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Supporting carers of people diagnosed with schizophrenia: evaluating change in nursing practice following training

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Background. United Kingdom legislation and clinical standards for schizophrenia challenge nurses to re-examine the support that they provide to carers. Nurses are in a key position to provide this support but may lack the necessary skills to do so. The training programme evaluated in the present study aimed to address this problem.

Study aim. To evaluate change in clinical practice brought about by post-registration training for mental health nurses in supporting carers of people diagnosed with schizophrenia.

Design/methods. The study was undertaken in collaboration between the Universities of Dundee and Glasgow, and Tayside National Health Service (NHS) Trust (Scotland). Respondents were nine nurses who completed training and then delivered a planned programme of support to carers. Data on nursing practice were gathered through semi-structured interviews with nurses before training and after providing support. Following the support intervention, carers also commented on the nurses' practice.

Findings. Eight of the nine nurses reported changes in practice in five key areas: They built collaborative relationships with carers, developed a carer focused approach to their practice, acknowledged and supported the carer role, and made progress in identifying carer needs and accessing resources to meet these needs. Nurses experienced difficulties supporting carers who had mental health problems or previous negative experiences of services. Those who lacked community experience also found it difficult to adjust to working in a community setting. Although clinical supervision helped them to work through these difficulties, they remain largely unresolved.

Conclusions. Findings from this study indicate that appropriate training may enable nurses to improve the support provided to carers of people diagnosed with

schizophrenia. This study represents an important stage in determining the nature of support offered to carers by nurses. While developed to help nurses to meet clinical standards set for schizophrenia in the UK, findings may have clinical significance for nurses in other countries.

Introduction

Current United Kingdom (UK) health and social care policies place the needs of carers to the fore on the service provision agenda (Hancock & Jarvis 1994, Department of Health [DoH] 1999a, 1999b). Commitment towards care in the community explicitly relies and builds on the family system to provide unpaid support to clients (James 1992, Nolan *et al.* 1999, Hirst & Arksey 2000, Nolan 2001). Evidence, however, consistently indicates that carers' needs for support remain largely ignored by health professionals (James 1992, Twigg & Atkin 1994, Atkinson & Coia 1995, Henwood 1998, Rose 1998, Warner & Wexler 1998, Hatfield 2000, Nolan 2001). Further, the most effective ways of meeting carers' needs remain unclear (Nolan *et al.* 1995, Rose 1998, Clinical Standards Board for Scotland [CSBS] 2001). If professional support offered to carers is to improve then health service professionals, including nurses, need to develop

What is already known about this topic

- Mental health nurse training and support programmes are mainly client- or family-centred rather than carer-focused.
- Carers' emotional and psychological needs remain largely unmet by current mental health nursing practice.
- Mental health nurses are in a key position to support carers but may lack the necessary knowledge and skills to do so.

What this paper adds

- The reported study indicates that practice change might result from a new training programme designed for mental health nurses to support carers of people diagnosed with schizophrenia.
- It suggests that carers' needs should be identified and resourced in ways that are acceptable to carers.
- It identifies that the next step is to assess the effectiveness of the support programme in meeting carers' needs and in reducing carer burden.

their understanding of carers' needs and develop interventions to meet these needs (Atkinson & Coia 1995, Casey 1995, Nolan *et al.* 1995, Kellett & Mannion 1999, Hatfield 2000, Magorrian 2001).

Background

This study focuses on the primary carer: i.e. a family or nonfamily member who provides care or support to someone diagnosed with schizophrenia and is living in the community. Evidence indicates that caring for a relative diagnosed with schizophrenia can be stressful and may result in increased burden (Cuijpers 1999). The UK National Strategy for Carers recognizes this and introduced measures to support carers (DoH 1999b). The National Framework for Mental Health England (DoH 1999a) places high priority on carers. Arising from this, clinical standards were set for the professional support of carers of people diagnosed with schizophrenia within Scotland (CSBS 2001).

There is a lack of robust evidence on the most effective means of providing support to these carers (DoH 1999a, CSBS 2001, CSBS 2002). As a result, the clinical standards fail to indicate how carer support should be achieved. Key findings from a national review of clinical standards for schizophrenia (Scotland) (CSBS 2002), found that while some innovative practices existed a comprehensive range of services was lacking. A review of support interventions for carers of people diagnosed with schizophrenia indicates that most professional support has an educational focus (Mari & Streiner 1994). However, carers also want emotional and practical support (CSBS 2002). Not surprisingly, many carers report that their needs are ignored or given low priority (Nolan *et al.* 1994, Twigg & Atkin 1994, Wray 1994, Atkinson & Coia 1995, Chambers *et al.* 2001). Spaniol (1987) and Milleken (2001) suggest that professionals are often unaware of carer needs and level of service dissatisfaction. Nolan and Grant (1989) highlight that this may lead to irrelevant support and Walker and Dewer (2001) indicate that this may result in misunderstandings that can increase carer stress and dissatisfaction and inhibit them from seeking further help.

Many mental health nurses are in a prime position to provide support to carers (Brooker 1990, Atkin & Twigg 1993, Neary 1993, Gray 1998, Nolan & Lundh 1999). However many may need to develop their knowledge, skills and attitudes to enable them to provide this support (Brooker 1990, Winefield & Burnett 1996, Szmukler & Bloch 1997, Milleken 2001). Traditionally mental health nursing interventions focus on the needs of clients and when nurses establish contact with carers the nature of this is largely determined by priorities that are set in this context (Walker & Dewer 2001). Hatfield (1997) proposes that health professionals should shift to a carer focus that will require them to work collaboratively with carers. This involves viewing the carer as an equal partner, determining their support needs, respecting their unique perspective and empowering them in a co-operative alliance. Post registration training for nurses may play an important part in promoting the required change in practice (Waddell 1991, Abrouzese 1996, Simpson 1999).

The study

Aim

To evaluate change in clinical practice brought about by post registration training for mental health nurses in supporting carers of people diagnosed with schizophrenia.

Study design and methods

This study uses a before and after design and involves a single sample of nurses from one National Health Service (NHS) Trust hospital within Scotland (Figure 1). No control group

was used. Nurses were interviewed at baseline, (1 week before starting the course), and at follow-up immediately after delivering the intervention (approximately 6 months after baseline). Carers were also interviewed after receiving the intervention, and asked to evaluate the nurses' practice. Questions contained in the nurse and carer interviews were based on the key practice outcomes of the training programme. The nurse and carer interviews were supplemented by a short self-administered postal questionnaire that gathered demographic information and details of how the support programme was delivered.

Training and intervention

The training and support interventions were developed and delivered during 1999 and 2001. Scheller (1993) proposes that to increase the likelihood of practice change following training, practice outcomes should be derived from an assessment of user needs. To achieve this, the content for the training and intervention were developed from a series of focus group discussions with carers, nurses and service managers (Gall *et al.* 2001). The training programme builds on an educationally focused training package developed by Atkinson and Coia (1995). The support intervention extends the work of Nolan *et al.*'s (1999) assessment of carer satisfaction, difficulties coping and managing.

Training

Training was developed, and validated, as a level three post registration module worth 20 Scottish Credit Accumulation Transfer points. Carers, one member of the National Schizophrenia Fellowship (Scotland) and nursing lecturers delivered it. The course was run 1 day per week over 12 weeks

Table 1 Training programme

Method	General content	Practice outcome
10 face to face interactive teaching sessions with extensive discussion	Carer stress, burden and satisfaction	Adopting a carer-focused approach
	Professional approaches to carer support	Collaborative working
	Support intervention: Partnership, collaboration and enabling	Identifying carers' needs
	Assessing carers' needs	
	Coping and managing Psychoeducation	
Two educational focused visits	Carers' perspective	Acknowledging and supporting care role
	Conflict	All outcomes
	Ethical/political/professional/legal issues	
	Carer support services Multidisciplinary working	Identifying resources to meet carers' needs

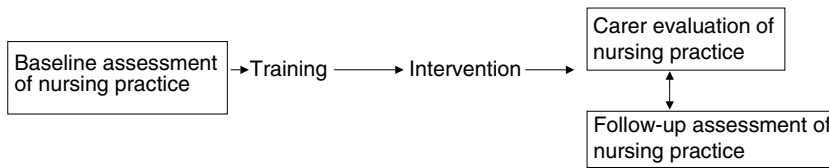


Figure 1 Support intervention.

(Table 1). The content for the training programme, which included exposure to carers real life experiences, focused on five key practice outcomes:

- working collaboratively with carers;
- utilizing a carer-focused approach;
- acknowledging and supporting the carer's role;
- helping carers identify their needs;
- accessing appropriate resources to meet the identified needs.

Support intervention

This comprised of a maximum of 12 support sessions delivered over a period of 12 weeks and involved carer assessment and intervention (Figure 2). A care history was taken followed by an assessment of carers' needs. Assessment involved a process of negotiation whereby the nurse assisted carers to identify their needs in four main areas:

- practical care needs;
- educational needs;
- coping and managing;
- satisfaction with caring.

Resources to meet these needs were explored, identified and discussed. Resources included the carers' expertise, experience, knowledge, or external resources, such as the nurses' expertise or additional support services. An agreed action plan was then formulated to address carers' needs. The remaining sessions were devoted to revisiting and developing action plans for outstanding or longer-term needs. The carers' assessment and action plans were recorded in a booklet developed for this purpose. The booklet was completed jointly by the nurse and carer and was retained by the carer. The development and content of the training and support intervention are more fully described elsewhere (Gall *et al.* 2001).

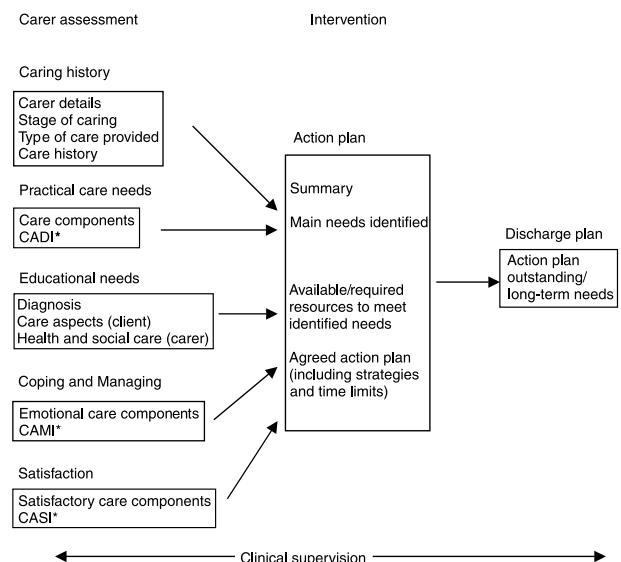
Samples

A non-random sample of 10 mental health nurses was selected to participate in training and deliver the intervention. Nurses were recruited through an internal hospital advertisement. Ten nurses applied and were accepted. All were working with people diagnosed with schizophrenia who had a main carer. Each nurse was asked to provide support to one carer. Carers were selected randomly from the nurse's recent

patient case list, and asked to participate in the study. Permission was obtained from the patient prior to approaching their carer. If a patient or carer refused to participate another was randomly selected and approached. Previous contact between the nurse and carer was minimal and only occurred in relation to client related issues. A carer was defined as the main carer for a relative diagnosed with schizophrenia who was living in the community. No restrictions were placed on the length of time caring or the severity of the client's illness.

Data collection and analysis

A researcher carried out all the nurse and carer interviews. Each interview lasted approximately 40 minutes and was audio taped. The interview contained questions relating to the key practice outcomes; working collaboratively with carers, utilizing a carer focused approach, acknowledging and supporting the carer's role, helping carers identify their needs, and accessing appropriate resources to meet the identified needs. Two weeks prior to this interview each nurse and carer was sent the short self-administered postal questionnaire.



*CADI – Carers Assessment of Difficulties Index
 *CAMI – Carers Assessment of Managing Index
 *CASI – Carers Assessment of Satisfaction Index

(*With permission of Nolan *et al* 1999)

Figure 2 Study design.

Audio recordings of all interviews were transcribed verbatim. Responses were grouped according to the key practice outcomes. The nurses responses prior to training were compared with their responses following the delivery of the intervention to one carer. The nurses responses following the intervention were also compared with the carer responses. Numbers and letters are used consistently throughout this paper to represent the nurse (N) and carer (C) pairs, e.g. N1 delivered support to C1. Quotes given in the text are illustrative and reflect responses commonly given by the nurses and carers.

Ethical issues and approval

Ethical approval for the study was obtained from the Local Research Ethics Committee. Each participant was provided with a written explanation of the study and gave their written consent before taking part. Consent was obtained from the carer, the client and the consultant in charge of the clients' care. Every effort was made to ensure the anonymity of participants.

Findings

Nurses

All are Registered Mental Health Nurses aged between 22 years and 51 years with clinical experience ranging from 1 to 14 years. The sample consists of three senior charge nurses, one charge nurse and six staff nurses. Nine are female. Six are ward based; three work in day care units and one is community based. Of the 10 nurses, nine provided support to a carer. One nurse, who did not provide support, moved to a managerial post and was unable to make contact with their carer (Table 2).

Carers

Nine carers received support. All are mothers of the clients. Six clients live with the carer, one lives part time with the carer, and two clients live on their own. The carers' ages ranged between 48 and 65 years and had cared for the client since the onset of the disorder, between 5 and 24 years (Table 2).

Support sessions

The number of sessions delivered by the nurses ranged between 1 and 12 and the duration varied between 45 minutes and 2 hours (Table 2). Eight carers requested home visits, and one nurse met the carer in a private room within

Table 2 Nurse and carer details: including contact hours for support sessions

Nurse/carers pairs	Nurses base	Duration of clients' diagnosis (years as carer)	Hours contact with carer
1	Ward	15	12
2	Day hospital	8	20
3	Ward	5	8
4	Ward	8	18
5	Ward	14	4
6	Ward	6	10
7	Community	24	22
8	Day hospital	5	1
9	Ward	12	15
10	Day hospital	N/A	0

the hospital. The number of sessions varied in response to carers' needs. Some had few support needs but still found it helpful to talk about carer related issues. Carers reporting more complex needs required more intensive support. Complex needs arose from the carers mental health or family problems, social isolation, the client's mental health problems or admission to hospital. Carers experienced no difficulties arranging sessions with a nurse.

Nurses accounts of practice

Working collaboratively with carers

Prior to training, nurses described their contact with carers as largely occurring during crisis or when carers required specific information about the client. Nurses described the nature of this contact as informal, ad hoc and unstructured, with no guarantee that carers received the input that they needed. None of the nurses had prior training in carer support and reported that their basic training had not prepared them to work with carers.

A key practice outcome was that nurses work collaboratively with carers. To achieve this nurses had to: listen to and acknowledge the carers' perspective; remove barriers preventing carers from openly communicating with them; acknowledge the expertise of the carer and adopt an expert to expert approach in their interactions with the carer. Following training, most nurses found working collaboratively with carers to be one of the easiest aspects of their practice.

Before I used to think I was the expert. I was there to give information. Now I am more prepared to listen to what carers have to say.

I learned a lot from (carer). I really did, about the illness. It is not that I didn't know about it but I learned what it is like, I suppose, for somebody caring 24 hours a day, 7 days a week.

Utilizing a carer-focused approach

Before training nurses expressed uncertainty about dealing with conflict between the needs of the client and the carer. This uncertainty was often resolved by prioritizing the needs of the client. As a result nurses felt that some carers were not getting the service that they expected.

The parents get upset, there is a lot of tears, they feel let down. They feel that they are not getting the services that they expect.

During training, nurses were asked to focus on the carers, not the patients' needs. On adopting a carer-focused approach in practice nurses were often surprised by carers accounts of their experience of caring and service provision, and felt privileged that carers were willing to openly share these.

I felt privileged, we all did, to be privy to such personal information.

What it brought home to me was how horrendous a life the relative had, without support, without anyone really understanding.

Acknowledging and supporting the carer's role

Prior to training, the nurses reported that their communication with carers was often superficial and lacked structure or understanding. Some nurses described their responses to carers as intuitive or derived from life experience. The nurses wanted a framework in which to develop their skills, strategies and confidence to engage effectively with carers.

Following training, nurses reported that as their understanding of carer related issues developed they were more able to acknowledge the carer's role and support them in this.

In some instances supporting the carer's role meant advocating on behalf of the carer to other members of the multidisciplinary team in order to raise awareness of the carers' perspective. The nurses also reported validating the carers' experiences and actions, and providing the carer with information and emotional support.

I am definitely more aware of carers' needs. I find myself advocating more saying, "no, this isn't right". The carer needed information, social support and emotional support.

Helping carers identify their needs

Prior to training the nurses reported that they lacked a practice framework that would enable them to assess carers' needs. Following training nurses valued having such a framework and reported that it had enabled them to identify a range of carer needs. The nurses' also reported increased awareness of carers' needs and ways of collaborating with carers to help them to identify their support needs.

There was a framework. I found that I got a lot of information from just listening to the carer and using the booklet as a point of reference.

I was much more able to ask questions and was a lot more comfortable doing so, also I knew what questions to ask.

Accessing appropriate resources to meet the identified needs

Prior to training nurses reported that they lacked the knowledge and skills to enable them to address carers' needs, as indicated in the following quote;

How to give carers' what they need not just what I think that they need.

In particular nurses reported a lack of confidence in providing information to carers', largely due to their own lack of awareness of what supports were available. Following training nurses were more aware of carer support services and how carers' could access these services. One nurse describes this;

I did not even know that half of these services existed, so yes, I felt that I was able to access them and find out for myself as well as the carer.

Conflict

The nurses reported a number of issues that they found difficult to address in practice. Some issues related to carer's previous negative experiences of services, their mental health problems, and the client abusing drugs or alcohol or being verbally or physically abusive to the carer. Some carers also reported interfamily conflicts or social isolation.

Assessment is about looking at the whole picture and the whole picture can be disastrous.

This led some nurses to report a lack of clarity regarding the parameters of their role in relation to carer issues. This was particularly evident for nurses who lacked experience of working in a community setting.

I think I felt swamped by the position the carer was in. Maybe, when you are used to working in a ward and then suddenly you are on your own.

Nurses felt uncomfortable hearing carer's negative accounts of health service providers. In particular they felt embarrassed about negative accounts of services in which they worked, and were concerned that carers' were reluctant to use these services. Five of the nine carers' reported past negative experiences.

When the carer was talking about services. When she was talking about not being recognized, not being listened to or believed. I was embarrassed to say that I was part of that service.

Clinical supervision

Clinical supervision was available from senior nurses experienced in community working. Seven of the nurses attended

regular group or 1–1 sessions, and found this beneficial to practice. Generally they found supervision enlightening, constructive and enabled exploration and reflection on clinical experience. This increased their awareness of conflicts and helped put these into context.

I have never had clinical supervision like this. The clinical supervision with (X) I cannot describe it as anything other than excellent. By reflecting all the time I was able to sort out problems and it was like someone simply switching on a light. I looked forward to the next session.

Two nurses did not attend supervision. One moved area and was unable to attend and did not arrange telephone supervision. The other was focused on developing her ability to work in a community setting with carers' and did not make time to attend. On reflection, both nurses felt that clinical supervision would have helped their clinical development.

Carers accounts

Working collaboratively with carers

Carers' accounts of their relationship with the nurses generally emphasized the nurses' ability to communicate and work in collaboration with them.

It was helpful, to be able to talk and ask questions. She was a good listener. I hid things from others. I don't like telling other people. But you don't mind telling the nurse.

I could talk to (nurse). She was approachable and understanding.

Carers reported no embarrassment in discussing personal difficulties and felt that issues were approached sensitively. As this quote illustrates, carers valued the nurses' ability to raise important issues.

At first yes, I didn't like to mention too much about financial problems. But the nurse brought that up. She was excellent.

Utilizing a carer focused approach

Carers reported that sessions were carer, rather than client focused and found it helpful to talk to someone knowledgeable and understanding about issues that were important to them.

It is about (me) and how I feel and (nurse) let me know that every time.

It was nice to talk to someone who understood. I have never spoken to somebody who knew what I was talking about. It was nice to speak to somebody who knew what it was about.

Carers also identified that support provided by these nurses differed from other professional contacts including those with

the client's Community Psychiatric Nurse (CPN). The following carer contrasts her relationship with the client's CPN.

With (nurse) it was about me and how I feel. With (CPN) it is more general about how my son is coping.

The nurse focused on me and listened to what I was saying.

Acknowledging and supporting the carer's role

Carers felt that nurses gained awareness of the life problems and extent of burden on them, particularly those coping 24 hours a day with someone with a severe mental health problem. Carers' felt that nurses developed their understanding of the complex issues involved in caring, and how this impacts on a carer's life. Carers' reported that nurses had acknowledged and supported them in their role as carers.

I found the support very welcome. Having somebody to listen to me. Before, a carer was never listened to. I would come home from visiting my son, have a good cry, go to bed and shut the doors. I was very, very traumatized. If I had someone like the nurse then, who I could talk it out with.

I just knew he was very ill, and (the nurse) helped me to see that my feelings were genuine. I wasn't panicking which was excellent.

Helping carers identify their needs

Carers identified a range of needs during the nurses' visits and developed resources to address these. (Table 3)

Despite the general ability of the nurses to support carers there were issues that the carers reported were not dealt with. Two carers' felt that nurses failed to address the question of who would care for the client if they were unable to continue caring.

But, what will happen to him if I die tomorrow, ever? I can't get a satisfactory answer to who is going to take charge and help him? Why is that?

Accessing appropriate resources to meet the identified needs

The main resources utilized by carers' to meet their needs are also presented in Table 3. A range of resources were utilized and included; carer-based resources, such as developing family interests; nurse based resources, such as stress management strategies and external resources such as carer support groups.

Discussion

Findings from this study suggest that practice change may be brought about by training nurses in supporting carers of people diagnosed with schizophrenia.

Table 3 Carer main needs and resources identified

	Carer								
	C1	C2	C3	C4	C5	C6	C7	C8	C9
Needs									
Social isolation	x					x	x		x
Diagnosed depression	x	x			x	x			
Stress				x	x		x		x
Fatigue				x	x	x	x		x
Over caring	x	x				x	x		x
Related family problems	x	x			x		x		
Low coping	x			x	x				
Low satisfaction									x
Financial difficulties		x							
Validate coping and managing			x						
Lack of professional support								x	x
Resources									
Developed social contacts	x					x			x
Joined carer support group						x	x		x
Stress management strategies		x				x	x		
Set limits on carer role	x	x				x	x		x
Developed interests with family							x		x
Coping/managing strategies	x			x		x			
Validated coping/managing			x						
Developed satisfaction with caring				x					x
Financial support		x							
Professional support					x				x

Study limitations

These findings need to be considered in relation to the study limitations. There are three main limitations: generalisability; reliability and validity of nurse and carer reports; and the level of inference associated with the study design.

The nurses involved in the study were predominately hospital based and had limited community experience. It is therefore difficult to generalize findings to other nursing populations particularly community nurses. Similarly, carers were derived from those already in contact with mental health services. Many carers', particularly those at an early stage of caring, may not be in contact with these services. It is unclear how they might view the support offered. It should also be acknowledged that the numbers in this study were small and there was great demographic variability within the samples.

It should be acknowledged that data on the nurses' practice are based on self-reports from nurses and carers and not observations of actual clinical encounters. Although carer's corroborated the nurse's reports, objective measures might have enabled a more detailed assessment of practice. Thus the reliability and validity of these data may be open to question. Carer outcomes could also have been measured, particularly in the areas of carer stress and burden.

As no control group was used it is difficult to infer what practice changes occurred as a result of training compared to those that may have been due to other factors. Further, no long-term follow up was carried out to determine if nurses maintained the practice change, or if carers derived long-term benefits.

Strengths of the study

There are, however, a number of strengths to the study. First, the training and support programmes were based on evidence from focus groups and existing programmes (Gall *et al.* 2001). Second, nurses' reports prior to and after training were compared and these were supported by carers' accounts. Finally, this may be the first study to provide evidence of the possible effectiveness of training in bringing about practice change in nurses providing support to carers of people diagnosed with schizophrenia, that is independent of the patient or family. Although effective training courses are available for nurses to develop their knowledge and skills of psychosocial or family interventions, these courses are primarily aimed at reducing relapse in the patient (Dixon and Lehman 1995, Brooker 2001). It is apparent that carers who maintain this patient group in the commu-

nity may themselves have a range of unmet support needs (Repper & Brooker 1998). There is no reported evidence of training courses that focus specifically on developing nurses knowledge and skills of supporting the carers' of people diagnosed with schizophrenia. The training programme evaluated in this study focused specifically on improving the support provided by nurses to such carers'. In doing so it encouraged nurses to change the focus of their practice to include the carer.

The results are encouraging and suggest that training may be an essential element in bringing about the practice change required to meet clinical standards set for the carers of people diagnosed with schizophrenia within the UK. While developed for nurses in the UK to help meet clinical standards set for schizophrenia, findings may have clinical significance for nurses in other countries. Prior to training the nurses described using an intuitive response towards carers'. The use of intuition as the basis of contact with carers is a finding noted in studies of health care professionals, and Goodman (1986) suggests that health professionals should not rely wholly on intuition to inform their practice. Following training, nurses made efforts to recognize, value and acknowledge carer difficulties, develop collaborative relationships with them and adopt a carer-focused approach. Bernheim (1989) reports that a major factor in changing nurses' attitudes is exposure to carers' difficulties. We believe that this was achieved through exposing nurses to carers' real life experiences within training.

Nurses did, however, experience some difficulties in implementing the intervention. The process of shifting towards a carer focus produced difficulty for those nurses faced with carers' complex psychological problems. Caring for a person diagnosed with schizophrenia can affect many aspects of a carer's life including their mental health (Evandrou 1990). Over half of the carers in a study carried out by Henwood (1998) developed stress-related illnesses, particularly depression, and Oldridge and Hughes (1992) found that 36% of a sample of carers experienced clinical levels of stress. Other studies confirm these findings (DoH 1999b, Tennakoon *et al.* 2000). Four of the nine carers in this study had a diagnosed depressive illness, and the same number reported stress. The nurses' role in relation to carers' mental health problems and the extent to which nurses can help directly with these problems may be limited. In these situations additional resources may be required, including referral to other health professionals.

Carers also commonly report family disruption and tense family relationships (Provencher 1996). Dealing directly with other family members is probably out with the role of the nurse in supporting the carer and may require the carer to

utilize other specialist services, such as family therapy. There are other needs reported by carers' that nurses may also be unable to deal with directly. For instance, some carers reported that nurses failed to understand their concerns about the client when they were unable to continue caring. In an exploratory study of the emotional needs of family carers carried out by Chambers *et al.* (2001) the future welfare of the client emerged as a major concern for carers. It would be unrealistic to expect nurses to meet all care-related needs and they may need help to recognize these limitations (Nolan & Grant 1989).

Nurses with community experience may be more able to provide support to carers of people diagnosed with schizophrenia. In this study, difficulties arose for nurses who lacked community experience. These nurses had to adjust to working in carers' homes while simultaneously developing new skills. Carers' wanted to be seen in their own environment. Community based, rather than ward based, nurses found this easier to achieve. In view of this, it may be more appropriate to train nurses who already feel comfortable in a community environment.

Providing clinical support to nurses is extremely important. The environment in which practice change has to occur can influence whether nurses make the practice change required (Cervero 1985, Scheller 1993). In this study service managers were involved in programme development. Clinical supervision was also implemented to ensure that the nurses had a support base. Clinical supervision emerged as a major factor in enabling nurses to overcome difficulties. This supports findings by Berg and Hallberg (1999) who conclude that clinical supervision, particularly the reflective and support components, help to reduce conflict. Clinical supervision should therefore, be considered a crucial component of carer support work, particularly during novice stages.

Recommendations

On the basis of this study some recommendations can be made for future training of nurses in the support of carers of people diagnosed with schizophrenia. Training should reflect carers needs and prepare nurses for the practice change that is required to meet those needs. Nurses with community experience may be best suited to future training programmes. Nurses should receive adequate clinical supervision when implementing the support intervention. Finally, the parameters of nurses' practice with carers should be explored within training and during clinical supervision and limitations acknowledged.

Given the limitations of the present study, further research is required to firmly establish the impact of the training

programme on community nurses' practice of carer support. This might include a stronger designed study that allows the support intervention to be compared with support that is provided to carers as standard community nursing practice. The impact of nurse-led support interventions on carer stress, burden and satisfaction should also be included. Such an inquiry may help identify the resources involved in providing effective support to carers' and develop understanding of which carers' would benefit most from professional support.

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