in the model must be analysed and their relationships mapped and understood. The inputs (CPN time, clerical and support service, transport, materials and drugs) must be identified and measured. Such data are already collected routinely in many CPN services, for example, using the ComCare and other computerized information systems. Some data on treatments and interventions (process) are also available. However, data on outcomes, for example, the change in the mental health status and quality of life of the patient, are not usually collected. This is because inputs can usually be measured, expressed in financial terms and aggregated to total cost, whereas outcomes are difficult to measure.

The isolation of environmental factors also poses a challenge in the evaluation of CPN services. An improvement in a patient's mental health status could be attributed to changes in the home or working environment, intervention by another health care professional, chance factors or the natural course of the disorder. The problem of attribution is an intractable one in the context of clinical evaluation. The only way of offsetting it is by a randomized controlled trial within the context of a research project such as the Springfield Controlled Trial. In day-to-day clinical practice, randomization would be impracticable, as well as causing ethical problems, over the whole range of mental illness.

The framework developed for the audit process allows the following questions to be addressed:

- Who refers the patient to CPN care?
- For what diagnoses or problems are patients referred?
- What is included in the care plan?
- How often do patients receive care?

- Where is the care given?
- What is the expected outcome of care?
- What is the actual outcome of care?
- Which patient groups receiving CPN care are associated with the best outcomes?
- On which patient groups does the care given appear to have little or no effect?

METHODOLOGY

Clinical audit involves the practitioner (in this case the CPN) defining the standards of care for particular conditions, but these standards, or protocols, are difficult to construct. One of the purposes of the pilot study was to give the CPNs the means to audit their own work by producing data collection instruments that they could use in the course of their practice as supplements to their nursing case notes, or eventually to replace large parts of them. The analysis of the data should provide information for peer group discussion of patient outcomes, so that the CPNs themselves could derive standards of care for particular groups of patients, against which to judge their effectiveness as individuals or as a group.

Indicators

Indicators that capture the five elements illustrated in Figure 11.1 have been identified as described below.

Exploration of the *demand* element involves classifying patients, and several methods are possible. One approach is to group patients according to the three specialist areas: adult psychiatric; elderly dementia; and children and adolescents. This reflects the organizational structure of the community mental health teams (CMHTs) in Northallerton Health Authority, which typically consisted of a consultant psychiatrist, CPNs, a clinical psychologist, an occupational therapist, a social worker and community day hospital nurses. The expected changes in mental health status for these groups of patients are very different, with the elderly demented patients likely to deteriorate, whereas an overall improvement would be likely for the child and adolescent group. A wide range of outcomes might be expected within the group of adult psychiatric patients, depending upon the diagnosis.

Thus, a second method of classification is by diagnostic group. It was decided to use a classification scheme based upon the World Health Organisation's *Ninth Revision of the International Classification of Diseases* (1978), giving as the four main categories organic states, psychoses, neuroses and other disorders.

However, during the study, it became apparent that CPNs plan their care around the patient's problems rather than the diagnosis. Therefore, it was decided to combine diagnosis information with a classification of problems. The classification of problems suggested by Hunt and Mangan (1990) was adopted, with the following categories: mood related; thought disorder; drug/substance problems; relationships; social behavioural; loss; self-injury; confusional states and others.

The most important, and the most costly, *input* is the time of the CPN, with CPN salaries accounting for nearly 80% of the total cost of the Northallerton CPN service in the financial year 1989/90. Therefore, information on inputs was concentrated on CPN time spent in direct contact with and travelling to patients.

In the context of community psychiatric nursing, *process* indicators were related primarily to the type of treatment or intervention and the place at which it occurred. The list of treatments and location of treatment were consistent with the categories employed in the existing information system.

As has already been stated, isolating the *environmental factors* poses a major problem in the evaluation of health care services, particularly in the context of multidisciplinary services such as community mental health care. The multidisciplinary working practices were recorded in terms of the CPN's and patients contacts with other professionals and agencies. Socio-demographic data, such as sex, age, marital status, occupation and household structure, were also collected.

It is generally accepted that measuring *outcome* in health care evaluation is difficult. Two alternative methods of measuring outcome were considered: either using existing standardized assessments or devising an assessment specifically for the CPN service.

The advantage of using standardized assessments (for example, General Health Questionnaire, Social Adjustment Scale, Hamilton Depression Scale) is that many of them have been tested for validity (that is, they actually measure what they are supposed to measure) and reliability (that is, they result in the same measure if used by different people). There are a large number of standardized assessments for mental health used by clinicians in the course of their practice but many of them are specific to a particular diagnostic category, or are designed for self-rating, or for use by a psychiatrist, and are therefore inappropriate for use by CPNs over the whole range of diagnoses.

It was therefore decided to devise an assessment specifically for the CPN service by measuring outcome on a range of dimensions that would apply across all groups of patients. Outcome indicators were identified under the following four headings:

1. Mental health of the patient.
2. Social functioning of the patient.
3. Family burden.
4. User satisfaction.

Some survey work on user satisfaction (both patient and GP) had already been carried out within the district. Therefore only the first three categories were pursued.

Thirty-three statements were included in a questionnaire under the broad headings of 'mental health status of the patient' (15 statements), 'social functioning of the patient' (nine statements) and 'family burden' (nine statements). A four-point ordinal scale was used to elicit judgements on the 33 statements with an additional option of 'not known' where a judgement could not be made.

Data collection instruments

The data collection instruments consisted of three forms (printed in different colours) to be completed by the CPNs for each individual patient.

1. An initial assessment form. This collected information on each new patient on referral and on existing patients the first time they were seen during the period of the three-month pilot study. The initial assessment form included socio-demographic information; referral details (including diagnosis, presenting problem and its duration, and medication); previous history of psychiatric illness and an assessment of the present mental health state of the patient, social functioning of the patient and family burden, together with expected changes over the period of the study. The expected changes in mental health state, social functioning and family burden following CPN care were assessed using the 33 statements on a five-point scale (major deterioration, slight deterioration, no change, slight improvement, and major improvement) plus a 'not known option'.

2. A treatment form. This was completed on every contact between the CPN and the patient, detailing the location and type of treatment, the time spent with the patient and travelling, the CPNs' and the patients' contacts with other professionals and agencies, and information about admission to hospital or day care since the last contact.

3. A final assessment form. This was completed at the end of the three-month study period, or on discharge if earlier. This recorded the reason for discharge, changes in the patient's personal details collected at the initial assessment, and assessment of the current health state of the patient so that changes during the three-month study period could be identified.

At the end of the three-month period of the pilot study, the forms were extracted from the patient's files for analysis.

SELECTED FINDINGS

A total of 2919 forms were returned for analysis: 377 initial assessment forms, 2137 treatment forms and 405 final discharge forms. These related to 436 different patients, but after patients with incomplete data sets had been excluded from the analysis, 367 patients remained, of whom 260 were already in the care of CPNs at the start of the pilot study.

During the three-month study period, 64 patients were discharged from CPN care, 31 of whom were new patients during the study period.

The database produced from the completed forms can be interrogated to produce analyses for audit purpose and to answer some of the descriptive questions mentioned earlier. In this chapter the database has been used to provide empirical data to describe the elements in the evaluation model and the relationships between them. The analyses undertaken are only examples and it must be emphasized that the potential uses of the database are much wider.

Demand

Analysis of the case-mix by type of patient and diagnosis is set out in Table 11.1. Adult psychiatric patients accounted for 75% of the patients in the sample, dementia patients for 18%, and children and adolescents 7%. The largest diagnostic group was patients with neuroses (113), but there were nearly as many psychotic patients (105). All but five of the patients suffering from organic disorders were dementia patients.

In the initial assessment form, CPNs were asked to classify patients according to the main presenting problem and to compare it with the referrer's and the patient's definition of the problem. There was most consistency between CPN, referrer and patient in the identification of mood-related problems, the category which had the greatest number of patients. The largest variations

Table 11.1 Number of patients in data sample by type and main diagnosis

	Organic	*Psychotic*	*Neurotic*	*Other*	*All*	*%*
Type of patient:						
Adult psychiatric	5	105	108	60	278	75
Dementia	62	0	3	0	65	18
Child and adolescent	0	0	2	22	24	7
Total	67	105	113	82	367	100
% of sample	18	29	31	22	100	

between CPNs and referrers are with respect to behavioural problems (where CPNs identified 10% more patients than referrers) and confusional states (where referrers identified 10% more than CPNs). The greatest discrepancy, however, was between CPNs and referrers on the one hand, and patients on the other hand. This was particularly the case in relation to problem identification, where over a quarter of patients could not tell what their problem was; the comparative figure for CPNs and referrers was less that 4%.

Analysis of the sample by source of referral showed that 70% of patients were referred to CPNs by their GP and 23% by a consultant psychiatrist. Only 2% were referred by other members of the CMHT. There was a difference in referral patterns for neurotic and psychotic patients, with a greater tendency for neurotic patients to be referred by their GP and for psychotic patients to be referred by a psychiatrist. Of neurotic patients, 81% were referred by their GP, compared with only 16% referred by psychiatrist, whereas the figures for psychotic patients were 55% and 36%, respectively.

Inputs

Use of CPN time (measured in number of contacts or number of minutes) can be analysed in relation to several variables, for example, by age, sex, diagnosis or presenting problem. Table 11.2 shows the use of CPN time by main diagnostic group. The most resource-consuming patients in terms of CPN time were those with neuroses, who used on average 262 minutes of CPN time during the study period, and (compared with psychotic patients) had fewer but longer contacts with their CPN.

When the four main diagnostic categories were broken down into more detailed diagnoses, further differences were found (see Table 11.2). Patients diagnosed as having obsessional neurosis used on average the greatest amount of CPN contact time (858 minutes per patient). However, there were only two patients in this category, which may distort the result. Excluding these two patients from the sample of patients with neuroses gave an average of just over 250 minutes of CPN time being spent per neurotic patient, a similar figure to that for psychotic patients.

It should be recognized that the complete picture of CPN resource use cannot be gauged by reference to average contact times. It is undoubtedly important to examine the *distribution* of times spent on patients with particular diagnoses. Nevertheless, the crude analysis presented in this study has increased knowledge of the service as a whole.

Process

The great majority (80%) of contacts between CPNs and their patients

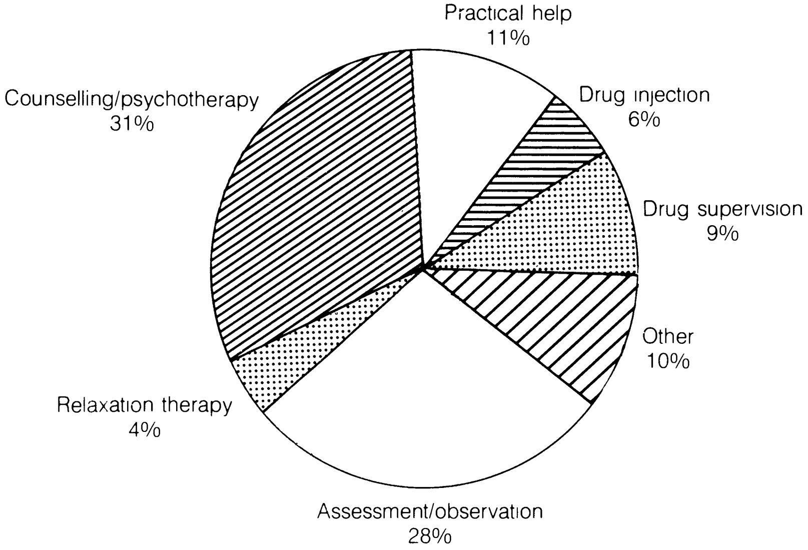
Table 11.2 Use of CPN time by principal diagnosis

		Contacts	*CPN time in minutes*	
	Patients	*/patient*	*/patient*	*/contact*
Organic states	67	5.5	227	41
Acute organic reaction	5	3.8	188	49
Chronic organic reaction	62	5.6	230	41
Psychoses:	105	6.0	250	42
Schizophrenia	55	6.0	224	37
Psychotic depression/ mania	50	5.9	278	47
Neuroses:	113	4.9	262	54
Neurotic depression	71	4.7	254	54
Anxieties/phobias	38	4.5	246	55
Obsessional neurosis	2	16.5	858	52
Hypochondriasis	2	7.0	270	39
Others:	82	4.0	227	57
Eating disorders	2	5.0	313	63
Personality disorders	5	6.6	323	49
Adjustment reaction	29	4.3	271	63
Substance abuse	9	3.4	155	45
Not yet made	22	3.8	502	132
No mental disorder	15	2.9	172	60
Total	367	5.1	244	48

took place in the patient's home. The remaining contacts were at locations such as health centres, hospital wards, and nursing and residential homes.

Figure 11.2 illustrates the distribution of different types of intervention by the CPNs. On average patients received ten treatments on five occasions during the three-month study period. Patients with psychoses received more treatments than other diagnostic groups, particularly in relation to the administration of drugs. Virtually all drug injections were given to psychotic patients. The most frequent types of treatment are counselling/psychotherapy and assessment/observation.

These findings, however, might be biased because the large number of treatments in the assessment/observation category may be caused by the requirement of the study to assess each patient twice in the three-month period, so that this category is over-represented.



	All
Drug supervision/monitoring	344
Drug injection	209
Practical help	412
Counsel/psychotherapy	1163
Relaxation	163
Assessment/observation	1045
Other	379
Total	3715

Figure 11.2 Type of treatment.

Environment

The number of contacts between CPNs and other professionals and carers about individual patients over the three-month survey period is shown in Table 11.3. It is clear that CPNs have frequent contacts with the referring GPs and psychiatrists, and also a considerable number of contacts with patients' relatives and friends. However, the data collected give the impression that CPNs are working as fairly independent practitioners with little consultation with other members of the CMHT except psychiatrists.

There are distinct differences in contact pattern between the four diagnostic groups. For patients with organic states the CPNs' contacts with other carers were relatively frequent, as were contacts with GPs, psychiatrists and ward

Table 11.3 Contacts by CPNs with other professionals and carers by main diagnostic group

	Main diagnosis				
	Organic	*Psychotic*	*Neurotic*	*Other*	*Total*
Other CPNs	44	34	14	7	99
GP	131	203	244	135	713
Psychiatrist	175	307	114	52	648
Occupational therapist	21	7	4	7	39
Clinical psychologist	1	5	15	8	29
Social worker	40	32	17	14	103
District nurse	7	6	4	2	19
Health visitor	13	14	15	21	63
Ward staff	153	12	19	11	195
Relatives/friends	186	170	129	86	571
Other	54	55	23	15	147
Total contacts	825	845	598	358	2626
Number of patients	67	105	113	82	367
Contacts per patient	12.3	8.0	5.3	4.4	7.1

staff. Interaction between CPNs and social workers was also most frequent for this group. For the group of patients diagnosed with psychoses, the CPNs appear to take regular advice from psychiatrists. Although only 36% of the patients were referred to CPN care by a psychiatrist, CPNs had on average about three contacts with a psychiatrist per psychotic patient. The CPNs appear to be working more independently when caring for patients diagnosed with neuroses and other diagnoses (see Table 11.3).

Similar data were collected for the patients' contacts with other professionals and relatives. This information was collected by the CPNs and its accuracy might be suspect if patients are (consciously or otherwise) failing to inform the CPN about all their contacts since the last visit. Data on the frequency and duration of such contacts has not been collected.

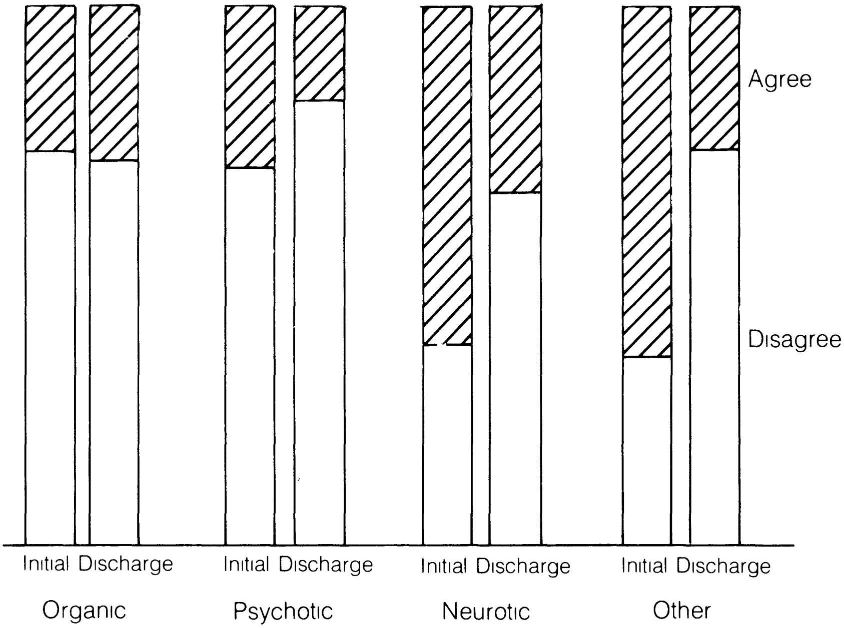
Analysis of the data suggests that over the three-month period patients, on average, had the same amount of contact with other carers as with the CPNs. The majority of contacts were, however, with relatives or friends, which accounted for around half of the reported contacts. Most patients also had contact with their GP and, especially for psychotic patients, with a psychiatrist.

Information about contact patterns was collected to given a picture of the interdisciplinary working relationships between members of the CMHT. It suggests that for only a limited number of patients are there frequent contacts with different professional groups. Whether a closer working relationship between members of the CMHT might be beneficial and appropriate for the patients could be assessed by analysing the database to establish whether patients achieved a better outcome when there was more frequent contact between CPNs and other professionals.

Outcome

As mentioned earlier, outcome was measured by the use of 33 statements which the CPNs were asked to consider in relation to individual patients.

Analysis of this outcome data is not straightforward because the measures are not additive and each statement must therefore be considered separately.



Statement 'Patient is unhappy or depressed'

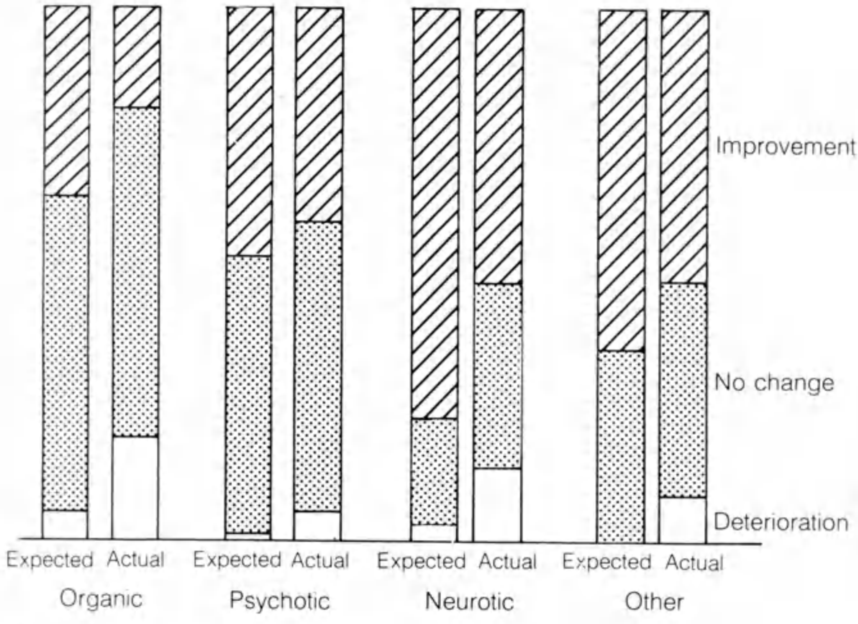
Diagnostic group	*Initial*		*Discharge*	
	Agree	*Disagree*	*Agree*	*Disagree*
Organic	47%	53%	29%	71%
Psychotic	30%	70%	17%	83%
Neurotic	63%	37%	36%	65%
Other	65%	35%	27%	72%

Figure 11.3 Initial and discharge assessments.

As an example of this analysis, data relating to the statement 'Patient is unhappy or depressed' are presented here.

At the time of initial assessment the CPNs perceived that the statement 'Patient is unhappy or depressed' was true for 48% and false for 52% of the 371 patients for whom assessment was made; at the final assessment, the statement was perceived to be true for 27% and false for 73%. This suggests that patients receiving CPN care have improved with respect to this dimension. Whether this improvement was as a result of CPN care is a matter for further analysis and debate.

Figure 11.3 illustrates the CPNs' assessment for patients by main diagnostic group. A relatively high proportion of patients diagnosed with neuroses or



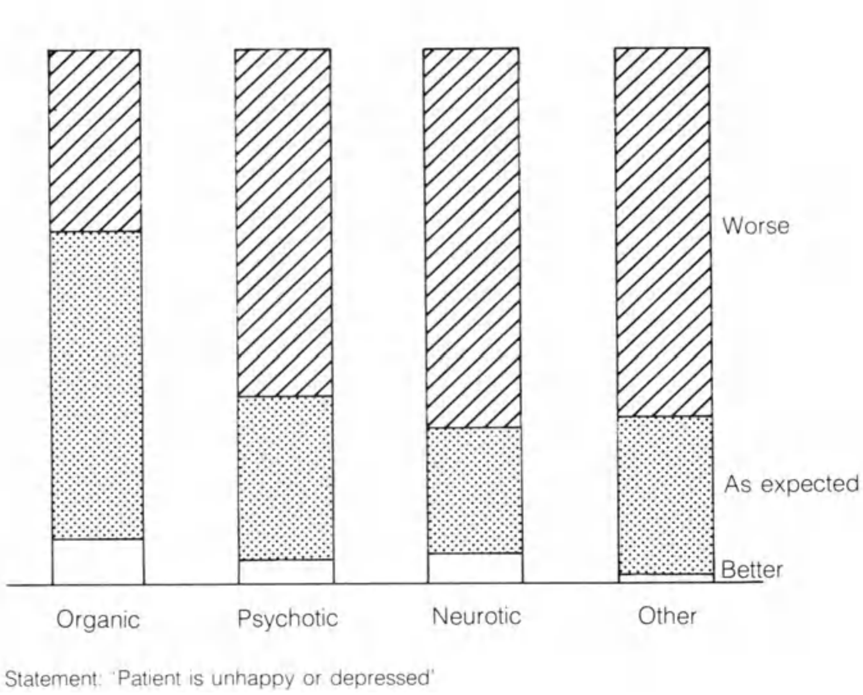
Statement: 'Patient is unhappy or depressed'

	Expected			Actual		
Diagnostic group	Improvement	No change	Deterioration	Improvement	No change	Deterioration
Organic	36%	59%	5%	19%	61%	19%
Psychotic	47%	52%	1%	41%	54%	5%
Neurotic	78%	20%	3%	52%	35%	14%
Other	64%	36%	0%	52%	40%	8%

Figure 11.4 Expected and actual changes.

other diagnoses were perceived to be unhappy and depressed in the initial assessment. By the final assessment the differences between the diagnostic groups were reduced on this dimension. It appears that patients with neuroses or other diagnoses had the largest improvement. The data do not indicate the cause of the improvement, whether it was due mainly to CPN intervention or to the natural history of the disease. Conversely, patients diagnosed with organic disorders deteriorated over the study period, which probably reflects the natural history associated with the main condition in this diagnostic group.

The extent to which CPNs were able to predict these changes in their patients at the initial assessment was also analysed. For 58% of all patients, CPNs expected an improvement in terms of the patient's unhappiness and depression, no change for 39% and deterioration for 3%. Over the three-month period



Diagnostic group	*Better than expected*	*As expected*	*Worse than expected*
Organic	34%	58%	8%
Psychotic	65%	31%	4%
Neurotic	71%	24%	5%
Other	69%	30%	1%

Figure 11.5 Achievement of expectations.

improvements from the initial assessment were achieved for 43%, no change occurred for 46% and 11% deteriorated.

Figure 11.4 illustrates the difference in expectations and actual changes for the four diagnostic groups. Overall, more patients deteriorated than expected over the three months. Similarly, fewer patients improved than had been expected. The expectations for improvement were relatively large for patients with neuroses, where 78% were expected to improve. Only 52% did, however, improve over the three months.

The differences between expectations and actual changes might be explained by the shortness of the survey period, so that many patients had not completed their treatment and therefore had not improved to the expected level. The design of the study required CPNs to formulate expectations of changes by the end of the study period. In reality this may have proved difficult in respect of some patients.

The above analysis considers only groups of patients and does not account for changes within the groups. Analysis within the group suggested that 4% of all patients improved more than expected, 33% achieved the expected changes and 63% were in a worse state than expected. Figure 11.5 shows that the group of patients with organic states was the group where most changes were as expected (58%), whereas less than a quarter of neurotic patients achieved changes as expected.

Similar analyses could be undertaken for all 33 statements, either for all patients on the CPNs' lists or for a subgroup of patients. These analyses could give an indication of the dimensions on which changes in health status are most likely to be expected, whether this is due to CPN intervention and/or the natural history of the illness.

DISCUSSION AND CONCLUSIONS

The data analysis presented here is a description of the whole CPN service. However, the database has potential for much more detailed interrogation and search for more specific findings which might be useful for CPNs to use in clinical audit and for managers of the service.

Clinical audit

Clinial audit is a continuous process aimed at improving the care of patients by setting standards of care and comparing the care given with those standards.

Most data collection systems implemented in community care are designed to produce information for the monitoring of service rather than the management of patient care. They often fail to give practitioners the information that is needed to evaluate the standard of care and therefore have little value in the audit process.

This study has developed and piloted a set of instruments which enables the CPNs to evaluate their own work as part of a clinical audit process. Protocols could be developed by the CPNs in peer group discussions according to the nature of the patients' illnesses or psychiatric problems. These protocols would be based upon the variables included in the data collection instruments and would describe the group of patients in terms of personal circumstances, the type and quantity of treatment offered and the expected outcomes.

Data about individual patients would be used in case conferences to establish whether the actual care provided (and reported) is consistent with the protocol. Cases where there were deviations from the protocol would then be discussed by the peer group to identify any special circumstances which could justify the deviation. These differences could then be explored for measures of good practice and ways of improving the delivery of care to be more efficient and less costly in terms of CPN time.

Management issues

The analysis of the data collected in the pilot phase will enable managers of the CPN service to define and measure workloads for the whole service or for individual CPNs.

Workload measures for the whole service are particularly relevant when, in the future, service agreements have to be made with purchasing authorities. It becomes possible to include not only quantitative variables (for example, number of patients on the lists and number of contacts), but also qualitative measures in terms of what care is given to patients and the effects of the care. With the routine use of the instruments, the service's performance in relation to the service contract can be monitored.

Another management issue at an operational level is the distribution of workload between CPNs. It may be possible to define workloads and continuously monitor whether the distribution is appropriate or requires adjustment.

The data might also help managers to address issues of a more strategic nature. The data analysis presented here has given a picture of the workload of a CPN service, and it appears that patients in the Northallerton service are drawn from a broad spectrum of psychiatric disorders. Whether that should continue or the service should achieve a higher degree of specialization is one issue that managers might wish to address.

Another example is the functioning of the CPN service in relation to the rest of the mental health services. The data analysis has given some insight into the degree of co-operation with other mental health professionals and the referral system. According to the policy of the Northallerton Mental Health Services Department, CPNs should accept referrals only from general practitioners or CMHT members. Yet a total of 19 (5%) of patients were reported as being referred from other sources. This indicates that CPNs might be more willing to operate an 'open' referral system than the formal system allows. However, relatively few (only 2%) of patients were referred from other members of the CMHT.

Another management issue concerns the working relationships with other mental health service professionals. The data collected suggest that CPNs made more frequent contact with social workers than did their patients. CPNs also contacted other nursing professionals, including their CPN colleagues, although contacts with the occupational therapists and clinical psychologists were less frequent for both CPNs and patients and mostly related to patients with organic states in the case of occupational therapists and neurotic patients in the case of clinical psychologists. The picture that emerged from the data analysis is one where the CPN acts as a 'key worker' in the case management of patients, contacting other professionals, friends and relatives for help, advice and information as the need arises.

These issues are a matter for debate between managers and mental health care professionals, as is the issue of whether better and less costly treatment could be achieved by alternative arrangements. Ultimately, it will be for the purchasers of mental health services to decide.

Further development of the method

It should be emphasized that this study is the first phase in the development of suitable ways of evaluating the clinical performance of CPN services. In the future, more work could be carried out to validate and refine the outcome measurement method. The inability to aggregate the measurements to form an overall score poses a problem in the interpretation of the data on outcomes.

There are two reasons as to why the measurements cannot, as they stand, be aggregated. First, the scales used in the outcome measurement are ordinal rather than cardinal. This means, for example, that the difference between 1 (major deterioration) and 2 (slight deterioration) is not necessarily the same as that between 2 and 3 (no change).

Second, the different dimensions of the outcome assessment have not been weighted to reflect their relative importance. For example, although there are 15 dimensions in the assessment of the mental health of the patient and only nine in the assessment of social functioning, it cannot be implied that the mental health category is more important than the social functioning category. Similarly, it does not imply that a patient's score on one dimension is equal to another one (for example, 'sleeping well' versus 'coping with the symptoms of the illness'). Given the figures are used to distinguish responses on the scales, there is a danger that additivity will be assumed and the scores summed erroneously.

A scoring system could be developed by using magnitude estimation or visual analogue scales to elicit valuations to overcome the first problem. The method of paired comparisons to derive weightings within and between the main categories of outcome could be used to address the second point. An overall score could be derived in this way which would facilitate the analysis and render it more suitable for use in clinical audit work.

In this study, actual outcomes were compared with expected outcomes. However, the identified changes in patient health states may merely be a result of CPNs adjusting their perceptions when assessing the outcomes. Therefore, the outcome measurement method should be tested for reliability and validity.

If the study were repeated in, say, a year's time then the changes in patients' health states could be highlighted in a time series analysis. However, one drawback of the analysis of the pilot database is the length of the study period. Three months is probably too short a time to achieve any real improvements in the condition of mentally ill patients, and this could account for the convergence of actual outcomes on most dimensions to 'no change' compared with expected outcomes where more variation was anticipated by CPNs both in improvements and deteriorations.

If, however, the method were adapted as a means of permanently collecting patient related data for peer review conferences, it is believed that the clinical audit process would enable CPNs to adjust their care practice closer to what is perceived to be good practice and thereby improve the overall care of patients and performance of the service.

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CHAPTER TWELVE

Attitudes towards supervision: a comparison of CPNs and managers

Susan Major

BACKGROUND

The present information on what supervision means to community psychiatric nurses (CPNs) is limited, although competing arguments have begun to emerge. These include conflicting reports of practice, definitions and attitudes towards supervision. Moreover, an agreed definition, theoretical framework or strategy for operationalizing CPN supervision has yet to be realized. Of attitudes, for those adopting a positive viewpoint supervision is seen to facilitate healthy attitudes, learning and competencies, vital to the practising CPN (Pollock, 1988). The need to discuss difficult cases in the face of clients' anxiety, fear, despair, failure and so on should make supervision the ideal forum for such discussion. On the other hand, anxieties and opposition towards supervision have also been reported (Wilkin, 1988), which elaborates on the lack of understanding which surrounds the purpose of supervision and the fear of criticism which leads CPNs to resist such practices. Such a position could be explained in terms of the conditions which foster both negative and positive attitudes. These conditions include the interaction between CPNs and their managers. On the negative side, the encounter is between individuals who are unequal in status and is frequently tension laden and based on disciplinary styles (Harries, 1976).

Thus, a picture emerges of the CPNs' exposure to emotional overload: yet for many supervision may be an unrewarding experience. These observations may imply an assumption that many managers and CPNs conform to, or resist, formal supervison because their attitudes are triggered by different objectives and varying degrees of appreciation and motivation. These difficulties and assumptions may also be due, in part, to the lack of empirical investigation into CPN supervision. Thus, the need to do research becomes highlighted. While the competing arguments mentioned earlier are vast, several areas of studies could be considered. This study, however, investigated just one aspect; namely, the attitudes of managers and CPNs towards supervision.

The principle objective was to examine if there was a difference between the attitudes of CPNs and managers towards supervision. Initial reading indicated that there was not a commonly agreed definition of attitude. Rokeach (1968) defined attitude as 'a learned orientation or disposition towards an object or situation, which provides a tendency to respond favourably or unfavourably to the object or situation'. Other words, for example, value, belief and behaviour emerged continually in the literature specific to attitude. Value can be defined as a belief upon which a person acts by preference; beliefs provide standards and motives which guide actions and behaviour as overt actions (Allport, 1955; Gross, 1987). Secard and Blackman (1964) suggested most definitions of attitude contained three dimensions:

1. The cognitive: what a person believes about the attitude, object objectivity.
2. The affective: what the person feels about the attitude object, that is, how favourably or unfavourably it is evaluated, reflecting its place in the person's scale of value.
3. The behavioural: how a person actually reacts to the attitude object based on cognitive and affective components.

These dimensions, although helpful overall, are highly related. In other words, if attitude related to how people feel and what they believe, assertions can be made about the way they behave. To use an example from supervision in community psychiatric nursing, the value could be that supervision improves standards of care. Arising from this the belief could be that supervision activities require an element of planning, followed by the behaviour (or practice) that all CPNs should receive supervision. The above synopsis of the meaning of attitude helped focus on the area of investigation.

Literature review

A review of the CPN literature provided evidence that authors were still attempting to 'discover' what supervision was, rather than citing evidence of strategies or theories for practice. Publications which present theoretical frameworks were taken from other mental health disciplines, and much of the CPN information presented here was anecdotal (for example, CPNA, 1985, 1989; Wilkin, 1988). The overriding assumption in the literature was that supervision was beneficial, although studies in the mental health field comparing practitioners were limited. However, Biasco and Redfering

(1976) reported that clients of supervised workers gained more than clients with unsupervised workers.

The benefits of supervision have been described by Pollock (1988). She stated that supervision allowed nurses the opportunity to focus on attitudes and feelings about management, while allowing an opportunity for insightful practice and staff development. The Firth, McIntee, McKweon *et al.* (1986) study asked ward staff by questionnaire, to describe their feelings about work and their perceived attributes and behaviours of their superior. They concluded that increased involvement, specific to decision making about clients and work arrangements, were affiliated with higher morale. Ritter (1989) pointed out that supervision enhanced care by clarifying ways in which authority was delegated, although she did not elaborate on how this was done. The CPNA (1985), although not backed by research, asserted that supervision had an important part to play in community psychiatric nursing. They included the following:

1. Enlightens CPNs to potential arduous problems, thus enabling them to make decisions more competently.
2. Provides sustenance through brainstorming ideas, knowledge and experience.
3. Provides opportunity to learn and develop skills through exploring emotions that may interfere with the client–nurse relationship.

While these benefits may have demystified the therapeutic contribution to practice, the existing CPN literature provided no framework or process for how these benefits were to be achieved, nor what the hallmarks of what good supervision were.

In contrast, Wilkin (1988) remarked that many CPNs and their managers gave only lip service to supervision; moreover some admitted that given the choice they would not engage in planned supervision sessions. Wooff and Goldberg's (1988) study highlighted the differences between CPNs and social workers in Salford. They suggested that social work training and practice incorporated supervision which helped maintain stable caseloads, while the CPNs who received supervision based on a style of discipline carried unworkable caseloads of increasing size. That said, there was no elaboration of how supervision helped practice, and generalizations were difficult because the study sample was small and drawn from one study centre. However, in the light of the issues raised, the present writer has assumed that the Salford CPNs viewed supervision from a negative perspective.

The CPNA (1985) and Wilkin (1988) both outline the lack of understanding in the aims of supervision, with many CPNs believing that supervision concerned itself only with authority. At face value, this conception could be explained thus:

- The distinction between management and practitioners, in particular the disciplinary style of management in psychiatric nursing (Harries, 1976).
- The lack of knowledge and theories underpinning CPN supervision.

- The role conflict and strain for managers and CPNs which concerns itself with two ambiguities: (1) The manager's role, involving multifaceted concepts concerning organizational demands, for instance, cost-effectiveness and efficiency, and (2) The team's role to provide the best possible care for their clients.

Evidence was located which suggested that working without supervision could be detrimental to both the nurses' wellbeing and client care. Hingley and Harris's (1986) UK study involving 515 senior nurses concluded that the lack of support, in particular from superiors, was a great source of stress. Half the sample suggested that they got feedback from their managers only when conduct was deficient. Platt-Knoch (1986) described how an experienced nurse failed to recognize a client's relapse because personal circumstances interfered with her competency in assessment and care. Platt-Knoch argued that supervision would have helped the nurse to appreciate her subjectivity.

Numerous papers have been written in an attempt to understand supervision more clearly. Withstanding the conflicting definitions, it is worth isolating and exploring the variables common to all the literature. This examination begins by looking at leadership practice, models and categories, the essential qualities of a supervisor and role conflict.

The notion of leader is complex. It can be allied not only to a hierarchical system, but to personal characteristics and behaviour of a team (Dublin, 1989). Most nurses view leadership as a hierarchial structure (Ritter, 1989; Yuill, 1968). The obvious difficulty with this was that this style implied supremacy; it was the supervisor who determines what actually happens in supervision. Contradictory findings have led to confusion when attempting to find a common practice. Fandier and Rielly (1986) suggested that supervision was practised widely in psychotherapy. By contrast, Wooff and Goldberg (1986) stated that supervision was not thought to be generally available to CPNs. White's (1990) preliminary findings suggested that 75.2% of CPNs were involved with colleagues in a supervisory relationship, although it was not the intention of his survey to determine its nature and further investigation of this area was warranted. Within clinical practice, models have, until recently, been ignored in the belief that supervision was an extension of therapy (Hart, 1982). Hart (1982) formulated three models; namely, skill development, personal growth and integration model. He summarized skill development as being aimed at increasing both proficiency and conceptual understanding of the supervisee. The relationship is that of teacher and learner. The assumption here was that the supervisor was the expert. The emphasis was placed on skills and client problems. With personal growth, Hart (1982) argued that the emphasis was to increase insight and affective sensitivity of the supervisee. The relationship was that of counsellor and client. The key problem with this model was that it implied that therapy may be taking place, although Hart argued that the distinction between therapy and supervision depended on the supervisor's skills. Clarity of distinction was made difficult, in part, because, in their choice of criteria for skilled helpers, the authors drew parallels; for example; Rogers's (1960) description of unconditional regard was recognized as being an essential quality in both therapist and supervisor.

Hart (1982) argued that integration aimed to help the supervisee integrate skills and self-awareness. It assumed that the hierarchical position associated with the supervisor is unimportant, as both offer and affect each other. Unlike the two models mentioned above, this model relied on the supervisee having achieved a level of competency in skills and personal growth. These interpretations by Hart (1982) reflect the pattern of supervision in the United States of America.

It is debatable whether these approaches have been realized in community psychiatric nursing in the UK, as current literature provides only descriptions of categories of supervision. Categories are generally understood to mean the style or method in which supervision is operationalized. The CPNA (1989) and Barber and Norman (1987) have acknowledged the importance of four aspects of supervision. They included the following:

1. Managerial, concerned with the maintenance of standards and functions of the organization.
2. Personal development, allowing for greater self-awareness for building strengths and coping skills.
3. Clinical, examining work carried out with clients. Aims to produce an understanding of care given.
4. Educational, referring to the development of skills and knowledge.

These categories were problematic in that difficulties arose because the authors did not elaborate on proposed strategies for integration or implementation, although contingency management theories suggested that supervision advanced for specific situations may be the most effective style (Steinmetz and Todd, 1983).

Supervision implied a relationship. Therefore, the relationship between supervisor and supervisee is fundamental to the therapeutic process of supervision. Pollock (1988a and b) suggested that supervisees learned to examine their own feelings and attitudes during supervision. This exploration process was made possible because the supervisor possessed qualities that brought about a helping relationship. This assumed that supervision was a dynamic process that promoted change, thus resistance may emerge. The focus for much of the literature was on the conflicting roles of managers and CPNs. An elaboration of this was provided by Wolsey and the Organizational and Personal Development Consultant Agency (1990), which was critical of both peer and managerial supervision; that is, while peer supervision may be emotionally supportive, it could be insufficient to develop skills, particularly if expertise is similar. On the other hand the managerial model of supervision based on bureaucratic ideology has the potential to block personal and skill development.

Given such an inconclusive summary from the substantive literature, the present study attempted to shed a little empirical light.

METHOD

Sample

The sample consisted of two groups, CPNs and CPN managers. For the purpose of this study working definitions were established thus: a CPN was any nurse below H grade (using the clinical grading criteria) whose job description encompassed the title 'CPN'. A manager was any nurse or team leader above G grade whose job description encompassed managerial responsibility for a CPN service. Two CPNs from each of the health districts in the West Midlands and Trent Regional Health Authorities ($n=68$) and randomly selected managers from these health districts ($n=38$) (in certain districts more than one manager was identified) were invited to participate in the study.

Although there is evidence (Honville and Jowell, 1978) of the risk of bias as a result of conducting a postal questionnaire, time and limited finance determined this choice of research method for the present study. Postal questionnaires also allowed the subjects time to consider their responses. Offset against these advantages are the disadvantages of poor response rates, especially when the instrument was seen to be complex (Moser and Kalton, 1971). However, to help overcome these problems, the following approaches were adopted. To add a personal dimension to the request for questionnaire completion, telephone calls were made to each manager in each health district. Details of the study were discussed, and their co-operation was gained to complete the questionnaire and to distribute the same to two CPNs whose names were alphabetically first on the list of team members. These managers were each sent a brief background to the study and three questionnaires; one for their own completion and two for distribution. The covering letter included an introduction to the study, assurances of anonymity, completion instructions, the return procedure and deadline. Three stamped self-addressed envelopes back to the researcher were included. A reminder letter was prepared, but was not sent, because of the initial high response rate.

CPNs and managers were asked to complete the same questionnaire, which had two main parts. First, a general section related to profesional variables and second, a 20-item Likert scale questionnaire. The items were developed from variables derived from the literature that would elicit attitudes towards supervision. Examples of these variables fell under the broad heading of practice, value and understanding. The use of these variables was affected by:

1. Definition of the word attitude.
2. The literature; there was a dearth of information concerning the accurate practice, value and understanding of CPN supervision.

Further space was provided in the questionnaire for respondents to express attitudes and feelings in their own words. An equal number of positively and negatively worded statements were prepared. Each statement was numbered and the numbers were chosen randomly by an independent colleague to determine the position of each in the questionnaire. Five response alternatives were provided; namely, strongly agree (SA); agree (A); uncertain (U); disagree (D); strongly disagree (SD). A scoring procedure was adopted which endorsed the positively worded statements with a high score, and the negatively worded statements were given a low score. This provided a clear indication of whether a favourable or unfavourable attitude existed towards the items listed. (Copies of the instrument are available on request from the author.)

The content validity was verified by using a panel of experts to comment on the appropriateness and relevance of the items towards issues concerning CPN supervision. Of the experts, two were senior research fellows, both of whom were involved in CPN research and development; the third expert was a graduate nurse (MSc), who was previously employed as a tutor/CPN practitioner with an interest in clinical supervision. Each was telephoned and invited to comment on the draft instrument. This was followed by an explanatory letter with the questionnaire/chart and a return envelope. The questionnaire was piloted with a group of CPNs and managers not included in the sample and, as a consequence, was slightly modified. The data from the pilot study was used to address the reliability of the instrument. The internal consistency was examined by using a coefficient alpha (Cronbach, 1951). The results are shown in Table 12.1.

Table 12.1 Coefficient alpha of pilot sample

	Pilot sample *n=12*
Total score	0.83
Subscales	
Value	.775
Understanding	.589
Practice	.563

SELECTED RESULTS

Of the 106 questionnaires posted, 94 were returned. Two were returned blank and one was returned four weeks after the deadline data. Therefore, 91 were available for analysis. The overall response was 85.3%. The CPN total was 89.7% (n=61). The manager total was 78.9% (n=30). It was worthwhile noting that some managers, 21% (n=8), chose not to participate in the study, yet it is evident that some still distributed the questionnaires to the CPNs. It is therefore not possible to indicate whether the non-respondents (7.3% CPNs; n=5) chose not to participate themselves or were not given the opportunity. As the questionnaires were returned, they were divided into the two groups (CPN and managers), checked for usability and assigned an identification code. The resultant data was coded onto spreadsheets. Following this, demographic characteristics were established from the general information section of the questionnaire, and a two-tailed t test was performed on the 20-item Likert scale.

Twenty-four health districts were located in the West Midlands Regional Health Authority and 12 health districts in Trent. There were 26 males and 35 females among the CPNs, and 19 males and 11 females among the managers. All CPNs (n=61) carried caseloads, whereas two-thirds (n=20) of managers saw clients. The ENB CPN course completers were distributed significantly differently between managers and CPNs: 73.3% (n=22) of managers were so qualified and 42.2% (n=28) CPNs held the qualification. The proportion was higher for both groups than the last known average of 37.5% (White, 1990). In addition, 26.2% (n=16) CPNs had undertaken a supervisor's course, as had the majority of managers; (80% n=24). Some examples of these included: community practitioners/teacher course and field work supervisor's course and workshops on clinical supervision. The respondents were asked about the length of time spent in community psychiatric nursing. Of managers, 30% (n=9) had five years' service or less, compared with 40 (65.5%) CPNs; 43.3% (n=14) of managers had six to ten years of service, whereas 21.3% (n=13) of CPNs had the same length of service. Of the remaining managers, seven (16.6%) had more than 11 years in community psychiatric nursing, and eight (13.1%) CPNs had the same number of years' service. The bases for respondents are given in Tables 12.2 and 12.3 and compared with the national position in 1990 (White, 1990). The noted trend for a shift in bases from a hospital setting to community bases was also reflected here.

A further question asked respondents to provide details of the different client groups on their caseloads. Just over half (53.3%) of the managers carried a generic caseload, compared to 29.5% of the CPNs. About two in five (42.6%) of CPNs worked with adults, whereas 40% (n=12) of managers worked in that area. Others reported working in specialized fields, including work with: elderly mentally ill people (CPNs 22.2%, n=14; managers 6.6%, n=2); child and adolescent (CPNs 3.2%, n=2); and neuropsychiatry (CPN 1.6%, n=1). Of the pay grades, the majority of managers were either H grade (43.3%, n=13); or I grade (46.6%, n=14). The remaining three were senior nurse 4 and 5 grades and one was within the general management structure. Most CPNs were G grade (91.7%, n=56) with five CPNs (8.1%) at F grade.

Table 12.2 Distribution of CPNs by operational base, compared with the national figures for 1990

Base	*CPN respondents (%)*	*National figures (UK) 1990* (%)*
Psychiatric unit of district general hospital	14.7	14.3
Psychiatric hospital	11.4	22.6
Day centre	3.2	–
Day hospital	6.5	8.4
Health centre/GP practice	18.8	22.5
Community mental health centre	26.2	18.5
Other	14.7	13.7

*White, 1990

Table 12.3 Distribution of managers by main base, compared with national figures for 1990

Base	*Manager respondents (%)*	*National figures 1990* (%)*
Psychiatric unit of district general hospital	20.0	20.9
Psychiatric hospital	30.0	28.3
Day hospital	6.6	5.2
Health centre/GP practice	3.3	4.2
Community mental health centre	15.3	9.4
Other	26.6	8.4
No main base	–	23.6

*White, 1990

It was observed that a proportion of CPNs (14.7%, n=9) and managers (16.6%, n=5) chose to describe their own experiences of supervision on the questionnaire. While some respondents described enthusiastic experiences (CPN, n=2; manager, n=3), three-quarters of CPNs and managers (n=2) had experiences related to problems associated with supervision. The following remarks were reported in the comments section of the questionnaire.

Managers' experiences

- The lack of understanding of what good supervision is and the value and benefits that can be gained are desperate from my experiences among CPNs.
- Peer group supervision strongly improves communication and moral.
- Supervision has been my experience for 11 years . . . I've always viewed it as positive, self-developing, but always in need of clarification as to goals, functions, style.

CPNs' experiences

- Although I find the thought of supervision threatening, it is essential to me if I am to work effectively and consistently . . . Currently I do not receive supervision of any sort.
- Supervision is essential for good practice and both personal and professional growth.
- There are problems in clinical supervision I receive. I recognize the following blocks – time restraint, difficulty in relationships. Problems around supervisor being my manager. Too few trained supervisors to go around.
- I have seen supervision used negatively, finding weaknesses and using them against people (disciplinary issues), but it should not be a disciplinary scenario.

In order to interpret these study data, the results of the 20-item Likert scale were tabulated. Items were divided into the subscale headings (value, understanding and practice) and each response, for example, strongly agree, was expressed as points (1–5 or 5–1). CPNs' and managers' percentages of these points were calculated (see Tables 12.4, 12.5, 12.6, 12.7, 12.8).

Table 12.4 was calculated primarily to help with the interpretation of the results, although on the basis of these data, it follows that overall explications can be made about the similarities in attitudes between the two groups. A constant theme emerged: the majority of CPNs and managers agreed overall with the positively worded statements and plainly disagreed with the negatively worded statements. For this reason, individual statistical tests were not performed on each item; however, evidence to show that such concomitance hold good are seen in Table 12.8. The minimum score for the CPNs was 66, for the managers, 73. The maximum score for the CPNs was 95; for the managers, 94 (Table 12.7). The mean and standard deviation of scores were computed (Table 12.8). The reliability of the instrument was assessed by calculation of the coefficient alpha for total scores, both for the pilot sample and total sample. This is shown in Table 12.9.

Table 12.4 Calculation of percentages of CPNs and managers of responses on the Likert scale grouped under the subscale heading 'value'

Responses on Likert scale specific to each statement		*% of CPNs (n=61)*	*% of managers (n=30)*
Supervision improves standards of care			
*	5	49.0	43.5
	4	36.9	50.0
	3	8.1	6.5
	2	–	–
	1	–	–
Too much emphasis is placed on the value of supervision			
—	1	1.6	–
	2	3.2	–
	3	11.4	6.6
	4	55.7	37.6
	5	24.5	36.6
Supervision can lead to personal development			
*	5	46.0	53.3
	4	47.5	43.3
	3	2.0	–
	2	–	3.5
	1	3.5	–
New skills can be gained in supervision			
*	5	34.5	36.6
	4	62.0	60.0
	3	–	3.3
	2	3.0	–
	1	–	–
Supervision relieves isolation			
*	5	40.9	43.3
	4	54.0	46.6
	3	4.9	3.3
	2	–	3.3
	1	–	–
Greater confidence results from supervision			
*	5	31.1	36.6
	4	52.4	50.0
	3	13.1	10.0
	2	–	3.3
	1	–	–

SA = strongly agree; A = agree, U = uncertain; D = disagree; SD = strongly disagree

* positive scoring (SA-5, A-4, U-3, D-2, SD-1)

— negative scoring (SA-1, A-2, U-3, D-4, SD-5)

Note: Fractional percentages have not been rounded off to a higher or lesser integer, therefore certain values may affect totals.

Table 12.5 Calculation of percentages of CPNs and managers of responses on the Likert scale grouped under the subscale heading 'understanding'

Responses on Likert scale specific to each statement		*% of CPNs (n=61)*	*% of managers (n=30)*
Supervision restricts autonomy			
–	1	3.2	46.6
	2	–	10.0
	3	–	–
	4	50.8	43.4
	5	45.9	46.6
I am generally suspicious of supervision			
–	1	1.6	3.3
	2	–	–
	3	3.2	–
	4	45.9	50.0
	5	47.5	46.6
Managers are the best supervisors			
–	1	–	–
	2	14.7	10.0
	3	14.7	16.6
	4	52.4	66.6
	5	32.7	3.3
Supervision is concerned with scrutinizing work			
–	1	1.6	–
	2	–	26.6
	3	9.8	3.3
	4	55.7	53.3
	5	19.6	15.0
I find supervision threatening			
–	1	–	–
	2	6.5	6.6
	3	4.9	–
	4	57.3	56.6
	5	29.5	36.6
Supervision means criticism			
–	1	1.6	–
	2	4.9	–
	3	4.9	–
	4	45.9	43.3
	5	36.0	56.6
Supervision is exercising leadership			
–	1	3.2	3.3
	2	13.1	10.0
	3	14.7	13.3
	4	42.6	46.6
	5	24.5	26.6
Supervision means discipline			
–	1	–	6.6
	2	24.5	26.6
	3	4.9	4.9
	4	44.2	33.3
	5	24.5	26.6

Table 12.6 Calculation of percentages of CPNs and managers of responses on the Likert scale grouped under the subscale heading 'practice'

Responses on Likert scale specific to each statement		*% of CPNs (n=61)*	*% of managers (n=30)*
All CPNs should receive supervision			
*	5	73.7	80.0
	4	26.1	20.0
	3	–	–
	2	1.0	–
	1	6.0	–
Experienced CPNs do not need supervision			
–	1	–	–
	2	–	–
	3	–	–
	4	42.5	50.0
	5	55.7	50.0
Supervision is essential in CPN training			
*	5	42.5	60.0
	4	34.4	40.0
	3	13.1	–
	2	6.5	–
	1	1.6	–
Other disciplines can give supervision			
*	5	11.4	16.6
	4	44.2	53.3
	3	14.7	–
	2	13.1	20.0
	1	16.3	–
Supervisors need appropriate training			
*	5	52.4	43.3
	4	42.6	43.3
	3	3.2	6.6
	2	–	3.3
	1	–	3.3
Supervision activities require an element of planning			
*	5	29.5	60.0
	4	65.5	36.6
	3	1.6	3.3
	2	1.6	–
	1	1.6	–

Table 12.7 Minimum and maximum scores

Respondents	*Minimum score*	*Maximum score*
CPNs	66	95
Managers	73	94

Table 12.8 Mean and standard deviation (sd)

Respondents	*Mean*	*sd*
CPNs	82.81	7.0
Managers	82.86	6.3

Table 12.9 Reliability (coefficient alpha) of the total sample (n=91)

	Total sample (n=91)
Total score	0.72

Table 12.10 Resultsof a t test on attitudes towards supervision

t	*df*	*p*
0.31	89	.9752

t = t test
df = degrees of freedom
p = probability

In order to be able to test for significant differences in responses, the null hypothesis – there is no signficiant difference between managers' and CPNs' attitudes towards supervision on this instrument – was tested using an unrelated t test. (Table 12.10).

The results failed to reject the null hypothesis. The data show that the differences in attitude between CPNs and managers towards supervision not to be statistically significant (t=0.31, df=89, p=0.9752, where t=t test, df=degrees of freedom and p=probability) at the 0.05 level.

The results in this study showed that different attitudes between CPNs and managers towards supervision were not present in the study sample. In fact, quite the opposite was found; CPNs' and managers' attitudes were apparently similar overall. The results indicated that a favourable attitude existed between the two groups in this study. The results may have several explanations. Conditions such as poor interactions between CPNs and managers may not be as important as previously stated. Findings regarding operational and main base accorded almost identically with White's (1990) findings (managers may not be working in the same place). Therefore it was possible that contact between CPNs and managers was limited.

It may have been that geographical distance between the two groups mobilized CPNs to make use of supervisors elsewhere; therefore, the expressed result that members of other disciplines could give supervision could be taken to be the 'norm'. Additionally, poor access to managers may have accounted for the finding that managers were not the best supervisors. Further, it may be that the positive attitudes of other groups (psychiatrists, psychologists and social workers) militates for supervision as a requisite for CPN work and thereby encourages supervisory practice.

Alternatively, the possibility exists that, at best, the results may be derived from a positive relationship or mutual understanding of each other's role. This could be because the demographic data suggested that most of the managers carried caseloads, and thereby understood the diffculties of CPN work at first hand. This situation may account for the unequivocally positive results (for example, mean score of at least 4) on items that all CPNs should have supervision (positively worded) and that experienced CPNs do not need supervision (negatively worded). Another variation could be that CPNs and managers have only recently become aware of the meaning of supervision. Data indicating high course attendance and the favourable attitudinal response to the statement that supervisors need training, might suggest that supervisory skills and knowledge have been acquired. It might be expected, therefore, that these new skills would lead the two groups to respond confidentially about the value of supervision. In connection with this, managers may still be working with CPNs whose 'conduct' is seen to be deficient, but managers are now better equipped to offer feedback on problems in an assertive and constructive manner. Hitherto, without such skills, feedback may have been defined negatively, thus leaving CPNs feeling threatened and disciplined. These skills, in turn, may have contributed to the favourable attitudinal result that supervision was not discipline, criticism or threatening. As such, at least for the respondents in this study, the negative effect of supervision expressed in the literature may be dated.

Basic training issues should be considered. The demographic data suggested that most of the subjects had spent considerable time in community psychiatric nursing. This was reflected in the predominance of G grades of the CPNs and the H and I grades of the managers. This suggested that the majority of the two groups did RMN training before the 1982 syllabus was introduced. There is little doubt that the previous RMN syllabus and, indeed, the ENB 810/811 courses are deficient in teaching skills (Wolsey, 1990). Therefore, it might be expected that those respondents who scored high on the statements specific to gaining skills, personal development and improving standards of care were dependent on supervision for the acquisition of skills to do CPN work. The interpretation of the overwhelming response that supervision improves standards of care was not immediately obvious; there was no sound evidence in the literature to suggest this was the case. It might, therefore, be possible that the groups made assumptions about improvements in care by reason of felt support; for example, attitudinal results suggested that supervision relieves isolation and leads to greater confidence. Needless to say, other factors not examined in this study may have contributed to this result.

METHODOLOGICAL CONSIDERATIONS

Several methodological concerns are evident in this study. The most plausible reason for the results obtained was the sample size. Since these data are based on sample evidence, there was a possibility that the sample could yield a result different from that if the total population was studied. Further, the present results could not be explained readily in terms of the published literature. First, some obvious drawbacks arose when this study was compared with previous work. In the absence of empirical data on supervision in community psychiatric nursing, direct comparison was made difficult. As mentioned earlier, much of the previous work draws conclusions based on individual opinion and interpretation. Second, some of the literature was American, which raised the question about its applicability to CPN services in the UK and to this present study. It was therefore reasonable to suggest that the literature should be interpreted with caution.

It is also possible that there could have been differences in attitude which were not detected by this study's methods, although the instrument has the advantage of being tested for reliability and validity. The results of the coefficient alpha were good. This was weakened, however, by the method for developing the subscales; these were identified subjectively by the researcher. The obvious question that arises is 'does the data coincide with the subscales?' The results might have been more tenable if confirmed by factor analysis. Of the validity, this referred only to the content validity, rather than construct or criteria-related validity, and assessment of content validity is based essentially on individual judgement and opinion and is therefore subjective.

Another possible reason for the results is that the demographic data revealed that the sample differed in some ways from the CPN/manager population. For example, the number of actual 800/810/811 course completers was significantly higher than the last known national average; the majority of managers carried caseloads, which was far more than envisaged, and most had attended supervisors' courses. Such differences were difficult to exclude from the present study, and would be removed or controlled only if a national survey was undertaken. This would allow for more confident generalizations from these data. However, these differences were offset by the fact that both groups were matched with the entire CPN population on other demographic characteristics.

Another factor also existed, namely that definitions and statements not expressed in this study may have contributed to the results. For example, an overall definition of supervision or category definitions (educational, managerial, personal and clinical) in the questionnaire might have produced different findings. Against this, however, the inclusion of any definitions could have lead to a bias in the researcher favour.

Other similar issues existed. It was not known if the sample were receiving supervision, or if it is available to them; explicit practices were not examined in this study. However, it is plausible to suggest that many respondents received supervision, as all were able to answer statements standardized to the first person, which may imply that respondents were drawing from personal experiences. Furthermore, White's (1990) preliminary findings suggested that 75.2% of CPNs received supervision, although he argued that this substantive area warranted further investigation, as the nature and extent of this supervision remained unclear.

It is not unreasonable to suggest here that respondents' attitudes may have been 'frozen' before they became CPNs. For example, their attitudes may have originated from previous experiences during training, working on hospital wards and even in different health authorities. The possibility also existed that the responses were not representative of the respondents' actual feelings. Moreover, it would be erroneous to assume that there was always a consistency between attitude and behaviour. In other words, respondents may have believed in the notion of prescribing and practising supervision, but with little evidence supporting the effectiveness of supervision (Hart, 1982).

The other issue was that of 'social desirability' (Polit and Hungler, 1987). While the topic of supervision has been the subject of many years' debate, the attention it currently receives through CPNA training events and so forth may have lead respondents to respond in a way that they deemed as being desirable within the CPN culture. This, in turn, may have contributed to the discrepancies between the subjective data (respondents' comments) and the objective measures (empirical evidence). For example, one respondent reported that she did not receive supervision, but her objective responses were very favourable.

Possible implications

This study was a pilot, but which had practical implications. Notwithstanding the methodological concerns, the practical interest to both CPNs and managers in their perception of supervision as being positive deserved some comment. This study attempted to clarify the relationship or mutual understanding which existed between CPN and managers specific to attitudes towards supervision. Certainly, analogues in the literature could now be questioned. In this case, both groups in the study could now be made aware of their shared commitment towards this topic. The collaborative effects could provide a basis for creative and flexible discussion about ideas and problems concerning supervisory practices at service level. Additionally, the causation of problems which still surround supervision were more likely to be answered if communication improves. Ways should be found which allow both groups to communicate these commitments, problems and ideas. However, until the effectiveness of supervision is assured through empirical studies, issues are unlikely to improve spontaneously. During the course of this study, the common attitudes towards supervision have emerged as key indicators for further work at service level. CPNs, managers and in-service teachers should take responsibility to provide opportunities and training in order to facilitate the growth of positive attitudes. Furthermore, until CPNs have their own verison of supervision that provides explicit definitions and models, they will continue to focus on other work which has been undertaken by other health professionals (Hart, 1982).

CONCLUSIONS

This study attempted to provide information about the attitudes of CPNs and managers towards supervision. The results indicated that a favourable attitude exists in the two groups. In this sense, the results could be interpreted as being positive, particularly if they were borne out of actual practice. They could in future provide the basis for creative and flexible work at service level and continued investigation. However, serious methodological issues have been encountered by this study. These will be faced by other studies in the same substantial area in the future and need to be addressed before unequivocal claims about attitudes can be made. In the absence of empirical comparative data from nursing literature, the claims here have been appropriately modest until the methods are devised and extended to a larger CPN population.

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