

**COMMUNITY PSYCHIATRIC NURSING EXPLAINED:  
AN ANALYSIS OF THE VIEWS OF PATIENTS, CARERS AND NURSES.**

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I declare that this thesis  
has been composed by myself  
and that the study reported  
in it was my own work

Linda Pollock

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"It is necessary to warn the reader that any appearance of clarity and systematization, which references to this research might give - is largely a retrospective phenomenon. The actual process of arriving at one's aims seems to the writer to be a muddled one! Clarification does not appear to be achieved with a few clever discussions with one's colleagues or by a few final inspirations. It appears rather as an outcome of experience, and a good deal of muddled thought, with the results that one's aims are subjected to frequent modifications. Sometimes one finds that one has been carrying out certain aims before one is aware of them, or that one is doing things which are directly contrary to one's clearest formulations. The only thing one can say with confidence is that the achievement of clarity depends on the ability simultaneously to tolerate two opposite experiences: a realisation that one is in a muddle on certain points, and a determination to get out of it."

(Shapiro (1963), p129)

(quoted in Sainsbury P and Kreitman N (eds) A clinical approach to fundamental research. London: Oxford University Press.

This thesis is dedicated to my mother - Doon, and grandfather - John Read. I wish you were both here to read the finished product.



## ABSTRACT

This study examines the work of two community psychiatric nursing services and evaluates performance in terms of how this was perceived by carers. Despite differences in the organisation of their services, similarities in the work emerged. A structured interview format - Repertory Grid Technique and the Laddering procedure - is used to explore the nurses' view of the work. A type of questionnaire, the Personal Questionnaire Rapid Scaling Technique is used to elicit the carers' and patients' view of the community psychiatric nurses, and to explore the carers' perception of the helpfulness of this intervention.

The study shows that the emphasis of the nurses' work is on 'making the system work' - with little guidance and direction, either from service organisers or from planners. Paradoxically, despite appearing to operate using varied *modus operandi*, the nurses provide a remarkably uniform service. The service appears to be uniform because of the constraints of finite resources (which limit the number of ways in which the nurses can work), and because the nurses are socialised into the work by their peers. The reality of community psychiatric nursing is that the nurses are not providing individualised care, but instead continually having to juggle resources and to justify *post hoc* the care that they give. This has never been previously documented, and must now be recognised by educationalists, managers and planners.

Another major finding is the emphasis the nurses placed on 'developing relationships'. This is vital to the community nurses, to allow them to make the system work (manage crisis, provide early treatment and prevent hospital admissions). Although the nurses take an eclectic approach to model use, the importance of 'developing relationships' reflects the nurses' use of the 'social model', and contradicts previous findings which emphasised medical model use, by (hospital-based) psychiatric nurses. Satisfaction with the relationship is an important feature of nurse/patient contact. The nurse is not perceived to be helpful to all carers, either for problem relief, or for the experience of caring; carers though, were unanimous that contact with the nurse was generally helpful. The importance of 'developing relationships' reflects the ideology of 'individualised care' used by the nurses; this approach succeeds in making carers and patients feel cared for and helped.

The nurses' work is patient focused and preoccupied with making the 'system' function, rather than providing comprehensive relief to carer's difficulties. Care offered to carers is secondary to that offered to patients, and limited by available resources. Carers were 'used' by the nurses to 'make the system work', although they did not feel 'used'. Certain aspects of caring are shared with the community psychiatric nurse, others are neglected. The more extreme feelings and experiences of carers are not relieved by contact with the nurse. (This is in contrast to 'problems', where, for some carers, extreme problems, appear to have been helped). The factors associated with the 'helped' carers are unknown.

This study shows that individual nurses clearly express the goals in their work, whereas the community psychiatric nursing services, in contrast, seem to be unclear about their's. Future managers must be more explicit about their aims and goals, and introduce a research component to evaluate and monitor the performance of local services.

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# **CHAPTER**

# **1**

## **Introduction**

## 1:1 AIMS AND OBJECTIVES

### *Introduction*

#### **Objectives**

The main objectives are to find out whether (1) community psychiatric nursing is effective, and (2) to develop a research tool to evaluate community psychiatric nursing services.

#### **Main aims**

These objectives are achieved by evaluating two community psychiatric nursing services. This evaluation is: firstly, at the level of individual practice, to provide qualitative information about the 'process' of community psychiatric nursing and secondly, in relation to the patients' and families' response to this service, to provide 'outcome' information.

#### ***1. Process Evaluation***

It is not clear from the literature what goals community psychiatric nurses are aiming for. The goals for community psychiatric nursing activity tend to have been stated in imprecise, broad terms (see p53), and the available quantitative measures tell us little about their attainment (see p78). Some goals of community psychiatric nursing activity can, of course, be measured in quantitative terms (see example on p8), but many others, e.g. improving a patient's social skills or his capacity to cope with stress, are less amenable to quantitative measures. The present research aims to provide a broad analysis of community psychiatric nursing practice, and to examine the values and assumptions underpinning the work of the community psychiatric nurses. The work of community psychiatric nursing specifically with carers, is also explored,

#### ***2. Outcome Evaluation***

The 'outcome' part of the study discovers how carers perceive community psychiatric nurses, and how carers' experience of problems are relieved by community psychiatric nursing intervention. The



literature on community care approaches in psychiatry suggests that one of the major effects of the change in orientation of care is that patients spend less time in hospital and more time with the people with whom they live. This effect of placing more responsibility on the family is loosely described as 'burden' in the literature. This term, first coined by Grad and Sainsbury (1963, 1968) and elaborated later by Hoenig and Hamilton (1965, 1967, 1969), refers to the hardship families suffer in adjusting their life style to accomodate a mentally ill person. One of the rationales for developing community psychiatric nursing has been to support families and carers of the mentally ill.

The patients' view of community psychiatric nursing is also obtained because it seemed unethical to approach relatives without permission of the psychiatric patients in the study.

#### Secondary aims

These are:

(i) to examine practice with a view to highlighting training needs of community psychiatric nurses.

(ii) to examine practice with a view to focusing on organisational factors relevant to community psychiatric nursing.

(iii) to review service goals in the community.

These aims are achieved by:

(1) describing and comparing the work of community psychiatric nurses in two different areas. This establishes a picture of the way in which a small number of community psychiatric nurses work.

(2) eliciting the families' and the patients' views of the two community psychiatric nursing services.

(3) identifying what it is that patients and families find helpful about community psychiatric nursing contact. This permits an evaluation of the community psychiatric nursing service in terms of the family's perception of their problems, as alleviated by the community psychiatric nursing contact.

This research focuses on gaps in current knowledge.

## 1:2 THE BACKGROUND TO THE PRESENT STUDY

This study was motivated by a concern to examine critically the work of community psychiatric nurses. This motivation arose out of doubts I had about the efficacy of community psychiatric nursing. These became all the more acute when faced with the reality of the practice situation, which gave contradictory and confusing feedback about the work of community psychiatric nursing: patients, carers and other workers, voluntary and professional, for example could be either for or against the development of this speciality; there were also conflicting views on the efficacy of community psychiatric nursing within psychiatric nursing itself.

The main reason for this interest was that I had been working in the speciality of community psychiatric nursing for almost five years. This was at a time when psychiatry generally was suffering from shortages of nursing staff. This was a factor commented on by the Scottish Mental Welfare Commission:

The most serious problem facing staff in their task of caring for patients is the shortage of nurses. It has been emphasised that this has ill-effects on the treatment and management of every type of psychiatric patient and that there are also worrying effects on the training and on the morale of the staff themselves.

(Mental Welfare Commission (1986), p35)

The development of specialities like community psychiatric nursing has compounded the existing shortages of trained psychiatric nurses in hospitals - a concern which the Scottish Hospital Advisory Service has expressed on several occasions:

We are pleased to note the developments of community psychiatric nursing services and day hospitals...but to some extent this has been at the expense of adequate numbers of trained staff in the long stay and geriatric psychiatry units

(SHHD (1983), p52)

The fact that the speciality of community psychiatric nursing was developing at the expense of hospital based provision of care presented a major dilemma for me as a practitioner.

On the one hand, I was committed professionally to high standards of care given by nurses in the community setting. I therefore maintained a high profile and continually argued for an increase numerically and the development, of nurses working in the community setting - to cope with the ever increasing demands made of the limited nurses in post. The service managers indicated that an increased availability of nursing staff for community work would result in hospital shortages: their priority was a responsibility for hospitalised patients - whose needs were immediate and visible. This response, reflecting the hospital orientation of the provision of the current psychiatric nursing services (see p16), reinforced my resolve to maintain the work of community psychiatric nursing on a high profile. Attached to an acute admission ward, from which I received two-thirds of referrals, I ensured that hospital based colleagues were aware of my work as a community psychiatric nurse and involved them in decisions about the nature of the work; I was also actively involved in the Community Psychiatric Nurses Association, a professional organisation whose expressed aim is to speak out on issues relevant to community psychiatric nursing.

Sometimes, however I could not help but question the wisdom of whether scarce resources (i.e. trained psychiatric nurses) should be diluted by the current, although limited, allocation of staff to community work. Should they not be concentrated on the areas of most pressing need, rather than continuing at present with the "robbing Peter to pay Paul" philosophy which provided a crisis management service? With this query in mind, I was interested in discovering more about the actual effects of community psychiatric nursing. It was perhaps a naive hope, but I anticipated that the findings would provide a solid foundation from which to argue for or against the future provision of community psychiatric nursing.

My work experience suggested that the local development of community psychiatric nursing was dependent on the personal interests of community psychiatric nurses, or the influence of other workers, e.g. nurse managers, GPs or psychiatrists. Planned development of community psychiatric nursing, linked with clear objectives or assessment of whether or not these had been achieved, seemed to be absent. The opportunity to do research afforded the



chance to examine the broader picture of community psychiatric nursing and focus on this issue more objectively.

A second major influence of my 'community' experience on the present research study was that community psychiatric nursing was, at that time, assessed quantitatively, a measure which did not accurately reflect the work of community psychiatric nurses (see discussion p78). Undertaking the present research study afforded the opportunity to investigate other methods of evaluating community psychiatric nursing. The solitary nature of the job, with an emphasis on unsupervised work in the home visiting situation, meant that a large part of community psychiatric nursing work was based on individual decision making. I was interested in discovering more about the actual work of community psychiatric nursing and in particular the values and assumptions underpinning the work.

Finally, this study was prompted by two other less personal and more general factors; first, the increased development of community psychiatric nursing epitomised by the attention given to 'community psychiatric nursing' in policy documents (see p72); second, the current emphasis in health care generally (Donabedian 1983), and psychiatric nursing in particular, on research and evaluation of services (Wilson-Barnett 1983 and Brooking 1986). These factors combine to make the present research both timely and relevant.

This thesis comprises five chapters. In the following section, the remaining part of Chapter 1, the 'conceptual framework' is elaborated; this provides the conceptual basis for the present study and outlines thinking which crucially affected the design of the study. Chapter 2 consists of the literature review: this sets the study into context and examines some of the issues relevant to both community psychiatric nursing and to the emergent study. The third chapter details the study itself and focuses on the methodology. Chapter 4 presents and discusses the results. The fifth and final chapter summarises the main issues that arose from the data and underlines some of the wider implications that emerge from the study.

### 1:3 THE CONCEPTUAL FRAMEWORK

The research question formulated for examination at the outset of the research study was: 'Is community psychiatric nursing effective?' With this in mind, the next section presents some of the literature in the area of health care evaluation and how this influenced the present study.

Two major influences on the present study can be identified; these are Suchman's model of the intellectual process of evaluation and Donabedian's model of the foci or mind's eye objects of evaluation. The relevance of these are elaborated below.

Initial reading indicated that the word 'effective' focused on the ability of a programme to be carried out successfully. Other words 'effects' and 'efficiency' continually emerged in the literature in relation to 'evaluation': 'the effects' of a programme are defined as the ultimate influence of a programme on a target and 'efficiency' as how well and at what cost relative to other ways of producing similar effects (Wright 1955, Cochrane 1971).

The mere mention of some of the phrases and words - 'ultimate influence', 'successfully', 'relative to other ways,' suggested that the task ahead would not be easy! 'Ultimate influence' suggested that activities may have grades of influence; who judges whether an action is successful or not?: the same activity may be judged both unsuccessful and successful by different assessors. Suchman (1967) defined 'evaluation' as:

*...the determination (whether based on opinions, records, subjective or objective data) of the results (whether desirable or undesirable, transient or permanent, immediate or delayed) attained by some activity (whether a program, or part of a program, a drug or a therapy, an ongoing or one-shot approach) designed to accomplish some valued goal or objective (whether ultimate, intermediate, or immediate, effort or performance, long or short range). This definition contains four key dimensions: (1) process - the "determination"; (2) criteria - the "results"; (3) stimulus - the "activity"; and (4) value - the "objective". The scientific method...provides the most promising means for "determining" the relationship of the "stimulus" to the "objective" in terms of measurable "criteria". (Suchman (1967), pp 31-32.) [Italics mine].*

This definition, although overall helpful, tends to confound values with objectives. Suchman continues:

The value-laden nature of one's objectives constitutes a major distinction between evaluative research and basic research aimed at hypothesis testing. A precondition to an evaluation study is the presence of some activity whose objectives are assumed to have value.  
(Suchman (1967), p32-33)

Values generally are seen at a higher level of abstraction than the goals derived from them. According to King (1962), "Values are the principles by which we establish priorities and hierarchies of importance among needs, demands, and goals". In terms of King's definition, values underlie or determine our goals and are thus of a prior and separate order from either goals or objectives. 'Values' of course, are very closely tied to the setting up of goals - one does not ask if something is of value without asking - value for what? This is recognised by Suchman (1967) who argues that the evaluation process itself stems from and returns to the formation of values:

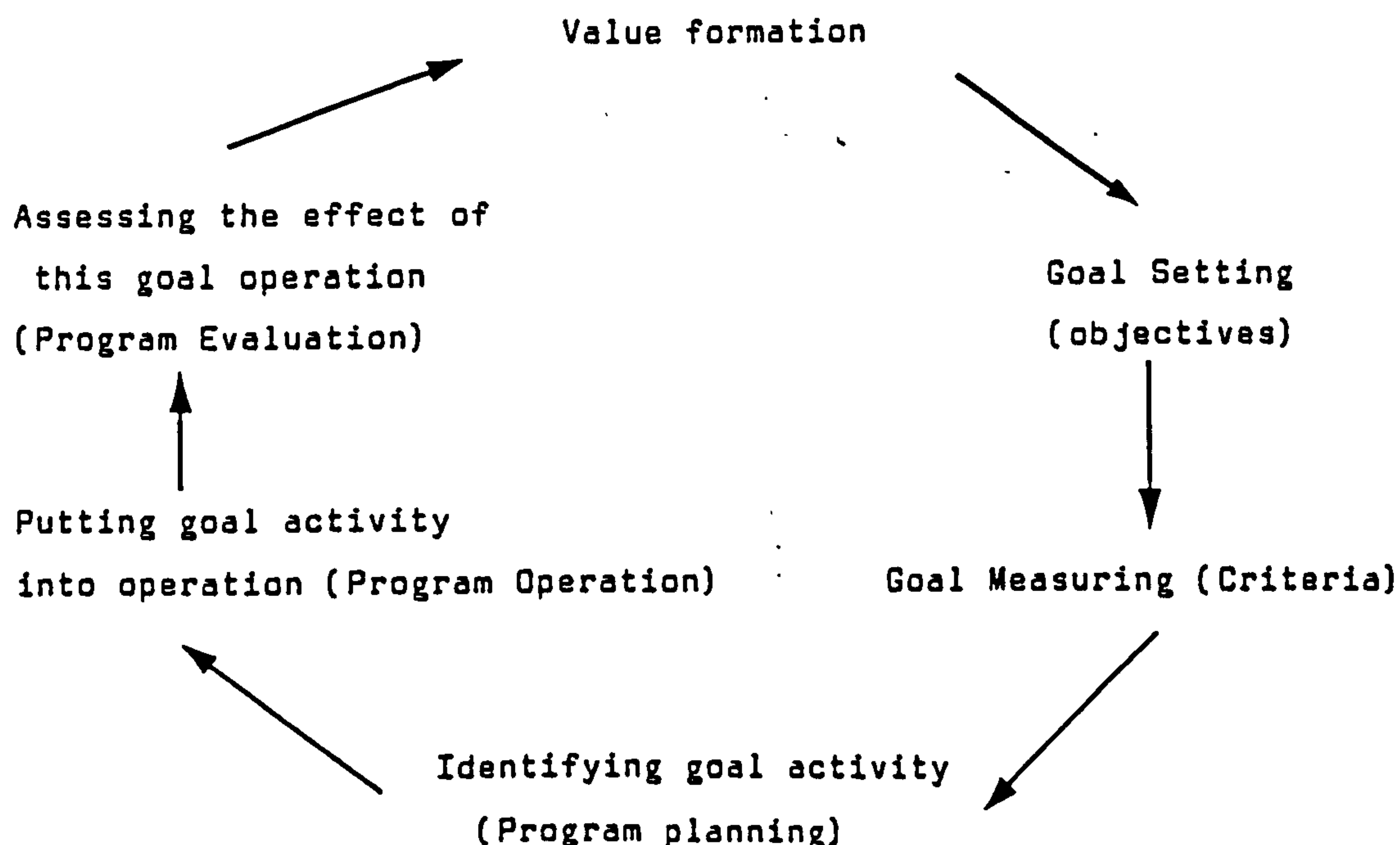


Figure 1: The evaluation process: (Suchman (1967), p34)



Figure 1 shows Suchman's final visualisation of the evaluation process. To take an example from community psychiatric nursing: the value could be - that the dignity of individuals should be preserved or that all adults have a right to participate in community life; arising from this, the goal set could be: admission to psychiatric hospital should be avoided or the number of admissions to psychiatric hospital reduced; in order to measure whether or not this goal is achieved, statistics on admissions could be obtained; the 'goal attaining activities' could then be identified, e.g. early sufferers detected; support services developed in the community for patients and families; domiciliary visiting organised. These activities would then be put into operation: liaison with GPs, health visitors and social workers would be organised on a regular basis; premises secured for day centres, social clubs or self help groups which would be advertised locally and via professionals; practical arrangements made about who would run and organise the group; These goal directed operations would be assessed to see if the stated predetermined objectives were achieved. Finally the initial value is reassessed. This scheme suggests that it is possible to isolate dimensions to be measured. The present study attempted to examine the values, assumptions and goal activities of the community psychiatric nurses and see if these were identifiable and separable.

Separation of the assumptions and goal activities of community psychiatric nurses may not be possible:

The many difficulties suggested - the breadth of the thing subsumed under a particular objective, the multiple objectives encompassed by many programs, the ambiguity inherent in any or all of the objectives as stated, and the disagreement as to the objectives - are characteristic of many programs and are enough to stagger the imagination of the evaluator.

(Hyman et al (1962), p7).

Despite the fact that health care programmes have multiple objectives, three types of 'goals' have been described: immediate, intermediate and ultimate goals:

Practically, there can be very little argument about this requirement that immediate and intermediate goals

constitute valid steps toward the attainment of some ultimate goal. Otherwise activity becomes substituted for effect and the goals that lead to the adoption of certain means tend to be forgotten as the means become ends in and of themselves. However knowledge is never complete and there must always be gaps in the 'cause/effect' sequence which can only be filled by making assumptions concerning the validity of the intermediate steps....such linkages are often if not usually taken for granted but upon challenge they must be reproducible.

(Suchman (1967), p56)

The present study aimed to explore and examine the goals of community psychiatric nursing as described by community psychiatric nurses.

The work of Donabedian (1966) offered a framework for health service evaluation focusing on structure - process -outcome. These were examined by Bloch (1975) with particular reference to nursing:

**STRUCTURE:** involves the study of factors of the system such as equipment, physical facilities, staffing levels and patterns, styles of supervision and management and characteristics of the care givers, attitudes and training.

**PROCESS:** involves the 'process' of giving care, namely what the care giver does. This includes visible behaviour but also invisible actions such as decision making.

**OUTCOME:** the results of care are examined in terms of change in the recipient of care.

(Bloch (1975), p256).

The above synopsis of evaluation research helped to focus my area of investigation. The literature review shows that there is a dearth of evaluative research on community psychiatric nursing. Studies examining the 'process' of community psychiatric nursing have tended to be quantitative rather than qualitative in nature. These studies focus on numbers (e.g. of caseloads, referrals or visits) and are limited because they do not provide meaningful measurements on which to determine clinical input, safe practice or forward planning. The few 'outcome' studies have been on specialised patient populations. Examination of the 'process' of community psychiatric nursing in this study was qualitative in nature and made explicit the goals and assumptions of the community psychiatric nurses. An 'outcome' evaluation of community psychiatric nursing, by looking at the consumers' view of that care, is also attempted.

# CHAPTER

# 2

Review of  
the literature



## 2:1 THE CONCEPT OF COMMUNITY CARE

### *Introduction*

Goals at policy level are essential to the context of the service at organisation and practice level. In this section, 'community care' as a policy goal is examined. This draws attention to the ambiguities inherent in the definitions of 'community care'. Consideration of the concept is broadened beyond the administrative structure to focus on care *in, for and by* the community.

#### Goals at policy making level

The term 'community care' is not a contemporary one. Suggestions of moves in that direction can be picked out of the literature. At the turn of the century, the Local Government Board recommended 'more homely' accommodation than the workhouse (PSSC-CHSC 1978). In 1918, the Board of Control of Mental Hospitals recommended early treatment of acute cases in general hospitals, and the Royal Commission on Lunacy and Mental Disorder (1924-6) combined with the annual reports of the Board of Control to add pressure for the appointment of almoners (medical social workers) to help keep families together (Lonsdale, Flowers, Saunders 1980). It was not until after World War Two that the policy of 'community care' became explicit.

'Community Care' is a policy which unites politicians, planners, social service and health care professionals and a wide range of pressure groups. 'Community care' has been a prominent policy goal of governments and a central guiding principle in the development of health and social services of both major political parties since World War Two.

#### Community care definitions

For such a pervasive concept, definition of 'community care' is surprisingly elusive. Sladden for instance has commented:

The phrase community care has become something of a slogan used without precision and in different senses in various contexts...The term is indiscriminately used to denote either a principle of administration or the actual range of

services provided. Similarly 'the community' is used to denote both a social group and a territory.  
(Sladden (1979, p7 and 9)

One of the most recent official documents on Community Care has commented:

The phrase 'community care' means little in itself. It is a phrase used by some descriptively, by others prescriptively: that is by some, as a shorthand way of describing certain specific services provided in certain ways and certain places; by others as an ideal principle in the light of which existing services are to be judged and new ones developed. It has in fact come to have such general reference as to be virtually meaningless.  
(Social Services Committee (House of Commons 1985 px)

The difficulties of 'community care' definitions were acknowledged by the DHSS Report (1981b) which classified these into two types, detailed below. The report draws a distinction between:

definitions which *describe* the services and resources which are involved (eg community care is those services provided outside of institutions...) and those which are in effect *statements of objectives* (eg community care is minimising the disruption of ordinary living...). Although it would not seem fruitful to offer one all-purpose definition it is important to specify what is meant whenever the term is used.

(DHSS (1981b), p5 (Italics mine)

This DHSS Report (1981b) suggested that the switching between the two different uses of the term 'community care' is the cause of confusion. The confusion also results from the inadequacy of the distinctions. The Report continues:

Used descriptively community care sometimes means those services provided by local authority social services departments rather than the NHS. This shorthand stems from the main policy thrust, stressed particularly in the late 1960s and early 1970s, of shifting the main responsibility for some people, particularly some long-stay hospital patients, from NHS to the PSS...the objectives, explicit or implicit in statements about community care, range from the very specific to all encompassing approaches to care giving. The client group in relation to which objectives are set is perhaps the most important variable. But the nature of the resources available and current practice patterns in a given locality also help fashion objectives.  
(DHSS (1981b), p7 and p9 respectively).



This discussion hints at the reality of service provision, which is complicated and cannot be successfully reduced to simple watertight definitions. 'Community (health) care' services themselves present problems of definition: primary health care services include GPs, Health visitors and district nurses and deal with some 90% of mental illness (see Goldberg and Huxley 1980 for discussion of this figure); yet the GP and community nursing services are funded differently. Personal Social Service Staff often exclude residential care when they use the term 'community care.' Frequently therefore 'community care' is used to mean all services provided outwith institutions, regardless of which agency (NHS, Voluntary or or Personal Social Services) provides them. This distinction is also problematic - do hostels come under the institutional umbrella? What about community based packages of care which combine using the institution and other supportive resources eg short spells of planned hospital admission or hospital day care with Community Psychiatric nurse follow-up, meals on wheels and provision of the home help service? A further complication is a growing tendency to equate 'community care' with support provided by individuals in a given community to its own most vulnerable members and to exclude formally provided services, whether from statutory agencies or the organised voluntary sector (see p26).

Government policy documents advocating the development of 'community care', do not clarify matters (DHSS 1971, 1974, 1975, 1976, 1981a and 1981b; Social Services Committee Report 1985 and SHHD 1976, 1979a and 1979b, 1980a and 1980b, 1985). These do not have a clear or consistent definition of the term.

Official reports also present confused aims and suggest ambiguities in outlined policies; this is epitomised most frequently by discussion of 'community care' without an elaboration of proposed strategies. DHSS (1971), for example expressed commitment to community care but argued that the services in greatest need of expansion were residential homes; a target of 15% increase in the number of residential places was set without planning forecasts for development of domiciliary services. Major capital spending is planned in the Scottish psychiatric hospitals (SWG 1984, 1985 and SHHD 1985); this is contrary to the expressed Scottish Health



Authorities Priorities for the Eighties Report (SHAPE: SHHD 1980b), which suggested that the large psychiatric hospitals should be reduced in size and small units be provided in reasonable proximity to the population they serve.

Somewhat paradoxically, the lack of clarity of definition may be responsible for the term's durability and attractiveness. Walker (1982) comments:

This lack of clarity is crucial in explaining the form that community care policies have taken, because it suggests different conceptions of *need* at different times and in relation to different groups.  
(Walker (1982), p19)

Arie (1972) called this vagueness, 'semantic plasticity'.

The definitions used in policy documents however, can be classified into three types of definitions: administrative, sociological and moral.

The '*administrative*' definitions tend to detail the resources to be developed and often emphasise care provision by the statutory and professional organisations. For example:

in this document the term 'Community' covers a whole range of provision including hospitals, hostels, day hospitals, residential homes, day care and domiciliary support. The term community care embraces primary health care and all the above services whether provided by health authority or local authorities...  
(DHSS (1977), p8)

The '*sociological*' definitions tend to be all embracing and emphasise the role of and the caring capacity of society. For example:

to help people live an independent life in their own homes for as long as possible.  
(DHSS (1976), p8)

The '*moral*' definitions tend to emphasise 'what is best' and focus on the role of lay carers and voluntary organisations:

to maintain a person's link with family, friends and normal life and to offer the support that meets his or her particular needs. Most people who need long term care can and should be looked after in the community. This is what

most of them want for themselves and what those responsible for their care believe to be best.  
(DHSS (1981a), p21)

These definitions are analogous to discussions of care *in, for and by* the community, each of which is elaborated below.

Despite the apparent agreement, then, about the 'goal' of 'community care', closer examination reveals that different people may not share the same view about the meaning of the concept: community care means different things at different times and in relation to different groups in need. 'Community care' in relation to specific client groups has been the subject of considerable attention but much less effort has been devoted to an overall analysis of the development of community care (DHSS (1981b), p2).

Notwithstanding the conflicting definitions of community care, it is worth exploring the concept of 'community care' further. This examination begins by looking at what care is like *in* the community setting; care *for* the community is then focused on, and finally what care *by* the community really means.

### ***Care *in* the community***

In the following paragraphs some of the literature on resource allocation within the Health Service generally is examined. Psychiatric care provision is then focused on, emphasising the situation in Scotland. This reveals that there is a need to develop services outwith hospital provision.

#### **Community care policy and practice compared**

Community care appears to be political rhetoric, rather than practical reality. This is borne out by the figures on resource allocation and use within the Health Service generally, which illustrate that resource allocation is still hospital-bound rather than community orientated (Haywood and Alaszewski 1980, Royal Commission on the National Health Service 1979). The Social Services Committee Report (House of Commons 1985, pxvi para24) talks of the impending 'crisis in the community' as far as psychiatry is concerned: "90% of care is provided by psychiatric hospitals while

90% of patients are in the community"; this reflects a preoccupation with hospital care, to the relative neglect of those outwith the hospital.

Looking at resource allocation in relation to specialities within the Health Service, it is clear that resources continue to be channelled into the high technology curative services rather than into the care of the long term chronic sick. This is despite the facts that around half of the hospital beds are occupied by long stay patients: elderly, mentally handicapped and the mentally ill (Salvage 1985, p73), and that most people use and consult the community based health facilities (Salvage 1985 p159). Townsend (1981 p81), further illustrates that there are more than twice as many bedfast and severely disabled people living in their own homes, as in all the institutions put together.

In Britain at large, community care services have been adversely affected by recent cuts in public spending (Walker, Omerod and Whitty 1979. PSSC 1979, POHG undated). Coordination between different services is quoted as being a vital component of community care (DHSS documents : 1971 p9-10, 1974 p35, 1976 p1 and 1981). As Walker (1982, p17) has commented, collaboration is a poor substitute for lack of resources.

#### Lack of community resources

The deficiency and shortfalls of service provision, contrary to official guidelines, have been well documented in official and independent reports (See Townsend and Davidson - Black Report 1982 as regards general health; Topliss and Gould 1981 as regards the disabled; Wertheimer 1982 for the mentally handicapped; Hunt 1978 for the elderly). As regards psychiatry, the Social Services Committee (House of Commons 1985), refers to 'the cart before the horse phenomenon' as being the hallmark of community care policies, where psychiatric hospital closures are pushed for, without the provision of an alternative infrastructure of community services (House of Commons 1985 pxviii, para 30). Brook and Cooper (1975) talk of the 'impending crisis' in psychiatry in which:

Paradoxically, increased demands have arisen largely as a result of the trend towards community care for the mentally



ill, which while reducing the numbers of mental hospital beds, has at the same time created a need for greatly expanded out-patient, day patient and domiciliary care. The burden on hospital psychiatry has become all the heavier because of the tardiness of local authorities in providing, and of central government in financing residential and day care placements for patients with chronic disabilities.

(Brook and Cooper (1975), p93).

More recently the Audit Commission (1986, p5) has recommended radical changes in organising community care in order to avoid "a continued waste of scarce resources and, worse still, care and support that is either lacking entirely, or inappropriate to the needs of some of the most disadvantaged members of society and the relatives who seek to care for them."

#### Care of the mentally ill in Scotland: hospital orientation of service

Care of the mentally ill in Scotland is more hospital orientated than in other parts of the UK. This hospital orientation partly reflects Scotland's more guarded commitment to community care which is apparent in policy statements: Scotland unlike England is not pursuing a policy of hospital closure (SHHD 1985, SWG 1984, 1985). These documents provide evidence of the divergence of Scottish policy from the rest of Britain. [Department of Health for Scotland 1962 recommended a running down of the psychiatric hospitals, whereas England and Wales' Hospital Plan of the same year envisaged eventual hospital closure]. Closure of mental hospitals has given impetus to debate on community care elsewhere e.g. the 'Italian experience': Jones and Poletti 1985; the American policy of 'deinstitutionalisation': Brown 1985b, in an attempt to focus attention on alternative forms of care and to learn from the experience of others.

#### Shortfall in Scottish psychiatric community services

Clarke (1982), The Mental Welfare Commission (MWC 1981 and 1986), and Mental Health in Focus (SHHD 1985) have all discussed shortfalls in the provision of services in relation to the mentally ill in Scotland. The most recent Scottish Policy document referring to care of the mentally ill points out that there are serious

shortfalls in the present service provision for meeting current demand: 3700 day places are urgently needed and out-patient clinics and increased involvement with primary care teams are major recommendations. A major injection of funding and reorientation of resources is required to meet present day demands (SHHD 1985). The Scottish Health Service Planning Council produced a national programme of health priorities for the eighties (The Shape Report: SHHD 1980b) which identified the mentally ill as a 'category A' priority target group. This report followed on from the Way Ahead (SHHD 1976) but the Shape Report differed from the first document in that SHHD intended to monitor progress of the implementation of Shape recommendations (SHHD 1985 p84). Yet according to a Scottish Working Group Report (SWG 1984), by 1984 only four of the fifteen Scottish Health Boards had produced complete planning statements and the remaining are unavailable for public discussion. Three examples below demonstrate that there is a need for services to be developed in the community to improve the standards of care for the mentally ill in Scotland:

(i) Demographic trends; elderly people are more prone than younger adults to become mentally ill. At present almost 17% of the population in Scotland is of pensionable age; 41% of old people living on their own are over 75; 25% of old people in Scotland have no children and 22% have no brothers or sisters; only a very small proportion of old people are in hospital or residential care - 5%. Clearly these figures lend support to the the notion of a more community orientated psychiatric service where there is a varied and larger variety of resources and treatments available. In the next ten years the PROPORTION of over 75s will have increased by 36%. These figures (from Age Concern 1984) also suggest that in the future the statutory services and 24 hour care will be in greater demand.

(ii) A recent Scottish survey of 'new chronic inpatients' (psychiatric patients aged 18-64 who on the census date had been in hospital more that one year but less than six years) in 14 Scottish hospitals, found that 38% of the patients did not need to be in

hospital if alternative accommodation was available (McCreadie et al 1983).

(iii) In a recent report, the Mental Welfare Commission (MWC 1986) suggests that there are a group of 'entrapped patients' who:

are detained in hospitals simply because there is no alternative means of caring for them and in whose case no feature of their condition makes it necessary that they should continue to be in hospital (Mental Welfare Commission (1986), p7).

This issue has been identified as a matter of concern, and is currently being investigated by the Commission and will be the subject of a future report.

The above summary on aspects of care 'IN' the community demonstrates that there is a lack of provision outwith the hospital, i.e. in the community setting. This applies throughout the National Health Service but is especially true of Scottish psychiatry. As it exists, community care is inadequately provided for the mentally ill. Present community resources should be expanded to meet projected needs. Lack of shifts in this direction suggest that the Health Service is not serious about providing psychiatric care 'in' the community. These points are emphasised in a recent publication by the Scottish Association for Mental Health, which reviews the community mental health services in Scotland: Drucker (1987).

#### *Care FOR the community*

Care *for* the community reflects the broadest interpretations of the concept and refers to increasing the caring potential of 'the community' at large. The idea of increasing the caring potential of 'the community', has proved an attractive approach to politicians - against a background of the health care system which is suffering decline (Walker 1982), and which has been criticised in recent years both for failing to promote egalitarianism and improve the health and life experiences of deprived groups (Wilding and George 1984), and for being inefficient and wasteful (DHSS 1983). This interpretation of 'community care' underpins current political thinking, as shown by



the Conservative Party Manifesto, quoted in Brenton (1985):

In the community we must do more to help people to help themselves, and families to look after their own. We must also encourage the voluntary movement and self-help groups working in partnership with the statutory agencies.  
(Brenton (1985), p142)

Brenton (1985), continues and comments "...this (focus on helping people to help themselves) has served to focus attention on the government's enthusiastic subscription to the ethos of community care, giving this form of care a new moral and ideological justification for the 1980's." Brenton further demonstrates that this view is common amongst politicians, regardless of party allegiance:

The growing political interest in the potential of voluntary social services may be directly linked to the desire to make economies in the public sector. Any searching examination of successive policy statements in recent years finds abundant evidence for this link, but it does not explain the whole story. In the rediscovery by politicians of the virtues of the voluntary sector, one may also detect, besides a preoccupation with the expenditure consequences of recession, the adoption and strengthening of distinct ideological positions. Labour ministers, particularly those with responsibilities for social services, shifted towards accepting that the voluntary sector could and should play a valuable complementary role alongside the main-line statutory services, and here they became virtually indistinguishable from the left of the Conservative Party. It is probably fair to say that economies in social expenditure remained the uppermost consideration and that this ideological shift for Labour contained a large dose of pragmatism. Nevertheless, the party had moved in the direction of 'welfare pluralism' both practically and rhetorically by the time the Thatcher government came to power to pursue a rather more drastic reappraisal of the role of the state.  
(Brenton (1985), p133-4)

This extract is quoted at length as it epitomises current political issues which, combined with the comments about the Health Service, are resulting in a "reappraisal of the role of the state in social welfare" (Hadley and Hatch 1982), and a move towards using voluntary agencies, and others, instead of the state to provide 'community care'. These issues are relevant to the work of community

psychiatric nursing in that service organisers are being asked to evaluate the work for which they have managerial accountability (see discussion p42).

Walker (1982) reviews the adverse impact of state policies on the caring capacity of the community, and he comments that few measures have been introduced to support the caring activities of families. He argues that "an increase in the caring capacity of the community requires action on employment, the relationship between sex and the labour market, housing, urban decay, incomes and public expenditure in order to promote a less hostile environment in which caring relationships can develop". Walker advocates that future services should be based on the expressed need of carers and those being cared for, that these should be flexible and that this would require a collaboration on the part of health and social service professionals to allow central planning and local initiatives to be reconciled. Major questions remain about whether or not these proposals could be possible.

Three interpretations of 'community care' were noted by Sladden:

- (1) as care of social problems by social agencies.
- (2) as any care or treatment which does not involve hospital admission.
- (3) as a comprehensive system of preventative psychiatry".

(Sladden (1979) p9-11)

The latter formulation is based on Caplan's threefold classification of preventative psychiatry:

which refers to the body of professional knowledge, both theoretical and practical which may be utilised to plan and carry out programs for the reduction of

- (i) the incidence of mental disorders of all types in the community - primary prevention;
- (ii) the duration of a significant number of those disorders which do occur - secondary prevention;
- (iii) the impairment which may result from those disorders - tertiary prevention.

(Caplan (1964), p16-17).

The first two interpretations noted by Sladden (1979) reflect the established patterns of psychiatric treatment in Britain where social and other approaches to care (mainly medical), are split off and



separated (Penfold and Walker 1981). This is mirrored at the national level by the separate development of health and social services.

The final interpretation is relevant to this discussion about 'care for the community'; this takes quite a different approach to care - prevention is introduced into the picture and the focus of concern is groups of people as well as individuals. Caplan's model, which embraces primary, secondary and tertiary prevention, implies that community care should be concerned as much with groups of populations as with individuals. Bellak has commented:

The preventive ideology requires the acceptance of responsibilities extending beyond the normal range of clinical functions to quasi-political community action (Bellak 1964).

It is debatable whether or not this approach to 'community care' can be taken by professionals and particularly community psychiatric nurses: current knowledge of causal factors in psychiatry are incomplete, for example, and it is therefore doubtful whether preventative approaches can be taken in psychiatry; further, professional training and practice are also generally focused on individuals (Hunter 1978), not groups, so it is unclear whether and how professionals and community psychiatric nurses are prepared for this role. There is in fact some evidence that taking a preventative approach in communities can have adverse effects: Cumming and Cumming (1957) found that the community tends not to be amenable to health education and Sarbin and Mancuso (1970) have shown that the public's increased awareness of illness and health education leads to reduced tolerance and increased diagnosing.

This 'preventative' approach appears to be gaining influence in contemporary psychiatry in Britain as evidenced by the attention given to social factors which are acknowledged as an influence on treatment and outcome (see recent research of Brown and Harris 1978 and discussion p32, about how this affects the work of community psychiatric nursing). Combined with the increased availability of drugs, these developments have led to an increased realisation of the



therapeutic and rehabilitative potential of the community setting itself.

### *Care BY the community*

Closer examination of the term 'community care' reveals that this is a value laden concept (Wilson 1982) because care by the community is considered desirable and further, preferable to institutional care. It is also assumed that this care outwith the institution will be with a family. These assumptions are explored, then challenged.

#### **The assumption of the desirability of care by the community**

In general 'community' is linked with images of the good life - of what is desirable and thought to promote intimacy and stability. There is nostalgia for the romantic image of village life with its healthy people and perfect forms of social control, where people pass on wisdom to successive generations, and mutual respect and support are the norm. This is set against the image of the metropolis and industrial, uncaring city, where people mingle impersonally, where life is organised contractually and judicially rather than according to tradition, and where disorganisation and disintegration is the order of the day. The findings of Barton (1959) and Goffman (1961) and a catalogue of hospital enquiries (DHSS 1974 and Martin 1984), gave an impetus to discussions on the supremacy of community care over institutional care; the debate has tended to degenerate into a good/bad dichotomy, reflecting the enduring and emotive imagery described above. Proof of the power of this polarisation in favour of community care is illustrated by the preoccupation of policy documents with community care, at the expense of discussing hospital care options, geared to avoid 'institutionalisation'.

#### **The assumption of the family**

The current Prime Minister, Margaret Thatcher, has described the 'welfare state' as the 'nanny state', and has argued on economic grounds to cut expenditure on the health and social services. Underpinning the economic arguments is the accusation that the

welfare state is over-collectivised and has diminished the vital freedoms and choices of individuals. Contained within this ideology is an appeal to values deeply embedded in nineteenth century traditions of liberal political economy with their heavy emphasis on *individual achievement and effort as a measure of social deservingness*. Moralistic Tory notions of the family as a primary source of authority and assistance combine with an accent on other forms of decentralised social responsibility, radically to shift the locus of collective obligation away from the state and central government towards care (of dependents) by 'the family'.

Wilson (1982) points out that 'the family' has become imbued with the valued qualities associated with community life. This means that the family has accordingly become poised against the opposite notion of the institution, with its less attractive sequelae (see Barton 1959). The integrity of the family has become one of the central assumptions of community care: the family is assumed to be responsible for care of dependents and it is assumed that the family is a cohesive and caring unit.

The assumptions behind community care are rarely stated in the literature, far less questioned. Exceptions to this statement are Hawks (1975) and Ashton (1978). Hawks suggests that the commitment to a policy of community care which favours decentralisation, delegation and participation, could be the result of medicine redefining areas of responsibility. It may also be related to the increased difficulties of staffing hospitals, as is also suggested by the comments of the Social Services Committee Report (House of Commons 1985 px).

The assumptions described above can be challenged:

#### **The myth of the desirability of community care**

The work of Barton (1959) and Goffman (1961), portrayed the institutional roots of much disordered behaviour which was previously believed to be an inevitable part of the course of chronic psychiatric illness. These authors showed that institutional care can produce 'institutional neurosis': symptoms characterised by 'apathy', lack of initiative and loss of interest. This loss of

interest is particularly marked in relation to personal possessions and the present. There is also an apparent lack of interest in and an ability to plan for the future. Barton (1959) lists several factors which are associated with the development of institutional neurosis: loss of contact with the outside world, enforced idleness, staff behaviour (particularly bossiness, brow-beating, brutality and teasing), ward atmosphere, loss of personal friends, drug effects and the loss of prospects outside the institution. Wing and Brown (1961) surveyed female schizophrenic patients in three psychiatric hospitals and found that poverty of the social environment (few personal possessions, pessimistic nurses and little contact with the outside world) was associated with most clinical disturbance. In a further account of the same study, Wing and Brown (1970) found that the most important single factor associated with clinical improvement was a reduction in time spent doing nothing: the category which distinguished patients who improved was work and occupational therapy. A desire to avoid 'institutionalisation' or the development of 'institutional neurosis' has been a major reason given for the (allegedly preferable) development of community care.

Milverton (1985), however, has argued that the factors associated with the production of institutionalisation can also be found in patients who are cared for in their own homes, and that patients can become institutionalised outwith the hospital ward. Freeman and Simmons (1958) also described the family home which could resemble 'a one person chronic' ward. This suggestion is founded on observation rather than systematic study.

Little systematic information is available about the routine of patients in the home setting. Brown et al (1966), in a survey of discharged hospital patients, found that many patients spent large amounts of time doing nothing. This could be considered similar to the 'enforced idleness' mentioned by Barton and hence taken to be evidence of the existence of 'institutional neurosis' outwith the hospital.

Hawks (1975) believes that institutionalisation is not an issue in today's hospitals, and that facilities for rehabilitation and social training far surpass that available in the community. Evidence of lack of community facilities (see p15) may provide some



support for Hawk's opinion.

More information is needed about the development of secondary handicap, outwith the institution. There is no evidence which shows the effect of community psychiatric nursing contact (or for that matter, other types of intervention) on discharged patients' risk of developing 'institutional neurosis'. More information is needed on this. It cannot be categorically stated that secondary handicap will not develop in the home situation; current evidence, in the form of shortage of resources could suggest that the reverse may be true. Home care then is not necessarily 'better' than institutional care.

#### **The myth of the cohesive and caring family:**

There is some evidence that the social security system is being eroded by deliberate government policy and inflation (Salvage 1985). Families find it hard to survive and hardship may lead to domestic violence, divorce, and children being taken into care. The rise in unemployment does little to foster family harmony and the present government's policy of encouraging migration in search of jobs probably tends to undermine family cohesion. The increase in one-parent families, divorces and second marriages (and second families), combined with an increase in women working (despite the recession - Gardiner 1981), all affect the family's capacity to care. Contemporary families, as described, may not be the cohesive unit one is led to believe.

#### **The myth of the family unit:**

A family by definition is a group of people. In reality 'caring' does not embrace the family 'as a group'. In practice it is the female kin who overwhelmingly care for the dependents (Townsend 1981, EOC 1982a and 1982b). This reflects the sexual division of labour in our society where women are predominantly associated with the private sphere of work - in the house - and men, the public sphere - outside the home - (Miller 1976). Elizabeth Wilson summarises this argument:

The community is an ideological portmanteau word for a reactionary, conservative ideology that oppresses women by silently confining them to the private sphere without so much as even mentioning them. Moreover, it attempts to

confine them, or at least implicitly to define them, at the same time as economic policy and social change pushes them into the public sphere of paid work, and yet simultaneously removes the last state props that supported them in their work in the 'community', that is in the family.  
(Walker (1982), p50)

Care BY the community is, then, in a very real sense being undertaken by female kin (often called 'informal carers'); friends and voluntary groups also assume a significant role in the provision of care. An extensive debate on the definition and role of voluntary organisations is not appropriate here (see the Wolfenden Committee Report 1978 and Brenton 1985 for details); suffice it to say that there has been an upsurge of interest in the potential of voluntary agencies in the care of the mentally ill in recent years, and that voluntary agencies also do valued and varied work. A classification, by function, of voluntary groups suggests the following typology: a service-providing function, a mutual aid function, a pressure group function, a resource function and a coordinating function.

It is a matter of urgency that the contribution of these non-governmental carers be acknowledged and particularly so with the curtailment of the care-giving capacity of contemporary women. Professional carers, at least, should be supporting the lay carers in this role. There is some evidence that moves are being made in this direction (see Scottish Action on Dementia Report 1986). Recent policy documents refer to 'partnerships' between the statutory and voluntary sectors (DHSS 1977), and the emphasis on 'joint planning' approaches to care provision points to potential areas of joint action and combined effort (SHHD 1985). Involvement of these groups could result in a more consistent approach to supporting informal networks, provide a more comprehensive system of care, and allow for joint initiatives.

It seems that 'community care' policies have been restricted in conception, limited in application and based on often unacceptable assumptions about the duty, willingness and ability of families (and women in particular), to care for dependents. This can no longer be considered a sound basis for providing community care.

Sladden further comments on 'community care':

Unless these divergent interpretations of community care are recognised and until a common approach is evolved, it is inevitable that there will be uncertainty and confusion about the contributions of the community psychiatric nurse. (Sladden (1979), p14).

In the following two sections the work of community psychiatric nursing is examined and the relevant literature on this speciality reviewed.



## 2:2 THE WORK OF COMMUNITY PSYCHIATRIC NURSING

This thesis is concerned with examination of the 'process' of community psychiatric nursing, what the nurses are doing. This also involves the notion of 'functioning', in a sociological sense, which may be used to describe the activity of an object or entity which fulfils some purpose. The term also has a second application, where it means the objective consequences of some social action or phenomenon. The consequences of such action may be intended and recognised by those involved, in which case, the function is 'manifest'; alternatively the consequences may be unintended and unrecognized in which case the function is 'latent'. In this sense, use of the term 'functioning' is also appropriate for the present study; which looks at the consequences of the work of the community psychiatric nurses.

In the next section, brief comment is made firstly, about the historical development and secondly, about the lack of a clear definition of community psychiatric nursing. The work of community psychiatric nursing is then detailed, in order to present the theoretical framework surrounding the practice of community psychiatric nurses and in order to set the context for examination of the work of community psychiatric nursing.

### *Definitions of community psychiatric nursing*

The historical development of community psychiatric nursing is reviewed by Baker (1968), Sladden (1979) and White and Mangan (1981). The development of community psychiatric nursing is explored and discussed further in section 2:5, p71. Hunter, in 1974 commented:

Papers or comments in nursing journals on community psychiatric nursing have increased considerably even though much of what has been written is of a general nature, rather than descriptive of what the nurses or services are actually doing.

Hunter (1974)

This state of affairs has changed since the mid 70's, and there has been an increase in the number of papers describing what community psychiatric nursing and services are actually doing (e.g. Roberts 1976, Leopoldt 1979a and 1979b, Donnelly 1977a, Ryce 1978, Coverdale 1980, Tough et al 1980, Sharpe 1980, Brough 1982). These and other papers demonstrate that use of the term 'community psychiatric nurse' cannot be guaranteed to mean the same thing to different people. Some community psychiatric nurses work full time in the community (Leopoldt 1974), whereas others assert that the job is so demanding that it can only be done part time (Warren 1971, Maisey 1975).

#### The work of community psychiatric nursing

In an attempt to detail the work of community psychiatric nursing, task centred definitions have arisen. These demonstrate that there are differing opinions of what a community psychiatric nurse should do: giving injections is considered a vital component of the work of the community psychiatric nurse by Nickerson (1972) and Warren (1971), and considered an 'informed contribution' by Leopoldt (1974); this activity is rejected as inappropriate by other authors (Stobie and Hopkins 1972a and 1972b): talking of Modocate clinics they comment that this therapy is most effectively carried out by the general practitioner with the help of a public health nurse.

It is possible that domiciliary visiting could be used as a defining characteristic of community psychiatric nursing (although it is acknowledged, as Pullen (1980) and Altschul (1972, 1973) have noted, that other professionals apart from community psychiatric nurses are involved in domiciliary work with psychiatric patients). Some authors consider that domiciliary visiting is coterminous with community psychiatric nursing (Henderson et al 1973): yet people called community psychiatric nurses work from various bases (Elliot-Cannon (1981): hospital base; White (1983): health centre base; Williamson et al (1981): district general hospital attachment;), and are not necessarily involved in home visiting (Kirkpatrick 1967, MacDonald 1972, Shires 1977).

Conflicting statements can be found about community psychiatric nursing activities by authors from the psychiatric nursing field (Sencicle 1981, Sharpe 1982) and by other professionals (Baker 1968, Hunter 1980, Henderson et al 1973, Pullen 1980, Ritson 1977, Tough et al 1980 and McKechnie et al 1981). It may be that different services have different priorities about the value of certain activities. It is unclear whether community psychiatric nurses within any one service hold similar values about activities, or whether they have a common rationale for their work. This issue is explored in the present study.

### *The practice of community psychiatric nursing*

The majority of community psychiatric nurses are not specifically trained for work in the community setting (see p73) and accordingly use models and theories learned during basic psychiatric nurse training. What follows is a brief review of the most common models and theories used by psychiatric nurses and hence available for community psychiatric nurses' use.

#### **The Nursing Process**

Up until the sixties professional nursing practice seemed to be based on instinct and empathy. The publication of Yura and Walsh's book (1967) marked a turning point in nursing practice, in that it introduced the 'nursing process' as a tool for clinical nurses; it is from this date that the practice of nursing has become more systematic. The 'nursing process' simply distinguished four clear stages in the provision of nursing care, namely assessment, planning, goal setting (and identification of nursing intervention or actions) and finally, evaluation. This approach has been criticised in that "it exhorts nurses to assess, but tells them little about what to assess. It encourages planning but says little about how to plan. It asks nurses to intervene, but fails to say in what ways. It advocates evaluation, but does not specify when or how" (Aggleton and Chalmers (1986), p vii). Nevertheless this approach to care remains the main prescriptive model used by most nurses.



## Models of care in psychiatric nursing

A 'model' is described by Riehl and Roy (1980) as:

a systematically constructed, scientifically based and logically related set of concepts which identify the essential components of nursing practice together with the theoretical basis of these concepts and values required for their use by the practitioner.

(Riehl and Roy (1980), p48).

'Models' (also called conceptual models) of nursing, have a number of components in that they are likely to make some comment on: the nature of people, the causes of problems likely to require nursing intervention, the nature of the assessment process, the nature of the planning and goal setting process, the focus of intervention during the implementation of the care plan, the nature of the process of evaluating the quality and effects of the care given and the role of the nurse. There are many 'models' available to nurses which can help in the provision of nursing care. For a summary of a range of nursing models, see Aggleton and Chalmers (1986). The following pages briefly review those which are most commonly used by psychiatric nurses.

Burgess (1985) describes four major 'models' which are widely used in psychiatric nursing: the biological or medical, social, psychological and behavioural. When a patient is being treated, the kind of assessment obtained, the meaning assigned to certain historical facts, and the treatment methods used depend on which model is chosen.

### 1. *The medical model*

The medical model forms the basis of most training (nursing and medical) in psychiatry (Drucker 1987), and results in the efforts of clinicians being on the identification of physiological malfunctions and chemical imbalances. A person's social behaviour and psychological process are thought to originate from physiological and biological activities. This reductionist view has been

criticised, as it encourages an understanding of people as "passive hosts of disease" (Reynolds 1985) and provides an illness orientated approach to care. Assessment is designed to determine what is medically wrong with the person and focuses on signs and symptoms which are usually obtained by taking a medical history and physically examining the patient. This process of assessment leads to a 'diagnosis' being made of a medical 'condition' and results in a plan of care in which treatment is prescribed (usually by doctors), to rectify the malfunction. Nurses in the medical model can find themselves as accessories to medicine and taking on a handmaiden role to doctors. Reed and Lomas (1984) talked about closed referral systems in community services (that is, community psychiatric nursing services which only receive referrals from consultant psychiatrists), and said that these perpetuate a line of accountability to the doctors who in fact prescribe nursing intervention.

## *2. The social model*

The social model of treatment has historical roots in the 'moral treatment' of the nineteenth century, where the emphasis was on the development of "friendly association, discussion of his difficulties and the daily pursuit of purposeful activity" (Rees 1957). The social view of psychiatric illness focuses on the way the individual functions in the social system. Treatment consists of reorganising the patient's relationship to the social system or reorganising the social system (for example, if an individual's behaviour is irrational he can be helped to stop acting in this way or the family helped to better tolerate the behaviour). Nursing intervention may include the creation of a therapeutic milieu, aiding the patient in improving social skills and competencies, focusing on patient's difficulties in a problem orientated way or establishing relationships with individuals to help them express their feelings and cope with their emotions. Using this model, the patient and nurse jointly negotiate the goals of nursing intervention.

### 3. *The psychological model*

The psychological model stems from the work of Sigmund Freud and has as its basis the belief that psychological disturbances are understandable and result from childhood experiences and distortions of reality, which lead to impaired personality development and inappropriate behaviour. Nursing intervention includes group and individual psychotherapy in order to help the patient gain a better understanding of himself. The model includes the nurse helping the patient verbalise feelings instead of acting immediately; the nurse encourages patients to talk, listens to them and supports them through emotional experiences and change. This is well described in the following passage from Burgess:

Initially the nurse should start by just listening and trying to understand the human process within the person, instead of trying to concentrate on specific interviewing techniques contained in some textbooks...The patient must know that the nurse is aware of his goals, his strivings and his wishes and that the nurse is working hard with him in order to accomplish these goals.  
(Burgess (1981), p57)

This extract shows how the nurses use interpersonal theories (see below).

### 4. *The behavioural model*

The behavioural model is the fourth model used by psychiatric nurses and rests on the conceptualisation of Pavlov's conditioned learning theory (for an elaboration of this and its use by psychiatric nurses, see Barker and Fraser 1985). Using this model, abnormal behaviour is assumed to have been learned and is maintained because it has positive benefits or avoids negative consequences. Nursing activity is aimed at altering the overt (maladaptive) behaviour and teaching patients other more appropriate forms of behaviour.

The psychiatric nurse implicitly uses one or a combination of conceptual models to assess and plan patient care by the process



referred to as 'clinical judgment'. This judgment may also be influenced by training, temperament, or the clinical bias of the nurse (or therapeutic setting), to see patients predominantly from one conceptual point of view. The decision to use one model often diminishes the possibility of using another model simultaneously. Psychiatric nurses have been described as taking an 'eclectic approach' to patients, where information derived from all models of care is used. The process of 'clinical judgment' results in planned care which is referred to as 'therapy'.

### Theories in psychiatric nursing

Additionally, psychiatric nurses may use certain theories to facilitate practice (some of the theories on which the models have been based have already been mentioned). Theories have been defined by Chinn and Jacobs (1983) as:

a set of concepts, definitions and propositions that project a systematic view of phenomena by designating specific interrelationships among concepts for purposes of describing, explaining, predicting and / or controlling phenomena.

(Chinn and Jacobs (1983), p21).

They are similar to models in that they are built up from ideas and concepts, but they are distinctive because they have an ability to explain and predict *specific* phenomena (Fawcett 1984). There are few theories which have been developed from nursing knowledge; most theories used in nursing are borrowed from the other sciences. Two examples of theories used in psychiatry are particularly relevant to the work of community psychiatric nurses: Interpersonal Relationship theory (Rogers 1957) and Crisis Intervention theory (Caplan 1964).

#### 1. *Interpersonal Relationship theory*

'Building relationships' is a generally accepted premise on which psychiatric nursing is based (see p152, Altschul 1972, Cormack 1976 and Reynolds 1985). Hildegard Peplau's work, defining the importance of interpersonal relations (Peplau 1952), was a milestone

in the direction of developing a theoretical base for psychiatric nursing. Peplau proposed a descriptive conceptual framework which drew heavily on Sullivan's interpersonal theory and, to a lesser extent, from learning theory (Sullivan 1953). This framework allows the nurse to help the patient examine situational factors, with the focus on improving interpersonal competencies that have been lost or never learned.

#### The nurse/patient relationship

The relationship between nurse and patient has been described as a 'caring relationship'. This is explored in numerous texts (for example see Downie and Telfer 1980) and can only be given a brief mention here. The word 'relationship' is used in two ways: to stand for the situation, occasion or bond which links two or more people (e.g. marriage, business association, or an emergency) or to stand for the attitude which people so linked have for each other (e.g. fear, pride, respect, love).

The bond which constitutes the nurse/patient 'relationship' consists of formal rules, legal and administrative (e.g. in psychiatry nurses can retain a patient in hospital care if the patient is a risk to himself or others). There are other vaguer sets of rules often referred to as the 'ethics' of the profession (for further details see Thompson et al 1983); in nursing these are enumerated in a nurses' Code of Professional Conduct (UKCC 1984).

Additionally certain kinds of attitudes are considered to accompany the development of a 'caring relationship'. The caring worker, for instance, should be impartial and as objective as possible in relation to distribution of benefits in accordance with needs and be non-judgmental (Timms and Watson 1978). Paradoxically, the nurse is discouraged from adopting a totally detached stance with the patient, but rather is encouraged to react to patients and help them gain insight into their behaviour and hold an attitude of compassion (see Downie et al 1974).

Psychiatric nurses in fact, are explicitly taught that successful therapy is dependent upon the possession by the nurse of three facilitating conditions: warmth, empathy and genuineness (Rogers 1957). This author suggests that aspects of the personality

and attitudes are crucial determinants of successful therapeutic outcome; he identified three essential attitudes which he suggested are critical factors in the therapeutic relationship: genuineness of human regard, a warm positive acceptance or non-judgmental approach to the patient and a caring and empathic understanding of the patient; Clare and Thompson (1981) go one step further, and state that theoretical experience and knowledge are less relevant in influencing successful outcome than personality factors. These attributes alone, regardless of model and theory use, are considered vital components of the caring relationship. This is demonstrated clearly by the comments below:

The quality of caring, as a genuine human concern, is important in the therapeutic alliance made with the patient. The patient must be made aware of the nurse's caring and must be convinced of the sincerity in order that definite progress may be made...Interest and caring about an individual are not technical skills; they are the basic arts of psychic healing.

Nurses do not need to tell the patient they care. They show concern for the patient by listening and by trying to understand the anguish or loneliness in the patient's heart. When nurses are comfortable enough to enable them not to worry about interview technique, posture, facial expression, and speech, the natural concerns for people will begin to show. It is then that the patient will know that the nurse cares.  
Burgess (1981), p57)

The care shown by a nurse for a patient has been described as 'friend-like' behaviour (Downie and Telfer 1980). The authors state: "The value of befriending must not be underestimated. For the lonely and helpless, befriending can be a lifeline". The nurse in fact has a difficult task of being both objective and impartial and yet caring and compassionate.

The difficulties surrounding developing 'nurse/patient relationships' are discussed at length by Schwartz and Shockley (1956) and Brown and Pedder (1979). The latter authors distinguish three elements in the development of the nurse/patient relationship: the working alliance, transference and counter transference. The former component resembles that discussed above; the latter two concepts refer to the emotional feelings, of both nurse and patient, arising out the caring relationship, which affect therapy and can



lead to patient dependency. Nurses are warned against getting too involved (showing too much compassion and concern) for patients, although helping patients (often in distress) and responding to them as individuals, by necessity means that nurses must 'get involved' (see Schwartz and Shockley 1956).

## *2. Crisis Intervention theory*

Caplan's threefold classification of mental illness (see p21 and Caplan 1964), is a theory which advocates that psychiatric workers be involved in preventative work aimed at firstly, reducing the incidence of mental illness (primary prevention); secondly, reducing the duration of disorders (secondary prevention) and thirdly, reducing the impairment that results from mental illness (tertiary prevention). This theory has had implications for the work of community psychiatric nurses and legitimates work with a variety of individuals in varied settings.

### *Primary prevention*

Caplan's theory has given rise to questions about whether or not 'primary prevention' in psychiatry is feasible. Some authors are sceptical of this (see p22); other authors assert that primary prevention of mental illness is possible by aiming to minimise parents' anxiety, before transmission to the next generation (Denham 1972). Pilkington (1973) claims that it is not possible to deal with chronic illness without becoming involved in the value systems of a society and devising means to influence them.

The Short Report (House of Commons 1985) however, suggests that the function of psychiatric services in primary prevention is a chimera and implies that community psychiatric nurses should be headed away from such ambitions.

### *Secondary and tertiary prevention*

The literature indicates that it is not known if early contact specifically with community psychiatric nurses, is preferable to later contact (although in relation to psychiatric treatment generally, there is substantial evidence in favour of early

intervention e.g. see Ratna (undated) and Orford 1987). The CPNA Survey (CPNA 1985b) says that the majority of community psychiatric nurses are hospital based (although there is considerable regional variation in this pattern). This could suggest that most community psychiatric nursing services are focusing on later, rather than early treatment, of mental distress (Goldberg and Huxley 1980) and it could be argued are dealing with secondary and tertiary preventative activities.

### *Crisis work*

From his initial theory, Caplan elaborated a 'crisis intervention approach' to care, which advocated that the optimum time to treat individuals in emotional distress (in order to effect change) was when they were in 'crisis'. Using crisis intervention theory allows nurses to legitimate work during crisis only (Langsley et al 1969). This latter approach to care has resulted in nurses establishing drop-in centres and crisis counselling services (Oldfield 1983) and using brief, time limited approaches to treatment of patients (Fisch 1982). Short spells in hospital have been used in the same way, in order to resolve crisis (Kennedy and Hird 1980). This approach has been used in all three phases of preventative work.

### *Health education*

Focusing on primary prevention and crisis work, brings us to the concept of 'health education'. The community psychiatric nurse's work in relation to health education is a topic of concern in contemporary literature.

Nurses have taught people about health since the establishment of the profession. In the early days, the teaching reflected the general concern about sanitation and living conditions: Florence Nightingale (1859) emphasised that ill health was the result of lack of whitewashing and ventilation, as well as careless diet and dress. Cohen (1981) and Redman (1980) more recently, have carried out reviews of how the nurse's educational role is perceived. These indicate that nurses accept that they have a health education role but that there is confusion over the extent and nature of the

activity required and uncertainty about how the nurse's role complements that of the doctor's. Hunter (1978) found that community psychiatric nurses created opportunities for education of both families and patients.

It seems, that on an individual basis, the nurse can use the nurse/patient relationship for health education; the nurse can identify gaps in the patient's knowledge, and gear information giving to the social class, education and experiences of the individual patient. The Community Psychiatric Nurses Association, CPNA (1985d) asserts that the community psychiatric nurse has an important part to play in health education, although these assertions are not backed by research evidence.

Health education can take place in all three phases of preventative work, referred to by Caplan (1964).

Before ending this section it is worth commenting on the skills of psychiatric nurses.

#### *The skills of the psychiatric nurse*

Sladden (1979, p30-40) and Cormack (1976, p28-35) among others, have reviewed the literature on the role of the psychiatric nurse. The skills of the psychiatric nurse have been difficult to identify in the practical situation. Goddard (1955) undertook a job analysis method to look at the work of the psychiatric nurse and recommended (Goddard 1958) that continuous observation studies of psychiatric nurses' duties needed to be made against the background environment and conditions in which the job is performed. Observation was a feature of later studies on psychiatric nursing: e.g. Oppenheim and Eeman (1955), John (1961), Cormack (1976), Altschul (1972a); these all failed to investigate the subjective meaning which nurses' ascribe to their own practice. Towell (1975) rectified this omission, by taking a sociological approach to the work of psychiatric nurses (in three different hospital wards); the emphasis of the enquiry was on common roles and experiences rather than on the individual differences of the nurse. Studies which have succeeded in identifying some of the skills and activities of the



psychiatric nurse are reviewed below.

John (1961) used the medical model (which reflected her general nurse training), to examine the work of psychiatric nurses in four Scottish hospitals. She found that psychiatric nurses did not attend to the physical needs of their patients. Her study can be criticised on the grounds that she failed to make explicit the rationale for selecting her data.

McIlwaine (1980), who focused on the care of neurotic patients, by comparing psychiatric nurses and patient's perception of activities, found that nurses were perceived as providers of pills, meals, support and reassurance. The personal qualities of the nurse were valued, as was the availability of the nurse to provide comfort in times of stress. McIlwaine's work emphasised the importance of the nurses' attitude in caring and showed that psychiatric nurses viewed neurotic patients negatively.

Identification of skills and activities that are particularly therapeutic is especially difficult. Cormack (1983) advanced knowledge in this direction and observed the behaviour of 14 charge nurses and classified their behaviour into 23 codes. He also developed a questionnaire designed to measure patients perceptions of psychiatric nurses; this was developed from comments, using critical incident technique, and derived from a group of psychiatric nurses whom he neither described nor defined. Cormack believed that these perceptions are in themselves a measure of the nurses' therapeutic value. What he has in fact derived is a measure of the process of psychiatric nursing in hospital, rather than a measurement of patient outcome or patient perception of therapeutic value. He focused on the interpersonal skills of psychiatric nurses and analysed his finding within a framework of goals. He considered that interpersonal skills of psychiatric nurses were used to reach three major types of goals: direct goals (formal: where specific and pre-determined goals are usually known to both patient and the nurse); direct goals (informal: where vague goals were used which were not necessarily known to the patient and nurse); and indirect goals (where the nurse acted as a facilitator for other professionals and allowed them to reach their goals). Cormack found that psychiatric nurses minimally used interpersonal skills in the

formal and structured sense. Virtually all examples of effective use of interpersonal skills were of the direct goal (informal) and indirect goal types. Cormack's work stands out, in that it is the first piece of research which has focused on and identified interpersonal skills used by psychiatric nurses.

As we saw earlier, the personality and attitude of the nurse, not skills acquisition may be a crucial factor in the development of the nurse/patient relationship. Shanley regards the approach of Rogers (1957) as a 'skill' and examined the therapeutic interactions of psychiatric nurses to explore the nurses' possession of empathy, unconditional regard, genuineness; he also examined how charge nurses evaluated student nurses, and developed an inventory to look at the relationship patients developed with nurses. Like Cormack's study (1976) this study focused on the patients' perception of 'process'. Shanley (1984) found that 90% of the nurses have relationships that offered facilitative conditions for therapeutic change in patients (by implication, one in ten nurses do not). The nurses offered higher levels of the facilitative conditions to women rather than men and to depressed rather than schizophrenic patients. Unconditionality of regard received the lowest score and it is unclear how this contributed to the relationship between nurse and patient.

Despite confusion about what skills the psychiatric nurses possess, there is a general consensus that psychiatric nurses, by virtue of their training, provide a beneficial contribution to the care of the mentally ill. The CPNA Survey (CPNA 1985b), shows that the majority of community psychiatric nurses are not specifically trained for community work, so it is reasonable to assume that community psychiatric nurses use the skills, models and theories acquired from their initial hospital-based training. This section has summarised those approaches used by psychiatric nurses who work in the community setting. It is unclear if nurses develop or acquire new skills from the experience of community work. An examination of the work of the community psychiatric nursing from the viewpoint of the nurses may help to clarify knowledge in this area.

## 2:3 EVALUATION OF COMMUNITY PSYCHIATRIC NURSING

### *The literature on community psychiatric nursing*

#### **Descriptive literature**

Much of the writing on community psychiatric nursing is anecdotal and descriptive. Although lacking in objectivity, these provide a valuable measure of the scale of development of community psychiatric nursing and the form which this is taking. They also demonstrate the enthusiasm of individual practitioners and services to share experiences, in an attempt to build up a body of knowledge about community psychiatric nursing. The concern to document the work of the individual community psychiatric nurses does not seem to have been matched by a broad examination of resources being applied to community psychiatric nursing activity and it is not clear how far existing knowledge of community psychiatric nursing is being utilised by service managers in evaluating effectiveness of such services.

Recent authors repeatedly bemoan the excess of descriptive work and comment on the necessity to evaluate community psychiatric nursing services (Leopoldt and Hurn 1973, Griffith and Mangan 1980, Mangan and Griffith 1982, Paykel et al 1982, and Brooker 1984b). As Leopoldt (1975) commented "amount of work is neither a measure of its effectiveness nor its necessity". Due to the excess of descriptive work examining community psychiatric nursing, it was determined that the emphasis of the present study be on evaluation.

#### **Evaluative literature**

The literature evaluating the work of community psychiatric nursing is reviewed below. Suchman (1967) proposed a distinction between evaluation and evaluation research. He defines 'evaluation' as: "the general process of judging the worthwhileness of some activity regardless of the method employed" and 'evaluation research' as "the specific use of the scientific method for the purpose of making an evaluation" This distinction separates 'evaluation' as a goal, from 'evaluation research' as a particular means of attaining that goal. As Luker (1982) comments:



Evaluation when used in a general way is said to refer to the everyday occurrence of making judgements of worth. Although this interpretation implies some form of logical or or rational thought it does not presuppose any systematic procedures of presenting objective evidence to support the judgement; evaluation when used in this way, refers only to the process of assessment or appraisal of worth. (Luker (1982), p13).

Use of the word 'research' implies systematic academic study which should be distinguished from non-systematic, journalistic description. Suchman's distinction facilitates examination of the literature on community psychiatric nursing. Many authors have evaluated the work of the community psychiatric nurse in Suchman's terms, but few have carried out evaluation research.

#### *The community psychiatric nursing literature and EVALUATION.*

Warren (1971) seems to have been one of the first authors who attempted to evaluate the work of the community psychiatric nurse. He took 1:10 sample of patients receiving intramuscular injections from community psychiatric nurses' caseloads; he examined these patients' history and found that those on medication had had fewer admissions since starting the injections. He assumed the 'medication giving' caused this reduced pattern of admissions and he then proceeded to calculate financial savings based on hypothetical costs of admissions (if the previous pattern had continued unabated). Warren concluded that the community psychiatric nursing service was cheaper. This study could not be considered a rigorous cost benefit analysis as Warren compares marginal costs of community psychiatric nursing care with average costs of inpatient stay. Jeevendrampillai (1982) also discusses costs of community psychiatric nursing and claims that community psychiatric nursing is cheap. The author calculates the figure of £2.50 per hour as the cost of domiciliary care; it is not known how this figure is derived and there are other costs of home care (support services and emotional costs: these are considered by Warren 1971).

Shaw (1977), a general practitioner, attempted to judge the worth of community psychiatric nursing by looking at the patients he

had referred to the community psychiatric nurse over a six month period; he presented a description of these by age, diagnosis and sex. He compared them with the hypothetical management of patients in the absence of community psychiatric nursing and concluded that the benefit to patients of community psychiatric nursing contact (compared with GP contact), were fewer prescriptions for psychotropic drugs and quicker psychiatric assessment (by community psychiatric nurses, rather than waiting for consultant or outpatient appointments). He concluded that the community psychiatric nursing care was better and cheaper.

Leopoldt et al (1974) described the experimental attachment of psychiatric nurses in health centres in Oxford and examined referral patterns and diagnostic groups. Harker et al (1976) reported on the same scheme, and said that community psychiatric nurse attachments enhance patient care and reduce stigma. These studies, and those of Llewellyn (1974), Maisey (1975), Corrigan and Soni (1977), Sharpe (1980), Brough (1982), all provide examples of studies which assert the worth of community psychiatric nursing by retrospectively examining referral patterns and admission rates, diagnosis and disposal of patients on community psychiatric nurses' caseloads. The authors tend to make assertions about the efficacy of community psychiatric nursing which are not entirely justified from the data, and alternative interpretations are possible. Llewellyn (1974) for example, regarded the fact of a developing service as evidence of a 'need' for community psychiatric nursing; the 'development' however, could be the result of other pressures and unrelated to 'need'. Brough commented:

These charts, apart from monitoring value, give a clear account of the services provided by community psychiatric nurses. It is not possible to say that it represents a need fulfilled as the nurses were working to full capacity and could not have met a higher demand.  
(Brough (1982), p788)

The charts do not, in fact, monitor value, although they give a vivid statistical analysis of changes in community psychiatric nursing provision over a specified time; there is also no evidence given, to

suggest that service development is related to specific needs. Corrigan and Soni (1977), Warren (1971) and Pullen (1980) all considered decrease in rates of hospital admission as an indication of 'successful' community psychiatric nursing intervention. Decrease in admissions of course could be caused by many factors - differing admission policies, varying criteria for admissions - not just the work of the community psychiatric nurse. Pullen (1980) asserts that the problem solving approach and 'family involvement' of domiciliary visits is 'useful' in one third of visits; no further elaboration of this is given (useful for what - providing background information, helping making treatment plans, or avoiding the decision to admit?).

Another criticism which can be levelled at many 'evaluations' of community psychiatric nursing services is that reporters are often positively biased in favour of their own services. Pharaony and Mills (1976) for instance, question other disciplines about 'the need' for community psychiatric nurses. The authors asked - do you think there is a need for community psychiatric nurses, and if there was a service, would you refer? For 'what' the community psychiatric nurses were needed was not detailed. The questions were biased towards gaining favourable answers about community psychiatric nursing. Balfour-Sclare (1971), for example, lists seven prerequisites of the success of a community health project. The criteria are stated as a 'matter of fact' although they are the author's idea of success and are not necessarily valid as measures of success for all community psychiatric nursing services.

Diers (1979) has stated that "without study the answer will be just guesswork." Many of the studies discussed as 'evaluation' would be considered guesswork by Diers. The few studies which have used systematic approaches to acquire objective information are reviewed below. These would be included under Suchman's category of 'evaluation research'.

### ***The community psychiatric nursing literature and EVALUATION RESEARCH***

The framework of evaluation offered by Donabedian (1966), of 'structure - process - outcome', (see p9), offers a skeleton around



which community psychiatric nursing evaluation research can be discussed. The 'evaluation research' which focuses on each of these three areas in community psychiatric nursing are presented below.

### Structure

Parnell (1974 and 1978) conducted the first survey of community psychiatric nursing which showed that service development, in England and Wales, lacked uniformity and that community psychiatric nurses worked from various bases and in varying capacities. Further surveys have illustrated that this picture remains valid today (CPNA surveys 1981, 1985b). Although these surveys provide limited information on Scotland's community psychiatric nursing teams, they have yielded a 'snap-shot' of what community psychiatric nursing is doing at any one time. They have enabled identification of trends and issues of relevance to community psychiatric nursing and the wider field of psychiatry.

Skidmore and Friend (1984a-f) carried out interviews on 120 community psychiatric nurses from 12 community psychiatric nursing services in England. Their research aim was to gain information on community psychiatric nursing in relation to specialism, education, enrolled nurses and community psychiatric nursing bases. They found that teams were shaped by the most dominant person in each and that community psychiatric nurses preferred a dual base; they found that nurses preferred 'specialism' but questioned the benefit of this approach for the patients; they also found that community psychiatric nurses considered that they lacked skills, and concluded that education was necessary to improve this deficit. The absence of information about the methods of data collection, the interview schedule or the data analysis make appraisal of this study difficult.

### Process

Process studies have generated detailed qualitative and quantitative information on community psychiatric nursing in specific occupational settings.

Altschul (1972,1973) conducted the first systematic study which

examined what the community psychiatric nurse was actually doing: she studied the records available at Dingleton Hospital, conducted observation of domiciliary visits and asked the professionals involved in these, to complete a check list of activities detailing aspects of this domiciliary care. The aim of this study was to investigate the multidisciplinary approach to the treatment of patients at home. Altschul's study suggests that professionals' work overlaps in the home situation (as judged by the professionals concerned). She found that the community psychiatric nurse was responsible for the continuity of patient care and that it was community psychiatric nurses who arranged visits and completed the records. She found that only one in three teams provided information on support people present at interviews, and that a high proportion of visits were made to patients who lived alone. The community psychiatric nurses tended to ask questions about interpersonal relationships; the check list results suggested that activities were not role specific. Altschul also attempted to obtain detailed reports by nursing staff to try to identify the activities and the thinking behind them; this was abandoned because of the nurses' difficulty with talking in detail about their thoughts, feelings, perceptions and actions. Altschul's exemplary efforts to undertake an in depth study of one psychiatric service suggested that it was unclear what skills community psychiatric nurses specifically offer in the domiciliary setting. This finding has since been corroborated in other studies.

Barker (1977) examines what the community psychiatric nurse is doing. Using diary analysis Barker identified three areas of patient dependency and proposed a model on which community psychiatric nurses' work was based. The author also piloted a questionnaire to be used as an assessment tool following domiciliary visits. This appears to be one of the first studies introducing systematic assessment into community psychiatric nursing work.

Sladden (1977 and 1979) described the activities of a group of hospital based community psychiatric nurses principally using interview technique and self recording procedures. This study took a holistic approach to community psychiatric nursing and studied nurse-patient contacts in depth; community psychiatric nursing

practice was analysed: the data on domiciliary contacts were obtained from the nurses, and neither patients nor carers were asked for their opinions; only the referrers' and GPs' views of the service were obtained. Activities of the community psychiatric nurses fell into three distinct categories: medical treatment: psychological adjustment and social relationships; socio-economic problems and resources. Sladden suggested that domiciliary and out-patient clinic care were differentiated on two counts. Firstly, by the use of different frames of reference (out-patient work was related to a medical frame of reference and home care to a socio-psychological one). Secondly, out-patient care was characterised by impersonal as opposed to individual type of care.

Harrison (1984) focused on community psychiatric nursing care of the elderly mentally infirm. He stated at the beginning of the questionnaire that he used in the study: "We want to ask relatives about relatives' problems, patients about their problems and not conjectures on each other's behalf". This laudable aim does not seem to have been achieved. The researcher developed a questionnaire which examined the community psychiatric nurses' views of problems found in the patients. He found that all the patients had at least 10 problems, and some as many as 50. It is unclear from his research whether community psychiatric nursing involvement relieved these problems, or whether the community psychiatric nurse was unwilling or unable to take action to resolve the problems. It may be that some of the problems were not perceived as such by patients and relatives, and therefore no action by the community psychiatric nurse would be indicated (see Blaxter 1976). Harrison's study provides valuable information on the social situation of the patients in the study: 32:69 had no caring relative living nearby and 41 (out of a total of 69) had less than one hour's daily contact with anyone at all (for 6 patients, the community psychiatric nurse was the only visitor).

McKendrick's work [(1981 and 1982) see p79], surveyed the quantitative measures used by services to measure performance. He found little consensus (between services) as to which aspects of care were recorded.

Statistical descriptions of community psychiatric nursing



services (see p76), can be considered here as they are attempts at quantifying the work of the community psychiatric nurse and providing information on the 'process' of community psychiatric nursing. James (1961) refers to 'process' as: "the number of times a bird flaps its wings without determination of how far he has flown". This graphic description warns of the shortcoming of studying 'process' without consideration of 'outcome'. Outcome studies will now be discussed; in community psychiatric nursing they are notable by their scarcity.

### Outcomes

Hunter (1978), in a large scale five year study of community psychiatric nursing care of schizophrenic patients, conducted the first outcome study of community psychiatric nurses. Mangan and Griffith (1982a) commented that:

Hunter (1978) found that retrospectively, community psychiatric nursing care was inferior to normal follow up, though one would have to be cautious in interpreting his data as there is a very real possibility that the patient samples were not adequately matched.  
(Mangan and Griffiths (1982a), p158)

This criticism is not entirely justified. Hunter compared two groups of patients (retrospectively matched by similarity of hospital background): one group received care from community psychiatric nurses, the other not. He found that the patients cared for by community psychiatric nurses spent more time in hospital and day care and had more out-patient attendances (compared with the control group). Whether this is considered 'inferior' is a value judgement. One could assert that contact with community psychiatric nurses could be leading to early detection of crises and treatment of problems (evidenced by increased time in hospital care). This could be perceived as preferable by patient and family. The differences in admission may be related not to community psychiatric nursing care at all but to other variables, for example better prognosis or family support; this would support Mangan and Griffith's comment that matching may have been inadequate.

Hunter's study, nevertheless, provided valuable information

about the outcome and process of community psychiatric nursing. He found that the most disturbed patients (as judged by the carers) were not receiving community psychiatric nursing care. This may suggest that community psychiatric nurses' contribution leads to less disturbance in patients whom they visit; or that it increases relatives' tolerance and abilities to cope with the disturbance. Hunter also found that patients' families do not seek help when they need it. He concluded that less stress should be placed on 1:1 relationships between nurses and patients and that more emphasis should be placed on social relationships and the development of interpersonal skills. Hunter provides little information on the methods of data collection. He suggests that he gains information from records (1978, p77), but it is unclear which records are being referred to. The 'in-depth' detail of information suggests that structured interviews may have been used by the nurses and researcher but reference is made only to research interviews (1978, p58) and that 'nurses described their work' (1978, p62-3). Hunter provides a case study format and compares nurse-patient-carer comments about patient care; this is combined with the researchers' analysis of the work of the community psychiatric nurses. He therefore provided consumer feedback about the value of the community psychiatric nursing service to families with schizophrenic relatives.

Studies which use patient samples, composed of subjects already referred to community psychiatric nurses, may be biased towards individuals thought to be at relatively higher risk of relapse. Paykel and his colleagues (1982 and 1983) to avoid this bias (present in Hunter's study), used a prospective randomised clinical trial. This study compared community psychiatric nursing care of a group of chronically neurotic women with the care from out-patient psychiatrists. Undertaken over an eighteen month period, this study uses many measures of outcome: symptoms, social functioning, family burden, consumer satisfaction, and economic cost. The authors demonstrated that the community psychiatric nurses do equally well as psychiatrists. The community psychiatric nurses were in fact perceived as being 'warmer' and patients were more satisfied with this care. This study also provided information

about the 'process' of community psychiatric nursing: community psychiatric nurses follow up the patients longer (than out-patient psychiatrists); this follow-up is systematic, in that discharge was planned, with gradual reduction of frequency of visits. Community psychiatric nursing care achieved more discharges (than the out-patient doctor service) by the end of the eighteen month study period. There was a small increase in GP contacts amongst the community psychiatric nurse/patient group.

The limitation of both of these outcome studies, is that they focus on specific diagnostic categories of patients and the findings are not necessarily generalisable to all patients cared for by community psychiatric nurses. A recent study by Rushforth (1986) focusing on parasuicide patients cared for by community psychiatric nurses, continues this emphasis.

Marks (1985), has conducted a randomised year long clinical trial also on neurotic patients, but comparing treatment by nurse therapists (psychiatric nurses with an additional behaviour therapy training), with care by GPs. Brooker (1985a), compares community psychiatric nurses with nurse therapists and commented that the main difference between the two is that therapists have a skills based training. It is not known to what extent this training affects patient care as no research has been completed comparing the work of the community psychiatric nurse and nurse therapist. In Marks' study patients who received treatment from nurse therapists did better compared with the GP group. At the end of one year, control patients who had not improved had crossover behavioural treatment and they improved. The author indicates the worthwhile gains that may ensue to patients and community from psychiatric nurses assuming a greater role in the care of patients with neurosis. It is suggested that GPs sought the advice of the nurses about general psychiatric patients hence extending the nurse's role to "that of a community psychiatric nurse" (Marks 1985, p1183). The measures used by Marks were problem and leisure ratings, problem related targets and a self administered fear questionnaire; no assessment of family burden was attempted. This study also focuses on a narrowly defined group of patients.





### *Relevance of this literature review to the present study*

#### **Structure**

The above review of the literature on community psychiatric nursing services, shows that evaluation research has taken place on a limited basis. There is a lack of information at the 'structural' level on community psychiatric nursing. Repetition of the CPNA Survey of 1985 and implementation of the DHSS Korner Recommendations (see p77) will rectify this to a certain extent.

#### **Process**

There is a lack of evaluative research focusing on the 'process' of community psychiatric nursing; overall, to date this has been in quantitative terms and there is a need for more information which generates 'qualitative' detail on the work of the community psychiatric nurse. McKendrick (1980) commented: "decisions are made daily on the organisation and development of community psychiatric nursing services throughout the country and little is known of the criteria upon which such decisions are based". The present study attempts to fill in this gap, and provides some answers to McKendrick's statement.

#### **Outcome**

Outcome studies on community psychiatric nursing are few; those which have been undertaken have been on specific diagnostic categories of patients (neurotics and schizophrenics) and have tended to use researcher orientated measures of outcome. There is a need to evaluate 'outcomes' in relation to other diagnostic groups that community psychiatric nurses care for. This factor underpinned the decisions relating to sample choice in the present study. There also appears to be a lack of information linking process with outcomes, and this too was a focus of interest in the present study.

## 2:4 THE GOALS AND OBJECTIVES OF COMMUNITY PSYCHIATRIC NURSING

### *Introduction*

In reviewing the current policy documents, on provision of psychiatric care, it was found that there is a lack of elaboration of strategy towards defined goals. The next section of the literature review explores whether or not this is also the case for community psychiatric nursing. The goals and objectives of community psychiatric nursing are elaborated, and the reasons for choosing the carer as the focus of interest in this study are given.

### **Strategy and community psychiatric nursing**

The lack of elaboration of strategy towards defined goals, evident in policy documents, raised questions about whether this is also the case for community psychiatric nursing. Use of the word strategy suggests a plan or method (the term has military derivations which include 'the art of manoeuvring an army effectively' and 'a large scale plan for winning a war'.) By implication, plans have objectives and goals.

Review of the community psychiatric nursing literature provides evidence that authors are searching for 'explanations' of service development rather than citing evidence of planning towards achievable goals. Many of the descriptions provided do not mention any theoretical framework surrounding community psychiatric nursing service development, and much of the information provided is anecdotal (Brennan 1981, Ainsworth 1981, Sencicle 1981).

### **Reasons for development of community psychiatric nursing**

Reasons for service development seem to be stated in preference to highlighting goals. The 'reasons' given for developing local community psychiatric nursing services include various expressed purposes or intentions, recommended/prescribed tasks and perceived advantages. These illustrate the ambiguity of the word 'reason' but yield information about implicit goals, objectives and 'process' criteria.

The reasons for the development of community psychiatric

nursing reflect two different levels of argument: one, arguing for the development of community psychiatric nursing and the other, arguing at the level of why specific services have developed. Often rationales are not separated clearly. The confusion discussed earlier in relation to community care at the conceptual level is mirrored here.

An examination of accounts of service development reveals a number of different types of rationale, some having quite complex ramifications, variations and structures. A typology of the rationales behind community psychiatric nursing service development is listed numerically below. It shows that the stimulus for community psychiatric nursing development has come from a desire to improve the organisation of services to patients: hence improving patient care (see rationales number 1-4, 6 and 8 below); and to improve the family's coping capacity (see rationales numbers 7 and 8 below); a desire to improve interprofessional relationships (see rationale number 5); to improve psychiatric nursing itself (see rationales numbers 10, 11 and 12 below), and for economic reasons (see rationale number 9 below). There are diverse motivations spurring the development of community psychiatric nursing: local factors, presence or absence of professionals and willingness of other professionals with whom to collaborate, combined with theoretical discussion of the preference of community care to institutional care, have given an impetus to community psychiatric nursing in specific areas.

#### *The rationales*

(1) Institutional care leads to secondary handicap which is considered undesirable and it is therefore argued that patients should not be admitted to hospital but preferably nursed at home (Roberts 1976).

(2) In accordance with government policy (and current professional practice), there is a desire to reduce the numbers of in-patients and length of hospital stay (MacDonald 1972). Pressure on hospital



beds requires early discharge to vacate beds (MacDonald 1972, Sharpe 1975). There is evidence in the literature that discharge can result in 'the revolving door syndrome' where a pattern of short term treatment and early discharge becomes repetitive. Nurses were therefore commissioned to undertake a supervisory and aftercare service (Nickerson 1972, Willey 1969, Kirkpatrick 1967, Marais 1976, Sharpe 1975) to try and avoid this relapse pattern. Psychiatric nurses were considered the ideal group to assume this role by providing 'continuity' from hospital care and by using the developing relationship to effect change (Kirkpatrick 1967, Warren 1971).

(3) Community care, that is nursing of the patient outwith the hospital is preferred to institutional care as patients can avoid being labelled (Shires 1977, Cohen 1978, Jeevendrampillai 1982). Stobie and Hopkins (1972) talk of avoiding the crisis of admission and Harker (1976) comments that contact with community psychiatric nurses avoids stigma. It is argued that care outwith hospital can allow patients to maintain their role for as long as possible (Stobie and Hopkins 1972) and responsibility can be maintained within the social group of the family (Pullen and Gilbert 1979a, Ritson 1977).

(4) The availability of drugs, particularly the long acting preparations of phenothiazines, is considered effective in preventing relapse of patients, particularly schizophrenic patients whose frequent readmissions were (assumed to be) related to failure to comply with drug regimes (Warren 1971). Community psychiatric nurses were considered the most appropriate professional to administer these drugs in the home situation (Nickerson 1972 Warren 1971 and Leopoldt 1974).

(5) Implicit in the literature is the suggestion that community psychiatric nurses can influence and change the attitudes of professionals and the public (Higgins 1984, Stobie and Hopkins 1972, MacDonald 1972 and Sharpe 1980). Psychiatric nurses possess particular skills (Kirkpatrick 1967, Haque 1973) which are

transferable and useful in the community setting. Roberts (1976) has commented that community psychiatric nurses can act in a consultative capacity to non psychiatric nurses who may have problems dealing with people showing symptoms of mental disorder. Clarke (1980) uses research evidence on psychiatric morbidity to argue that community psychiatric nurse and health visitor liaison is needed. Anderson (1972) has commented on the need for community psychiatric nurses to educate other professionals in psychiatric knowledge.

(6) Assessment at home, by the community psychiatric nurse, enables contact with relatives and accordingly can give greater insight into patient's behaviour (Hunter 1978, Stobie and Hopkins 1972a, Henderson et al 1973) and provide supplementary information on social history and living situations (Weeks and Greene 1966, May 1965a & b).

(7) Home assessment also enables community psychiatric nurses to offer support to the family and carers of the patient (Barker and Black 1971, Roberts 1976).

(8) Community psychiatric nurses can implement treatment quickly and early help can be given which helps patients and carers (MacDonald 1979 and Leopoldt 1979a and b).

(9) Community psychiatric nurses can relieve medical staff time at out patient clinics (Leopoldt 1973, Sharpe 1975) and can see patients previously dealt with by a psychiatrist (Leopoldt 1975) or compensate for a shortage of psychiatric social workers (Sharpe 1975).

Three other reasons have been given to justify the continued development of community psychiatric nursing:

(10) The work of the community psychiatric nurse is considered rewarding and interesting and may involve learning new skills (Henderson et al 1973), increased job satisfaction (Maisey 1975), and reduction in wastage of psychiatric nurses (MacDonald 1972).

(11) Experience provided by community psychiatric nursing teams was considered beneficial to students and trained nurses whose training was considered to be too institutionally orientated (Sharpe 1975).

(12) Community psychiatric nurses were considered to fulfil a useful function as disseminators of information on family and social aspects to the team and institution (Maisey 1975).

As can be seen from this list, most of the writing about reasons for development took place in the seventies. This seems to have coincided with a marked increase in the speciality of community psychiatric nursing; documentation of 'reasons' for development may be linked to the need for the speciality to gain recognition. Since the seventies, community psychiatric nursing has gained acceptance within the field and the literature of the eighties has moved on from general comments about the reasons why community psychiatric nurses are needed, to looking at more specific issues like education and training, details about practice and evaluation of the effectiveness of services.

#### **Goal setting and community psychiatric nursing**

Community psychiatric nursing services do not seem to set goals for their corporate activities although individual nurses are increasingly using a systematic approach to care. Recent papers for instance, suggest that goal setting is a feature of community psychiatric nurses' work with individual patients (Persaud 1985, Ditton 1984): this is related to increased use of 'nursing process' approaches to patient care taken by some community psychiatric nurses (Williamson 1982: also see Chapter 2:2). Goal setting otherwise, does not appear to be a feature of the work of community psychiatric nursing services. Goals can be inferred from the reasons given but authors tend not to elaborate on these, nor examine whether specific aims are met.

Statistical data, although not entirely satisfactory as a means for evaluation of services (see Chapter 2:5), may be utilised to ascertain goal attainment. Inasmuch as one can make general comments based on the literature, descriptive statistics on



community psychiatric nursing services appear to be collected routinely, analysed retrospectively and used to justify changes in patterns of community psychiatric nursing care rather than for forward planning (Sharpe 1980, Maisey 1975, Leopoldt 1979). Only two articles provide evidence of statistics being used for forward planning: those of Sharpe (1982) and Holloway (1984). Sharpe (1982) conducted a survey of GPs in the Croydon area, in order to plan a future community psychiatric nursing service. He found that 84% of the GPs wanted an attached community psychiatric nurse and was able to gain a clear idea of these GPs' expectations of the community psychiatric nurse. Holloway (1984) carried out a project which demonstrated the value of a proposed mental health centre and resulted in improvement and changes in future service provision. These two papers could be the tip of a large hidden iceberg, of course, but the lack of statistics at national level (see p77), would give some support for the conclusion that statistics are not used for planning services. The present study looks at the goals set by two community psychiatric nursing services and investigates the work of community psychiatric nursing to examine the values and assumptions underpinning the work at local level.

#### ***The community psychiatric nursing literature and contact with carers***

Three of the above listed reasons refer to the carers of the mentally ill and state the advantages of community psychiatric nurse contact with carers. Contact between the nurses and carers is considered to be beneficial to the nurses and facilitate the process of assessment and treatment of patients (by implication this will also help the patients and carers, as appropriate and speedy care will be implemented). Community psychiatric nursing contact is also considered beneficial to the carers, who, it is argued, receive support and also relief at the earliest opportunity.

The discussion above (see Chapter 2:1), on the effect of community care policies suggests that the 'family' (especially women kin), are expected to look after sick members, and that this expectation shows little sign of changing, quite the reverse. In view of this, it seems appropriate to take stock of the present

situation and assess what support carers are currently receiving.

Obviously, carers could receive 'support' from a variety of sources (see Blaxter 1976 and Orford 1987 for a summary of the issues involved). The above comments indicate, however, that 'support of the carers' is one reason for the existence of the community psychiatric nursing services. This study was therefore intended to assess the help which carers perceive as given by community psychiatric nurses. Further, this study provided the opportunity to examine the process of community psychiatric nursing and find out to what extent supporting the carers affected the work of community psychiatric nursing.

A brief review follows of the literature pertaining to the community psychiatric nurses' contact with carers.

There have been two trains of thought as regards the family and the work of the community psychiatric nurse and these differentiated even the first two community psychiatric nursing services. At Warlingham Park Hospital, May and Moore (1963) commented:

detailed investigation of the patient's family situation or modification of his environment and of difficulties in interpersonal relationships is not expected.  
(May and Moore (1963).)

Community psychiatric nursing work in the above mentioned community psychiatric nursing service was closely supervised by a consultant psychiatrist. Clearly this service did not expect therapeutic change by involvement of the community psychiatric nurses in family work, although it was acknowledged that the community psychiatric nurse would reassure relatives by their continued contact.

The other early community psychiatric nursing service at Moorhaven Hospital (Weeks and Greene 1966), in contrast, recognised that the community psychiatric nurses would have an active role in family; this service, supervised by a social worker considered knowledgeable in family care, developed with the expressed aim that community psychiatric nurses should look for stresses within the family and take appropriate steps to remedy these (Llewelyn 1974). These two services have very different focuses of attention. The first has a primary focus on the patient who is considered



'separate' from the social network in which he lives. Other services have developed like this, where the family is only considered as being important peripherally to the patient. Sharpe (1975), for example, cites 13 reasons for the work of the community psychiatric nurses; only one makes reference to relatives. The second focus is one in which the family is viewed as an integral part of patient care. These two approaches are comparable to using the medical model and social model of care respectively (see Chapter 2:2: using the former model, a person becomes a passive patient where behaviour is observed and 'symptoms' isolated and treated; using a social model of care the patient is seen as actively involved in a social network which is included in care given).

Studies of the psychiatric nurses work in the hospital setting suggest that nurses are minimally involved with relatives. Cormack (1976) found that in the hospital setting, psychiatric nurses were rarely seen to initiate conversations with patients' relatives; only 2% of nursing activities involved relatives. These were similar findings to those of Oppenheim and Eeman (1955). Cormack also found that contacts with relatives were held in a public place, patients were rarely present and the content of the interactions was related to superficial information exchange rather than to the participation of the relatives as part of the treatment process.

It is reasonable to assume that, compared with hospital or ward-based psychiatric nurses, community psychiatric nurses may be involved more with relatives. Because community psychiatric nurses are providing care in the home situation, contact with carers is more likely to occur, than in the psychiatric hospitals, which are typically situated in inaccessible rural settings. To visit patients in their own home situation is different, compared with a ward or hospital; in the patient's home, the nurse is the guest and the dynamics would be different; one would assume too, that by virtue of the family's involvement in caring (see Chapter 2:1), the family, patient and community psychiatric nurse would, by necessity be actively involved.

Do community psychiatric nurses have contact with relatives in the home situation? This, of course, depends in the first instance



on whether relatives live with the patients. Quine (1981) has shown that many discharged patients do not live with relatives. Harrison (1984) found that almost half of the patients in a community psychiatric nursing sample, had no relatives living nearby. It could be that community psychiatric nurses tend to visit patients without families. The patients of the community psychiatric nurses in Harrison's study (1984), were elderly; availability of relatives may depend on patient type. Creer et al (1982) found that even after many years of illness, as many as 50% of relatives may still be in contact with relatives.

If relatives are available, do community psychiatric nurses interact with the relatives? Available evidence is inconsistent. Skidmore and Friend (1984a) found that few community psychiatric nurses interacted at all with relatives. Pullen (1980), however, described an extramural psychiatric service and commented that in one third of the visits, involvement of relatives was 'useful' although no elaboration of 'useful for what' was provided. He commented that 80% of the visits included contact with the relatives, this was compared with only 17% of the out-patient attenders. Sladden (1979) showed that relatives were seen with 2% of patients who attended an injection clinic, but in 40% of the home visits. Thus compared with out patient appointments, home care allows contact with family and the setting in which patients are seen may be an important influence on whether or not relatives are seen by the community psychiatric nurses.

Sladden also analysed nurse/patient contacts; she found that observation and assessment activities were more numerous if a family member was present. This suggests that relatives are involved in the assessment activities of the community psychiatric nurses rather than in treatment. Sladden found that community psychiatric nurses used cognitive approaches to patients and families. These were more frequently used at initial contacts and especially where patients were deteriorating. The community psychiatric nurses in the study only appeared to actively help patients and families understand the situation in times of crisis; helping patients and families gain understanding of the situation was not seen as ongoing work. Sladden's findings showed that family members (if present) provide

information that is helpful to community psychiatric nurses in assessment, but they do not take up the opportunity of these contacts in long term therapy. No information was gained in this study about the family's view of the service (an omission fully acknowledged by the researcher herself). There indeed seems to be a need gain information from the family about the benefits of a community psychiatric nursing contact, in order to assess accurately whether or not community psychiatric nurses should involve families in treatment. This was explored in the present study.

### *The community psychiatric nursing literature and 'burden'*

One of the reasons underpinning work of the community psychiatric nurses' with carers was to help them cope with caring for a mentally ill relative at home. What evidence is there in the literature that the carers need help?

One of the major effects of the change in orientation of care (i.e. from less institutional care to care in the community) is that patients spend less time in hospital and more time with the people with whom they live, often the family. Several authors have provided evidence of the effect that the presence of a mentally ill person can have on relatives. Kreitman (1964) showed, in a controlled study, that spouses of neurotic patients have more physical and psychological symptoms compared with normal control subjects. Other studies have since showed that families are affected in many ways by other types of chronic mental illness: Wing et al (1964), Waters and Northover (1965) and Rutter (1966). This effect on families is loosely described in the literature as 'burden', a term coined by Grad and Sainsbury (1963, 1968). A widespread interest was shown in the topic of 'burden' in the sixties, when community care programmes were enthusiastically introduced. Since then, schizophrenic patients constitute the only group in which interest in family burden has been sustained. (A recent chapter by Kuipers (1987), which reviews the effect of depression on family life and publications by Gilhooly (1984) and Scottish Action on Dementia (1986a and 1986b) suggest that interest in the relationship of 'burden' and other mental illnesses may be



reviving). Kreisman and Joy (1974) nevertheless criticised researchers for taking a "scatter-shot" approach to their data, and failing to follow through on promising leads; they commented: "This lack of sustained interest has left us with fundamental pieces of information missing".

The features of burden have more often been commented on rather than objectively studied (Willey 1969, Ashton 1978, Moore 1982, Eastwood 1983). The dissection of the concept of burden through the effects on the performance of various roles carried out by the patient's relatives was an approach first taken by Mills (1962). The study of Grad and Sainsbury (1963 and 1968) advanced the measurement of 'burden' by using a three point rating scale rather than the descriptive sketches given by their predecessors. These authors showed that caring for a psychiatrically ill relative could cause disturbance in the social and leisure activities of families; disturb the domestic routine, upset other members of the household and affect their capacity to work by making demands and obstructing employment opportunities; and strain the mental and physical health of the carers.

Hoenig and Hamilton (1967 and 1968) also investigated burden. They differentiated between 'objective' burden (the severity of difficulty observed) and 'subjective' burden (the degree of strain reported). They found a disparity between the two types of burden. The meaning of this disparity is unclear, but it was interpreted by Hoenig and Hamilton as evidence of the willingness on the part of relatives to assume a burden. As Hoenig and Hamilton point out "a burden may be taken on in loving care and as a source of obligation and not sensed as such and may be preferred to what others, anxious to help, regard as relief." This disparity may however be evidence of relatives' reluctance to complain about caring or relatives' low expectation of service provision (Hawks 1975).

In Hoenig and Hamilton's study, 46% of families felt the patient was a burden; 75% of these did not complain although they were suffering severe objective and subjective burden. Grad and Sainsbury found that many relatives had suffered problems for more than two years. Hunter (1978), found that schizophrenic patients' relatives did not ask community psychiatric nurses for help even if



they needed it. These studies, and others [Creer and Wing (1974), Creer et al (1982)], strongly suggest that many relatives will not ask for help and that, if service provision is based on demands from relatives, lengthy periods of suffering will have been experienced before help is given. Further, these authors drew clear inferences from their findings for future service provision, aimed at helping families cope and providing community facilities to relieve carers. The failure of the mental health service professionals to do this, is well documented (see Chapter 2:1 and Creer et al 1982). Recent studies do, however, suggest that professional intervention with families caring for schizophrenic patients is being undertaken on a limited basis, and that this is beneficial to patients and carers [Falloon et al (1982); Leff et al (1982) and Barrowclough and Tarrrier (1984) and Tarrrier and Barrowclough 1986].

Burden should not necessarily be presumed to be a negative experience, undergone reluctantly. Studies of carers' experiences have revealed evidence of carers benefiting from living with a psychiatrically ill relative. Stevens (1972) described how tolerance of a patient is not necessarily dysfunctional, and can lead to social solidarity of the family and can prevent social isolation of elderly relatives.

The weight of opinion however, is that negative effects and disruption of family life are caused by caring for a psychiatrically ill dependent (Creer and Wing 1974, and more recently Pai and Kapur 1982, Pai and Nagarajaih 1982 and Gibbons 1984). The Equal Opportunities Reports (EOC 1980, 1982, 1984) also reveal a picture of employment and social opportunities foregone, physical fatigue and emotional stress, compounded by financial difficulties and lack of social recognition. These surveys focused on carers of elderly and handicapped relatives. Other authors have drawn similar conclusions: Wheatley (1980a and 1980b) in a study focusing on care of the elderly; Wertheimer (1982) and Bayley (1973) in relation to care of the mentally handicapped; and Topliss (1981) and Blaxter (1976) as regards the physically handicapped.

As Blaxter (1976) has commented, families have to cope with many crises and adjust lifestyles to accommodate changing circumstances of family members: poverty or unemployment, someone

leaving by marriage, emigration, or death; going to prison or changing jobs are but a few possible examples of changes. It is unclear from the literature whether the mechanisms required to cope with these life events are similar to those required to care for a dependent relative. It is also unclear whether different stresses are involved in caring for a mentally or physically ill relative; or what different stresses are associated with different diagnostic categories.

Accounts given of carers' experiences suggest that the negative effects of mental illness are the most burdensome symptoms: Creer and Wing (1974) found that withdrawal such as lack of conversation, underactivity and slowness were problematic for relatives; Vaughn and Leff (1976) found that lack of communication, interest, affection, and initiative were the focus of the majority of critical comments made by relatives; Fadden et al (1987) has found that the negative symptoms of depressive illness were the most difficult to deal with. Grad and Sainsbury's study (1963 and 1968), showed that relatives most burdened, were those caring for patients with organic psychosis, suggesting that the combination of physical sequelae with mental illness is particularly stressful.

The literature reviewed above, suggests that there are legitimate reasons for community psychiatric nurses' contact with relatives if they can help them cope with 'burden'.

#### *The community psychiatric nursing literature and schizophrenia*

In addition to helping carers cope with 'burden', the literature suggests that community psychiatric nurses could help the families of schizophrenic patients in other ways. As far as schizophrenic patients are concerned, contact with the family plays a crucial role in the course of the illness.

Early studies of discharged schizophrenic patients, suggested that 'with whom' the patient lived, seemed to influence the course of the illness. Brown et al (1958), followed up 229 male patients on discharge from hospital. They found that successful outcome was associated with patients' clinical state on discharge, with their subsequent employment, and with the social group into which they

were discharged. Patients staying with parents, wives or in large hostels did LESS well than those staying with siblings or in lodgings. The findings also suggested that there was an optimum degree of stimulation which suited schizophrenic patients; what the relatives do (or do not do - see below) influenced the course of schizophrenia.

Brown's initial observations were further extended in a series of increasingly elaborate studies (Brown et al 1962, 1966, 1972; Rutter 1966; Vaughn and Leff 1976a and b). These studies strongly suggest that it is not the relationship of carer and the patient that affects the course of schizophrenia, but rather, the behaviour of the key relative.

Leff and Vaughn have coined the term 'expressed emotion', to describe this behaviour (Leff and Vaughn 1976a and b); this is a measure of the number of critical comments made by relatives and the extent of emotional over-involvement and hostility expressed within the family (assessed by use of the Camberwell Family Interview); they noted that certain families with a schizophrenic member demonstrated 'high-expressed emotion' and that patients returning to live with these relatives had a higher relapse rate than those returning to 'low expressed emotion' families. Recent evidence suggests that this factor may also be relevant to depressed patients: see Hooley et al 1986.

There appear to be two ways of minimising this effect: Leff and Vaughn (1981), suggested that medication may have a protective effect on schizophrenic patients who live with families with 'high expressed emotion'. Vaughn and Leff (1976a) further suggested that reducing contact with relatives (to less than 35 hours per week) had a protective effect on these patients.

Barrowclough and Tarrrier (1984) have reviewed the studies assessing the effect of psychosocial interventions with schizophrenic families and considered the studies of Leff et al (1982) and Falloon et al (1982) to be well designed. The results indicate the benefit to families, of (social) intervention, which can reduce the incidence of relapse of schizophrenic illness.

Leff et al (1982) prospectively allocated 'high expressed emotion' patient/families to differing treatment groups, either



routine out-patient treatment or to intervention aimed at helping families reduce critical comments and face-to-face contact with patients. A follow-up study has since been completed with similar results (Leff et al 1985). Falloon et al's study (1982), allocated schizophrenics on maintenance medication to either home treatment or clinic based supportive care. The family therapy approach sought to lessen stress in the patient and family through improved understanding of the illness and in behavioural training to problem solving. After nine months the family approach to treatment was seen to be clearly superior.

This section clearly demonstrates the interventions that are possible for families looking after schizophrenic relatives and indicates that community psychiatric nurses could have a valid role to play with carers.

#### *The community psychiatric nursing literature and continuity*

Before ending this section it is worth discussing the notion of 'continuity of care'. This is relevant to the care given to carers by community psychiatric nurses.

Community psychiatric nurses are assumed to provide 'continuity of care' to patients. Definition of the phrase 'continuity of care' is unclear. There seem to be a range of implied meanings covered by the term. Kirkpatrick (1967) suggests 'continuity of care' means contact with the same nurse during and after hospitalisation; Altschul (1972, 1973) and Pullen (1980) use the term 'follow-up' to describe the implementation of a consistent treatment plan; the term 'follow-up' and 'continuity of care' seem to be used interchangeably. Hunter (1974 and 1978) describes community psychiatric nursing as providing a 'continuing care service'.

The idea behind 'continuity of care' seems to be that it is beneficial for patients to continue contact with psychiatric personnel, who can provide on-going support to individuals and families (Hunter 1974). Research which examined the effect of intervention with schizophrenic patients and their families (Falloon et al 1982 and Leff et al 1982), and research which has studied the

benefits of day care [Herz et al (1971); Washburn et al (1976)], lend support to this claim.

Hunter (1978) furnishes us with information about patients' and families' feelings about 'continuity of care'. Hunter (1978) found that the caregivers appreciated the long term support of the community psychiatric nurses. He found, however, that the emphasis of care was on the patient, and he recommended that "more active and open co-operation should be sought from caregivers in particular".

Allied to the notion of 'continuity of care' is the belief that it is wrong to discharge patients, either to a non-psychiatric professional or to no professional care at all, after an acute phase of illness or after a long period of hospitalisation (Ashton 1978). This belief has been encouraged by the recent literature which suggests that community care policies result in patients being 'dumped' in bedsitters and doss houses and generally neglected by the psychiatric services (McBrien 1985 and Brown 1985b). Sladden (1979) found that the nurses in her study tended to keep patients on the books and were reluctant to discharge patients. This 'holding on' to patients could be interpreted as the community psychiatric nurses' fear of public or professional criticism.

Also implied in the term 'continuity of care' is that a relationship between patient and nurse is continuing to develop (Hunter 1974 and Kirkpatrick 1967). Paykel et al (1982, 1983) provide some research evidence to support the idea that relationships develop between patients and nurses. These authors found that community psychiatric nurses were perceived as 'warmer' by patients compared to out-patient doctors. The patients were also more satisfied with care received, suggesting that patients make judgments about the quality of the relationships they have with their therapists (although this could also suggest that patients do not want to make the effort to travel into out-patient departments!).

It is unclear whether tasks need to be undertaken to ensure that a relationship develops between nurse and patient. Hunter (1978) found that injection giving led to conversation between nurse/patient/caregiver stopping. It is also unclear whether a relationship with one individual nurse is desirable and necessary to

provide 'continuity of care'. Sladden (1979) found that many patients had contact with either *one* community psychiatric nurse (these patients were usually seen in the home situation) or *all five* community psychiatric nurses in the study (most of whom were seen in the injection clinic).

The term 'continuity of care' also is used to refer to contacts with other professionals and agencies with whom the community psychiatric nurse and patients have contact. Other authors use different terms for this activity e.g. liaison, but the implication is that this activity is needed to provide continued care to patients. Sladden (1979) found that the community psychiatric nurses did not value contacts with GPs, and Hunter (1978) found that there was little contact between community psychiatric nurses and other agencies.

Examination of the term 'continuity of care' has shown that understanding of the term is varied and confusing and the research evidence which is available on community psychiatric nursing and 'continuity of care' is limited. Examination of the nurses' work will allow exploration of whether or not this is a relevant concept to the community psychiatric nurses.

In this section the goals inherent in the work of community psychiatric nursing have been examined, and in particular the nurse's work with carers has been focused on. This leads to the choice of the 'carer' as one of the major foci of the study, and emphasises the need to examine the work of the community psychiatric nurses.

To summarise, the 'carer' is chosen as the focus, for several reasons. First, some of the documented rationales given for community psychiatric nursing service provision include giving support and help to the carers of the mentally ill who are looked after at home. The literature further confirms that community psychiatric nurses could have a legitimate role with relatives: either by specific interventions to reduce the 'burden' or 'expressed emotion' experienced by carers, or by providing continuity of care.



Secondly, review of the literature on community care policies suggests that the 'family', especially women, care for the mentally ill at home. In view of this and the limited 'community' resources available, it seems timely therefore, to find out what support carers are currently receiving from the community psychiatric nursing services (see Chapter 2:1). This, combined with the burdensome (seriously onerous and negative) nature of the carers' experiences, underlines the importance of evaluating the effect of the community psychiatric nursing input.

Finally, there has been little recent interest in the topic of 'burden'; this appears to be an omission if one considers the fact that the role of family and non-professionals in care of the mentally ill seems to be on the increase (see Chapter 2:1). These comments indicate that it is urgent to attempt an evaluation of the help received by the informal carers.

The present study examines the carers' perception of help received by community psychiatric nurses. Examination of the process of community psychiatric nursing will show how 'supporting the carers' is viewed by the nurses.

## 2:5 THE NATIONAL CONTEXT OF THE STUDY.

### *Summary*

The following section presents a brief historical review of the development of community psychiatric nursing services and sets the national framework within which the present study was completed. Review of the literature in this section confirmed the decision to focus the study on examination of the work of community psychiatric nursing itself, and suggested an investigation of a service at local level.

To summarise what follows: the relevant policy documents are examined: these show that the evolution of community psychiatric nursing services has been unplanned at national level, and as a result, community psychiatric nursing services lack shared, explicit policies.

There is uncertainty about how staffing levels for community psychiatric services should be decided. Manpower data for community psychiatric nursing are either unavailable or are concealed within national/regional and local data for psychiatric nursing in general. The Korner Recommendations (although not going to be adopted in Scotland) could offer an alternative model to change this situation (DHSS 1984, see below).

Any prescription or data base must contain presuppositions about aims, goals and objectives of community psychiatric nursing, As we saw in the previous section, which explored the goals and objectives of community psychiatric nursing services, there are few accurate descriptions about the work of community psychiatric nurses and there is uncertainty about what standards, services are aiming for or hoping to achieve. The following review shows that policy makers recommend target figures for the development of community psychiatric nursing as a speciality. This would seem to be paradoxical when community psychiatric nurses' work is still not clearly defined. It seems illogical to recommend an increase in numbers of community psychiatric nurses when there is doubt about what they do.

*Policy documents and community psychiatric nursing development.*

Community psychiatric nursing as a speciality has been gaining a higher profile over the years. The first recorded beginnings of community psychiatric nursing were in 1954 at Warlingham Park Hospital and in 1952 in Moorhaven Hospital (May and Moore 1963 and Greene 1968). The first official document which discusses community psychiatric nursing (DHSS 1975) called it 'a district psychiatric nursing service'. In 1968 only passing reference was made that community psychiatric nursing was worthy of 'general study' DHSS (1968). That community psychiatric nursing was developing during this period is borne out by Brook and Cooper (1975).

Because of the apparent increase of community psychiatric nurses, Parnell (1974) was commissioned to carry out the first survey of community psychiatric nursing in England and Wales. By 1980, community psychiatric nursing was sufficiently recognised within the mental health field to warrant the attention of psychiatrists (Royal College of Psychiatrists 1980). In 1981, the Royal College of General Practitioners commented on the value of community psychiatric nursing intervention during crises and life changes (Royal College of General Practitioners 1981). Recent policy documents have devoted considerable space to the discussion of community psychiatric nursing (Social Services Committee Report 1985 and SHHD 1985). However, despite the increased interest in, and assertions of, the 'general' value of community psychiatric nursing, policy documents are still unclear about what is offered by community psychiatric nurses and the services in which they work. It is not surprising therefore, to find that the training needs of community psychiatric nurses are still being debated and argued: a prerequisite to the development of any training course must be the possession of a clear idea of what the nurses are being trained for. This clarity of purpose is absent in community psychiatric nursing today.

*Training and community psychiatric nursing*

Specific training for this role started in the early seventies, but has been slow to expand and has still been received only by a minority of practising community psychiatric nurses.

In 1974, an outline curriculum for a community psychiatric



nursing course (a post registration course for registered mental nurses) was published (Leopoldt 1974). Other courses have been mounted for the training of community psychiatric nurses: England has nine training centres for community psychiatric nursing, Scotland three. The contents of these courses are difficult to define and are not as well described as other post-registration courses, like behaviour therapy (Brooker 1985b); the courses offered have been criticised because they do not offer training in specific clinical skills (Brooker 1984a, Skidmore and Friend 1984b and CPNA 1985a).

#### The number of trained community psychiatric nurses

Not all practising community psychiatric nurses, however, have undergone a post registration course. Dunnel and Dobbs (1982) estimated that only about 15% of the community psychiatric nurses in their sample had completed courses in community psychiatric nursing. Brooker noted that this figure was an underestimate, and calculated (based on English National Board data) that 725 out of the total of 2500 community psychiatric nurses in England are trained (Brooker 1985b). Based on responses to parliamentary questions on trained community psychiatric nurses, there were 181 trained community psychiatric nurses in Scotland in 1983 (McKay 1985). The Community Psychiatric Nurses Association conducted a survey of community psychiatric nurses in Scotland and England (CPNA 1985b), which found that only 22.4% (i.e. 618) of practising community psychiatric nurses had completed a community psychiatric nursing course. The survey found that since 1980 there had been an increase of only 303 in the number of community psychiatric nurses holding the post-registration certificate, compared with an increase in psychiatric nurses working in the community from 1667 to 2758 over the same period (CPNA 1985b).

The issue of mandatory training for community psychiatric nurses is the subject of much recent debate (Devlin 1984, Skidmore and Friend 1984b, Manchester 1984, Simmons and Brooker 1986 and Dexter and Morrall 1987). The Royal College of Nursing along with the CPNA, has recommended mandatory training for community psychiatric nurses, (RCN and CPNA 1982a) but training, so far, for

community psychiatric nursing has remained optional and still is not a prerequisite to practice.

Against this background of uncertainty about what community psychiatric nurses do and debate about how they are prepared for the work, policy documents nevertheless have made recommendations about developments of the speciality of community psychiatric nursing.

*Population ratios and community psychiatric nursing development.*

How are levels of community psychiatric nurse staffing decided? There seem to be two main methods of doing this: firstly, based on population ratios and secondly, based on estimates of need. It was proposed for example, that psychiatric nurse staffing should be related to 'the total needs of the population' (DHSS 1975). This vague reference to a 'population' in the statement is confusing as it is unclear which population this refers to: British-wide, Scottish-wide or that of the local areas. The concept of 'need' is also notoriously difficult to define (Blaxter 1976, chapter 1). Since 1975, attempts to meet the 'needs' of the population have been met by establishing psychiatric nurse targets in relation to population ratios. In 1975 in England, community psychiatric nurses were included with psychiatric nurse staffing:

In the light of present and expected future numbers of psychiatric nurses, the DHSS is aiming at an initial target in each health district of a level of psychiatric nurse staffing of 85 per 100,000 population increasing gradually as resources permit to 100 nurses per 100,000 population. The present national average is in excess of 90 per 100,000, but they are not evenly distributed. (DHSS (1975), p74, para 9.14)

In Scotland community psychiatric nurse staffing is still not considered separately from psychiatric nursing generally, targets for which are based on in-patient bed occupancy (SHHD 1985, CANO 1975). These guidelines provide a basis for nurse staffing levels in residential institutions but they may not provide a model for community psychiatric nursing.

There is comment in the literature about the development of community psychiatric nursing services on the basis of CPN:population ratios. The first reference to CPN:population ratios



was by Brook and Cooper (1975) who suggest a ratio of 1 CPN:30,000 population. The most recent reference is by Marks (1985), who suggests 1 CPN:25,000 population. Carr, Butterworth and Hodges (1980), derived a ratio of 1 CPN:15,000 population with an anticipated increase of targets of 1 CPN:7,500 in the long term. The Community Psychiatric Nurses Association have proposed targets of 1 CPN:10,000 population (CPNA 1985). This figure has been adopted as a desired ratio for the development of community psychiatric nursing services, in at least one part of the United Kingdom, in connection with a planned hospital closure (Friern and Claybury Hospitals in North East Thames Regional Authority).

This method of deciding community psychiatric establishments has been criticised on methodological grounds (Brook and Cooper 1975) and on the basis that the ratios are unrealistic (Rushforth 1986 and Royal College of Psychiatrists 1980). Mangen and Griffith (1982) suggest that professional interests have introduced 'bias in the data':

In the current absence of adequate data on staffing needs in the mental health services, there are few reliable guidelines on which to depend. Such guidelines as there are, are input-orientated, relying on arbitrary assumptions about levels of need for mental health care and a particular agency's ability to meet them. The pressure to promote the interests of the profession under review adds to the bias in the data.

Mangen and Griffith (1982)

Despite these criticisms the use of targets and ratios have stimulated debate about the development of community psychiatric nursing within the larger field of psychiatric nursing and mental health care.

#### Difficulties of the development of community psychiatric nursing

Plans to develop community psychiatric nursing seem to be put forward, without examination of the resulting implications. One of the problems facing community psychiatric nursing for instance, as a developing speciality, is the problem of developing a new speciality in psychiatric nursing, when psychiatric nursing itself suffers from inadequate numbers (SHHD 1980 and 1985, MWC 1981). This problem is



compounded in Scotland, as the following quote suggests:

Improved recruitment of mental nurses is impeded by the fact that there is a single functional budget for nurse training and the great majority of student nurses go into general nurse training programmes. This approach maintains a self perpetuating pattern of recruitment which discourages improvements and developments in standards of care within the psychiatric services.  
(SHHD (1985), p89)

Another problem is that the development of community services and community psychiatric nurses increases the demands on the existing pool of trained psychiatric nurses (see p3).

#### Numbers of community psychiatric nurses

Community psychiatric nursing has been described as a 'burgeoning' speciality (Devlin 1985) but there is little information available on the scale and nature of the work of community psychiatric nurses or on community psychiatric nursing staff numbers and deployment to support this assertion.

This absence of a quantitative data base about community psychiatric nursing was focused on by Baxter (1984) who calculated the growth in number of community psychiatric nurses in the United Kingdom by looking at the demand for community psychiatric nurses in the situations vacant column of a nursing journal. This is not a reliable method of collecting information about the growth of community psychiatric nursing. The lack of numerical information on community psychiatric nurses was referred to as "gaps in the Department's system of statistical returns" (DHSS 1985, pxcviii) and has been commented on in the literature by Brook and Cooper (1975), Power (1976), and Shore (1977).

Two surveys conducted by the Community Psychiatric Nurses Association (CPNA 1981 and CPNA 1985b) provide the only available quantitative baseline examining changes in development and organisation of community psychiatric nursing. These surveys, show that between 1981 and 1985, across all grades, the number of community psychiatric nurses in Great Britain has increased by 65%. The 1985 Survey, made an attempt to provide a statistical analysis of community psychiatric nursing, but is primarily focused on

England and Wales. Figures for Scotland as a whole (CPNA 1985b) show that Scotland's existing community psychiatric nursing teams are predominantly hospital based and receive most referrals from psychiatrists.

Health Boards in Scotland do not seem to collect figures about community psychiatric nursing on a consistent basis; those that are available, (from John McKay, in written replies to parliamentary questions in January 1985), provide figures for qualified nurses only up to 1983 (see Drucker 1987).

### **Data collection procedures and community psychiatric nursing information**

In this era of cost effectiveness (Dimmock 1985a-c), it would appear to be a matter of urgency to examine at national level, the resources which are being applied to community psychiatric nursing activity. At present there is no standardised data base for community psychiatric nursing although quantitative measures are most commonly used to record the work of community psychiatric nurses.

### **Lack of a standardised data base**

A standardised data base would facilitate a broad examination of, and provide a basis for comparison of the structure, organisation and development of different community psychiatric nursing services. The DHSS is at present reviewing its data collection system, and community health services including community psychiatric nursing are being given special consideration (DHSS 1984: A Report on the collection and use of information about services for and in the community). This report (the Korner report) recommends the collection of information which will facilitate assessment of psychiatric care in the community and on a nationwide basis. Managers will be obliged by systematic and periodic evaluation to look at their objectives and functions. The report also makes a distinction between services TO the community - defined as prevention or intervention which is provided as a matter of policy - and patient care IN the community - services in response to individual demand for treatment or care - (DHSS 1984 p7 para 1.16).



This provides a framework and challenge to community psychiatric nurses to clarify their work.

#### Quantitative measures

Many authors have focused on the difficulties of 'quantifying' aspects of community psychiatric nursing. For instance: "A survey form can never present a complete picture. Number of referrals says nothing about the nature of the referrals, frequency of the visits, the distances travelled or the results achieved" (Leopoldt (1975), p57). Brough (1980) argued that community psychiatric nurses' caseloads are not a useful baseline for estimating workload. Beard (1980) commented that numbers on caseloads do not serve as a meaningful measurement on which to determine clinical input, safe practice or forward planning. McKendrick (1981b) has commented: "Client dependency and nursing activity are difficult to quantify and the fluid nature of the community psychiatric nurse / client interaction does not lend itself to simplistic interpretations such as 'timing of a visit'" (McKendrick (1981b), p102). Measures which focus exclusively on patient or domiciliary contacts can be criticised as they take no account of the other activities of community psychiatric nurses e.g. liaison with other professionals. Number of referrals and discharge rates do not simply equate with effectiveness. Clients needs and team functioning have to be considered.

Tyrell (1975) has commented that numbers have advantages in providing information to guide use of resources, stating that they are less ambiguous than words alone, and that they enable aspects of a situation to be seen in overall perspective. He warns that preferences or assumptions about the relevance of the measurement to the situation are always involved. The above authors would not support Tyrell's comments.

The current methods used to collect information on community psychiatric nursing are limited and have not been adapted to reflect the increase in psychiatric domiciliary work (Tyrell 1975, Wiseman 1981 and McKendrick 1981b). McKendrick examined the recording systems of a sample of community psychiatric nursing services and found that there was concern to measure the activities of the



community psychiatric nurses, at local level, but that there was little consensus (between services) as to which aspects of the community psychiatric nurses' work were important. McKendrick said "The initiatives of the community psychiatric nurses and community psychiatric nursing managers in introducing these measures of their performance is to be applauded...as a method of evaluating and planning service" (McKendrick (1981b), p108). Without accurate information about either the numbers or types of nursing personnel in the community psychiatric nursing or the quality of care provided, planning is difficult.

#### **Planned development of community psychiatric nursing.**

Community psychiatric nursing appears to be developing rather haphazardly rather than in a planned and organised fashion. This is borne out by the comments of Mangen and Griffith (1982):

Community Psychiatric Nursing shares with other British social and health services, a common history of isolated experimental development leading incrementally and without the benefit of clear policy guidelines to a national provision...there is a great diversity in the range of patients managed in the therapeutic settings and in the forms of intervention.

(Mangen and Griffith (1982), p157)

Numerical information supporting this "local and uneven development" has only recently been available from the Community Psychiatric Nursing Association (CPNA 1985). The findings showed that:

Community psychiatric nursing team growth is not correlated with population increase or decrease (OPCS 1985); an index of social deprivation (Rice et al 1985); or progress towards achieving Resource Allocation Working Party targets (Health Care, UK 1985).

(CPNA (1985)

There remains a lack of information on community psychiatric nursing service development in Scotland (see above). Reasons for differing development in different areas are unclear. Brooker (1985a) interviewed a sample of managers in an attempt to find the reasons for community psychiatric nursing service development (or otherwise). He found that one of the reasons related to growth, was

the opportunities provided by joint funding, which enabled increase of community psychiatric nursing teams.

Mangen and Griffith criticise the uneven development of community psychiatric nursing services: "The local and ad hoc character of the development of services has given rise to serious problems in formulating an overall strategy" (Mangen and Griffith (1982,) p165). The difficulties involved in formulating overall strategies for community psychiatric nursing mirror those of defining 'community care'.

#### The development of local community psychiatric nursing service.

It could be argued that an overall strategy is not desirable and that services should develop in response to local needs. This seems to have been the sentiment of the DHSS document of 1975, which states:

the planning of psychiatric nursing services for the future still needs to relate nurse staffing to the total needs of the population rather than to one particular type of facility...as the pattern of services changes, so it will be necessary to change the pattern of deployment of nursing staff within the district and it will be one of the responsibilities of local nursing management to decide how best to deploy staff between the different elements of the district services.  
(DHSS (1975), p74)

This statement clearly defines the local nurse managers as responsible for service provision. Mangen and Griffith (1982) maintain that service development must be debated at national level. The authors assert that the continued expansion of community psychiatric nursing services must be assessed within psychiatric nursing as a whole and be closely related to manpower planning in mental health care. This cannot take place without statistical information.

In reviewing the state of development of community psychiatric nursing services, it is clear that they have developed differently and locally. The following questions emerge: first, do the services being developed meet local needs and are service priorities set at local level? Second, are the assumptions involved in service

development made explicit? These questions had a major effect on the present study and directed the enquiry to an evaluation of local community psychiatric nursing services. This evaluation was from the viewpoint of the family on the one hand and the assumptions of the community psychiatric nurses on the other.



# CHAPTER

# 3

## **The study itself**

### 3:1 APPLICATION OF THE LITERATURE REVIEW

The aims and objectives of the present study have already been detailed in Chapter 1:1, p1-2. Before going on to detail the work, a summary will be made of the literature review, in order to refocus the attention of the reader to the concern of this study.

The literature review has shown that there are very few 'outcome' studies of community psychiatric nursing and those that have been done have been on specific diagnostic groups of patients. The review also revealed that the 'process' of community psychiatric nursing has escaped intensive study by previous researchers.

The way community psychiatric nurses actually work is worthy of close scrutiny particularly because little is known about the nature of the work in practice. Knowledge about community psychiatric nursing is based on a quantitative data base and limited to the *theory* of how community psychiatric nurses work. The work of community psychiatric nursing has not previously been explored nor examined, in order to ascertain whether or not the nurses put the 'theory into practice'. It was considered a valuable exercise, to examine the work more closely and find out how the nurses view the work. This would provide sound foundation for the future development of community psychiatric nursing services; current development, as the review has shown, is haphazard and uneven.

The literature also suggested that the work of community psychiatric nursing is stated in vague and imprecise terms; this mirrors the ambiguity and confusion surrounding definitions of 'community care' at the policy making level. It was therefore worth investigating one community psychiatric nursing service to see whether the nurses worked with a common purpose and to explore whether the goals, assumptions and values of community psychiatric nurses can be discerned with clarity, from the nurses in the practice situation.

Exploration of the term 'community care' showed that its meaning is varied and confusing; review of the concept showed that resources 'in' the community are limited, that there is a dual emphasis in current government policy: to promote care 'for' the community (i.e. to increase the caring potential of the community) and to avoid institutional care (and rather encourage care 'by' the family). The literature further suggested that community psychiatric nurses theoretically have a role to play with the families of patients who are mentally ill and cared for at home. In particular, the review showed that nurses would be able to 'support the carers' by relieving 'burden', reducing expressed emotion and providing 'continuity of care'.

The above comments on the effect of policy on informal carers, combined with the lack of 'outcome' studies in community psychiatric nursing led to the decision to produce an 'outcome' measure of community psychiatric nursing by examining the carers' view of helpfulness of the community psychiatric nursing contact. Further it was hoped to look at the 'fit' between the goals expressed by the nurses and those perceived by the carers.

The following study therefore emerged which aimed to evaluate community psychiatric nursing, firstly at the level of individual practice, to provide qualitative information about the 'process' of community psychiatric nursing generally and more specifically in relation to carers, nursing mentally ill patients at home. Secondly, this study focused on 'outcome', by providing feedback from the carers about their view of community psychiatric nursing work, and about problem relief in relation to community psychiatric nursing intervention.

Review of growth of community psychiatric nursing as a speciality showed that development of community psychiatric nursing services is local in nature. For this reason it seems logical to study community psychiatric nursing at a local level. The work of two different community psychiatric nursing services is described and compared: to establish the way that community psychiatric nurses work. The carers' views of these community psychiatric nursing services and nursing helpfulness were also obtained.



### 3:2 LOCAL CONTEXT OF THE STUDY.

In the following section a description is given of the two hospitals and community psychiatric nursing services where the study took place. A summary of these details can be found in tables 1 and 2: p86 and p90.

#### *The setting of the study: East and West Hospitals*

The hospitals included in the study remain anonymous. This decision was the researcher's and was based on the fact that a central feature of the study was the analysis of practice of individual community psychiatric nurses. Obscuring the name of the hospitals serves to protect the individual community psychiatric nurses who may otherwise have been identifiable. To protect the identity of the few male community psychiatric nurses in the study, the convention of referring to all the individual community psychiatric nurses as 'he' is adopted.

#### **The Parent Hospitals described**

The term 'parent' is used here to describe the hospital which employed the community psychiatric nurses: in practice the nurses' work would not necessarily entail daily contact with the hospital. Each of the parent hospitals, as they existed at the time of the field work for the study (see figure 2, p95), is described separately below, in the text. Table 1 (p86) summarises the details of these descriptions. The reasons for the choice of these hospitals are detailed on p96.

#### *1. East Hospital*

East Hospital was situated in a rural setting in a mining area which covered a population of approximately 100,000. A small Victorian built psychiatric hospital, it had almost 300 beds, which provided the full range of psychiatric services; two thirds of the in-patient beds were for psychogeriatric patients, but there was an acute admission unit and three rehabilitation wards. The hospital

functioned as three units: psychogeriatric, rehabilitation and acute, and each had a Consultant psychiatrist and a Nursing Officer. Within these units, each ward functioned as a clinical team; nurses provided the twenty-four hour care, but there was social worker, clinical psychologist and occupational therapist / or occupational therapy helper input, which allowed the wards to believe they worked as a multi-disciplinary team. In most areas, clinical methods of treatment were eclectic, but the 'medical model' approach to care predominated (where patients were seen in terms of medical diagnosis and the activities of the nurses were related to 'symptoms' - gathering information about symptoms to provide a diagnosis or to reduce the experience or effect of symptoms, for example, by treatments, whether this be medication giving, psychological or social: see also p31-34). Combined with its clinical functions, the hospital was a training area for students and trainees of a variety of disciplines: nursing, psychiatry, general medicine, clinical psychology and social work. The extra mural facilities offered by the parent hospital were varied: one day centre and a supervised group home were situated in the hospital grounds; these provided opportunity for patients to be discharged gradually from the hospital setting. Additionally, there was a range of day care facilities and group homes available for use by patients, either pre- or post- hospitalisation. A degree of unanimity was maintained, within the parent hospital, through unified administrative structures and professional groups, and through periodic movements of staff in training.

## *2. West Hospital*

West Hospital was a small Victorian built psychiatric hospital, which served the psychiatric needs of approximately 300,000 people. The surrounding mining area was mainly rural but there were small pockets of population. Bigger than East Hospital, it had almost 650 beds and more than double the number of wards, one third of which were for psychogeriatric patients. Three nursing officers were responsible for three functional units in the hospital: acute, psychogeriatric and rehabilitation; additionally there was a night duty and 'community' nursing officer.

**Table 1: Summary of the descriptions of the parent hospitals in the two data collection sites:**

**The Parent hospitals:**

**EAST HOSPITAL**

**WEST HOSPITAL**

rural setting;  
 unified administrative  
 structures;  
 training area for nurses,  
 OTs, Social workers and  
 psychologists  
 eclectic use of models

psychogeriatric beds: two thirds of total

one third of total;

Hospital size: smaller;

larger;

medical cover: by trainees and trained  
 psychiatrists, by catchment area;

trained psychiatrists,  
 by sectorisation;

**Community facilities:**

Full range of services offered:

More limited resources:

Variety of day care services

No community day care

A number of group homes;

No group home

**NB: Similarities between the two services, detailed in the centre of this chart. Differences, in columns under respective name of 'parent hospital'**



In some respects the hospital offered a limited psychiatric service: patients were discharged straight into the community as there were no hostels or group homes to provide a graded discharge; there were no day centres situated outwith the hospital. There was a recently built day hospital attached to the parent hospital which provided separate day care for twenty five psychogeriatric and acutely ill patients. Clinically the work was similar to East Hospital and the medical model approach to care predominated.

The hospital was not an accredited training hospital for medical, psychiatry or general practice students; all other disciplines had training placements in West Hospital. Medical cover, by trained psychiatrists, responsible to the Consultant in Charge, was organised on the basis of 'sectorisation,' where each doctor had responsibility for a defined geographical area.

### **The Community Psychiatric Nursing Services**

In the following text, the community psychiatric nursing services of the two parent hospitals are described in detail. The differences and similarities of the two services are summarised in Table 2, p90.

#### *1. East Hospital*

##### *The community psychiatric nurses*

The eight community psychiatric nurses, of various grades (see below), had worked in the community team at the hospital for 2 - 6 years. The service began as a follow-up service in the mid sixties. Costs were met initially from the hospital budget; thus the development was at the expense of hospital staffing. By the time of the study all but three of the community posts had been transferred to a different budget.

Only one of the charge nurses was specifically trained for work as a 'community psychiatric nurse.' Another of the charge nurses was seconded, part-time, on a community psychiatric nursing course, for the duration of the study. The experience of individuals in

psychiatric nursing before appointment to the community team, ranged from 2-15 years. Two nurses were also general nurse trained. The community psychiatric nurses, in addition to formal training, received in-service training and opportunities to attend study days and conferences.

#### *Organisation of the community psychiatric nursing services*

There was a Nursing Officer in charge of the community psychiatric nursing service in East Hospital, who had overall responsibility for coordinating and monitoring the service. This was a joint appointment, in that although he had an active clinical role in the community psychiatric nursing team, he also had a service commitment to the parent hospital: this involved providing hospital senior nurse cover, on a rota basis, for early mornings, evenings and weekends.

The remaining nursing component of the community psychiatric nursing service operated from two different bases and exhibited a certain amount of specialisation of function. There was the hospital based team which comprised two charge nurses and an enrolled nurse. Each had designated responsibility for specific patient groups: one charge nurse worked with the psychogeriatrics and the other with the acutely ill; the enrolled nurse worked predominantly with 'chronic' patients, and was responsible for the supervision of the four group homes and the running of an injection clinic. The nature of the work of these nurses was the provision of a home visiting service.

There were also 'day centre' based community psychiatric nurses, who worked from three satellite day centres; these consisted of two charge nurses, one staff nurse and one enrolled nurse. Each of these day centres was described as having responsibility for provision of care to distinct 'types' of patients and each was organised differently.

Two part-time day centres, for ambulant confused elderly, were run by the staff nurse (with the support of an occupational therapy helper). These were in local community centres, whose layout and toilet facilities were considered inadequate for the purpose. The

day centres provided diversional activities for the elderly; this, combined with home visiting, was considered to provide a respite service for carers.

A day unit for 'chronic patients,' run by one of the charge nurses (with support from an occupational helper), provided therapeutic programmes aimed at rehabilitation and provision of "working, domestic recreational and social pursuits" and a home visiting service. A third day centre, organised by an enrolled nurse and a charge nurse (with social work support), was developed as an alternative to the traditional treatment offered by the hospital setting, for 'personality disordered' patients. The expressed aim of the day centre was "to prevent hospitalisation...bring psychiatry into the context of the family and community, in the hope of diminishing the stigma attached to mental illness," by means of group therapy on a day care basis and home visiting by the community psychiatric nurses. A weekly injection clinic was also held at this centre.

Each community psychiatric nurse provided a 9am - 5pm service. An 'on call' service (which the nurses described as a crisis intervention service: see p37 for an explanation of this term), operated on a 24 hour basis, seven days a week. Emergency requests (from GPs or the parent psychiatric hospital) for psychiatric assessment at the weekend were dealt with by joint visits of the 'on call' nurse and the duty psychiatrist. The majority of referrals to the community psychiatric nurses were *via* consultant psychiatrists from the parent hospital. Direct GP referral of ex-patients was occasionally accepted; two of the charge nurses attended the consultant's out-patient clinics, from where referrals were received. The above quotations are from a printed pamphlet describing one of the day centres. The therapeutic atmosphere created there, was "deliberately informal"; that of the hospital base and remaining day centres was similarly relaxed: business and patient interactions were conducted in a joking and flippant manner.



Table 2: Summary of the descriptions of the community psychiatric nursing services in the two data collection sites: similarities between services, in centre of chart, differences in columns under respective 'parent hospital'.

The Community psychiatric nursing services:

EAST HOSPITAL	WEST HOSPITAL
<p>developed from after-care services;  services began in 60's;  organised centrally,  by CPN/ N/O, also had hospital responsibilities;  Nurses worked 9-5pm  one trained CPN  one undergoing training</p>	
<p>Catchment-wide service  Weekend cover provided  Consultant referral system</p>	<p>Sectorised service  No weekend service  Open referral system  active GP liaison</p>
<b>The CPNs:</b>	
Total number: 8	10
<p>Grades: assorted  (C/Ns; S/Ns; E/Ns)</p>	all C/Ns
Less experienced psychiatric nurses	More experienced
a hospital-based team	
plus three day centre-bases;	<p>plus three general hospital centre-bases;</p>
<p>no planned, regular contact  with hospital wards</p>	
<p>a more static day care service  specialist function/workload  CPNs had shared clients</p>	<p>domiciliary/community work  generic function/workload  CPNs had personal clients</p>

## *2. West Hospital*

### *The community psychiatric nurses*

There were ten community psychiatric nurses in the second study area. All of these were employed at charge nurse grade and had worked in the community team at the hospital for 2 - 12 years. This service had started as an after-care service, almost fifteen years previously. All the 'community posts' were separately funded.

One of the charge nurses was specifically trained for work as a 'community psychiatric nurse,' and for the duration of the study period one of the charge nurses was seconded, on a full-time community psychiatric nursing course. The experience of individuals in psychiatric nursing, before appointment to the community team, ranged from 12-30 years, therefore this group were an older and more experienced group than in East hospital. In addition to the psychiatric training, two of the nurses were dual trained, one as a general nurse, the second having completed a post-basic training in family therapy. As in East Hospital, the community psychiatric nurses in addition to formal training, received in-service training and opportunities to update knowledge by attendance at study days and conferences.

### *Organisation of the community psychiatric nursing services*

The community psychiatric nursing service was managed and organised by a Nursing Officer who occasionally 'covered' the parent hospital; the Nursing Officer was responsible for the organisation and management of all the community psychiatric nurses, whose offices were in hospitals, separate from the parent psychiatric hospital. At the time of the study the Nursing Officer's post was vacant due to promotion of the previous postholder.

From the outset it was apparent that this service offered a different perspective from that in East Hospital, where the service was more static and day care based (see section 4:2). In West Hospital, all the community psychiatric nurses actively liaised with the GPs and an open referral system operated. The service

emphasised the 'generic' role of the community psychiatric nurses, although individual nurses' skills and preferences necessitated some specialism. At the request of GPs, the community psychiatric nurses provided 'home assessments' and arranged for holiday admissions to the parent hospital, of patients suffering from dementia; the community psychiatric nurses did not retain these patients on their caseloads nor provide regular visits.

The community psychiatric nurses in West hospital worked from four different bases: the parent psychiatric hospital and three satellite general hospitals. The catchment area of West Hospital was divided into north and south. Each was covered by community psychiatric nurses operating from two bases; each catering for a specific geographical area.

One of the bases in the southern region was the parent hospital and three of the community psychiatric nurses worked from there. One of these was on the community psychiatric nursing course: details of his work were not included in this study; the remaining two were partly attached to local GP practices, from whom direct referrals were received. Much of the work was with anxiety and stress related disorders, and both shared the running and organisation of a depot clinic. Another community psychiatric nurse worked in the southern region; this nurse worked mostly with consultant referrals doing a range of activities including anxiety management, group work and medication provision.

The remaining community psychiatric nurses served the northern catchment area of the hospital and worked from two different bases. The first base was an office in the administrative suite of a small modern district general hospital; here, two community psychiatric nurses worked. Both of the charge nurses worked with chronic schizophrenic patients and ran a social support group; one organised the depot clinics and organised social skills groups; the other concentrated on group work for people with anxiety management problems and ran a self help group (with a trained addiction counsellor from the local social services) for drug dependent people. In addition to the work mentioned they provided a home visiting and assessment service. The charge nurses received



referrals from the consultant psychiatrists at the parent hospital and from the psychiatrists based at the district general hospital which had two psychiatric wards.

The second base was also in a small general hospital; here four community psychiatric nurses shared the same base as the district nurses. There was no psychiatric ward in this hospital. In response to the lack of day centres in the region one of these community psychiatric nurses had been appointed to provide a 'mobile day care service' similar to that described by Shires (1977). There were plans to expand this service to one of a team approach, but at the time of the study the community psychiatric nurse alone provided day care on a sessional basis, in various venues scattered throughout the region. The care offered was related to the community psychiatric nurse's skills, and specifically aimed at preventing hospital admissions of people who 'often had disordered lives and were in need of support over crises.' This community psychiatric nurse organised 'stress control skills' groups; 'a prescribed drug abusers group' aimed at helping stop the abuse of anxiolytic medicines; analytical groups using transactional analysis; and 'social treatment groups' aimed at helping 'young adults cope with relationship difficulties and develop appropriate adaptive behaviour'. This nurse was involved in marital therapy with couples, and saw clients on an individual basis. Referrals were from local GPs and one psychiatrist from the parent hospital.

Of the remaining three nurses at the second base, two received referrals of ex-patients from the parent hospital consultant and organised the injection clinic, support groups, a home visiting and assessment service; the third received mostly GP referrals and was actively involved in 'helping people grow and develop out of the sick role,' using individual casework approaches, joint work with families and couples, and group therapy techniques.

The individual community psychiatric nurses provided a 9am-5pm service and there was no 'on call' or crisis intervention service, in contrast to East Hospital.

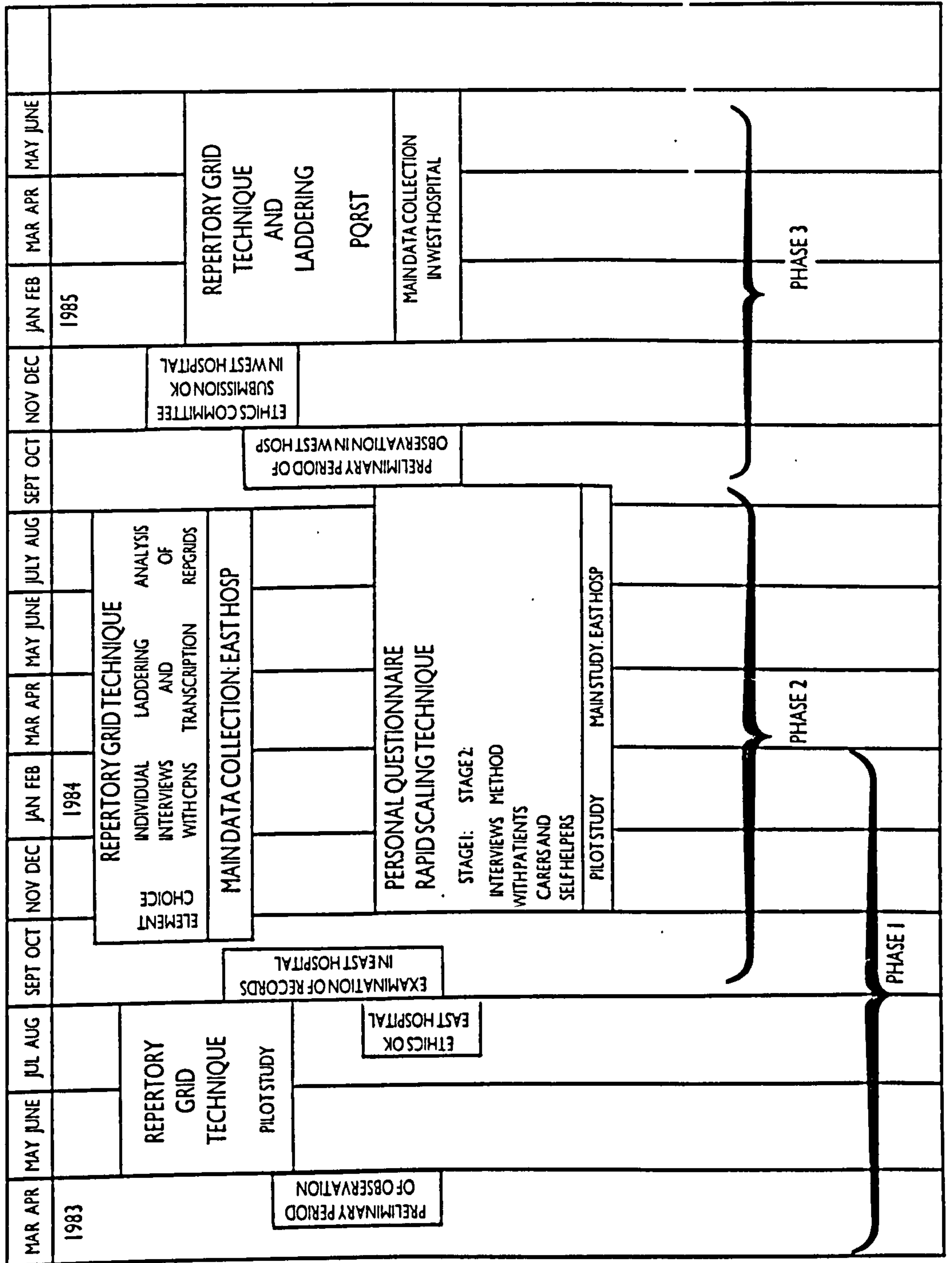
### 3:3 THE RESEARCH PLAN

The research plan for the study comprised three successive phases. During the first phase, pilot work took place in relation to the two chosen methods used in the study (see Chapter 3:5). The first phase was followed by two main data collection phases, one in East Hospital, the other in West Hospital (see Chapter 3:2 and 3:4). To assist the reader in following the various phases, they are set out in the form of a diagram (Figure 2, p95), which also details when each phase took place and its duration.

Each main data collection phase was preceded by a preliminary period of observation, spent attached to the community psychiatric nurses being studied, when I was able to familiarise myself with the work and geographical area covered by the community psychiatric nurses; to form relaxed relationships with the community psychiatric nurses, nursing management in the hospital and other professionals in contact with the community psychiatric nurses and to organise the practicalities of implementation of the main data collection phases.

Altschul (1972) commented on the importance of a pre-pilot stage in research studies in order to get to know the research setting, formulate plans and make decisions about implementing the research, a point also made by Lofland and Lofland (1984). Rossi and Williams (1972) commented: "instance after instance can be cited of strained relationships between evaluators and the evaluated (Rossi and Williams (1972), p42). The pre-pilot stages of this study helped me get to know the research settings and avoided the development of 'strained relationships.' My experience of 'doing research' was more akin to that described by Spradley (1980) who talked of "the insider/outsider experience". This describes the simultaneous experience of feeling part of the setting being researched, and yet at other times, feeling like an outsider. Lack of strained relationships, may have been related to the pre-pilot activities or to my background as a community psychiatric nurse. A drawback of 'being known' and being well received, was that I may have missed important data; further, I may have been reluctant to question them as stringently as a stranger might. The choice of method may have compensated somewhat for this (Chapter 3:5).

Figure two: Diagram showing phases of data collection during present study





### 3:4 THE MAIN STUDY

The following section provides details of the two main data collection phases of the present study, which took place consecutively in East and West Hospitals. Information about the choice of the community psychiatric nursing services and the selection of the subjects (nurses, patients, carers) for inclusion in the Main Study is presented below.

#### *The choice of Parent Hospitals*

##### **East Hospital**

East Hospital was chosen as a research site because the Nursing Officer of the community psychiatric nursing team approached me informally and requested that this service be considered for any research I was undertaking. In the absence of any criteria on which to judge a 'typical' community psychiatric nursing service (p29), there seemed no reason to refuse the Nursing Officer's request. The criterion of 'newness' is used to determine research sites. Struening and Guttentag (1975) have noted, "the old established program is rarely a candidate for research. It is the new and innovative program that is put on trial while the hardy perennials go on, thro' sheer weight of tradition, whether or not they are accomplishing their goals." Bearing these comments in mind, it was decided to examine a community psychiatric nursing service of the 'hardy perennial' type; the long-standing and stable nature of the service based at East Hospital (see p86) fulfilled this specification and the service was therefore chosen.

##### **West Hospital**

The study was extended to a second site, environmentally similar to the first, the intention being to see how far the findings in East Hospital were borne out and which were weakened. Despite the initial similarities of the hospitals and the community psychiatric nursing services, closer examination revealed that there were also marked differences (see Chapter 3:2, p86 and p90).

### *Gaining Access*

#### **East Hospital : access to the community psychiatric nurses**

The existing Health Board policy regarding 'access' for nursing research in East Hospital required a 'top down' approach, *via* the nursing hierarchy. Permission was accordingly granted to approach staff in East Hospital, and as already stated, the Nursing Officer was pleased to be involved. The participation of the community psychiatric nurses was voluntary, but it is doubtful that the individual nurses felt entirely free to opt out of a project sanctioned by senior staff. The friendly, open and welcoming manner of the community psychiatric nurses, and the fact that they co-operated in the study which made considerable demands on their time, patience and energy, suggested that any doubts that existed about the research or myself had been shelved.

#### **East Hospital: access to patients and carers**

During the preliminary period of observation, the study was discussed with senior medical and nursing staff. As the research was non-intrusive, it was at first considered unnecessary to take the proposed research to the ethics committee. Before final permission was granted to do the research, the study was discussed at the Hospital Multi-disciplinary Management Group; they considered that the involvement of patients warranted scrutiny of the study by the local Ethics Committee. Written application for approval by the Ethics Committee was sought and given, but not without delay (see figure 2, p95).

Contact names and addresses of patients and respective carers were needed for both the pilot and the main study. The community psychiatric nursing and medical staff approved the final list of names, to ensure that there were no clinical reasons which may have militated against me approaching any individual; no name was removed from the initial list.

Patients were specifically asked if they were willing to talk to me about the community psychiatric nursing service and also to complete a questionnaire (see methods Chapter 3:5). No formal consent form was signed. No advance warning was given of the

research or my visit (see p143). With the exception of carers of demented patients, permission of individual patients was sought prior to a carer being approached.

**West Hospital: access to the community psychiatric nurses**

As in East Hospital a 'top down approach' was made, via the nursing hierarchy, to gain permission to do the research with the community psychiatric nurses in West Hospital. Accordingly, the reservations about the 'voluntary' participation of the nurses, mentioned above, are relevant here. This did not seem to produce an adverse reaction, quite the contrary in fact: the community psychiatric nurses were interested in, extremely obliging and welcoming of the research activities.

**West Hospital: access to patients and carers**

An approach to the Ethics Committee was mandatory in the second area of data collection and involved appearing in person to 'justify the study'. Two main outcomes resulted from this, both of which were related to safeguarding access to the patients' records; first, medical staff (the consultant in charge), had to give written agreement to individual patients entering the study (Appendix 1: p303: this form was designed by myself); second, patients had to sign a consent form (Appendix 2, p304: use of a form designed specifically for this study was not allowed; the form provided was for the patients' use, and more appropriate for medical trials). A lengthy debate about the deliberations of the Ethics Committee is inappropriate here, but it should be noted that the preoccupation of the Committee was with concern for the patient. Although, by implication, information about the carer was also protected, carer consent was neither discussed or specifically requested. The signing of a consent form was considered unnecessary by the researcher and may have biased the responses. The respondents accepted the consent procedure as a matter of course.

Approach to the patients and carers was as for East Hospital; before doing the questionnaire (see p129), all respondents were asked to complete the consent form which was explained as a requirement of the committee which had allowed me to do this study.



### *Selection of the community psychiatric nurses*

#### **East Hospital**

During the preliminary period of observation in East Hospital, I had to decide which nurses should be involved in the study. I was confronted with the issue of who should be defined as 'a community psychiatric nurse'. Perhaps surprisingly, members of the same 'community psychiatric nursing team' had differing views on whether they considered themselves to be community psychiatric nurses. Some said they were not 'community psychiatric nurses' but saw themselves rather, as 'hospital psychiatric nurses working in the community.' This may have been an artefact of the research - the nurses' anxiety at being the subjects of research and fear that they were being judged against criteria of community psychiatric nursing practice for which they were not specifically trained. The uncertainty about the use of the term 'community psychiatric nurse', referred to in the literature (see p29) is also relevant to the practitioners.

The reaction against being called a 'community psychiatric nurse' was exclusively limited to those nurses who worked from a day centre base. I considered excluding the day centre nurses but decided not to do this, as the nursing officer saw these nurses to be 'community psychiatric nurses' and different from the hospital based psychiatric nurses. So all eight nurses in the 'East' team took part in the research.

#### **West Hospital**

The difficulties of definition, apparent for the nurses based in East Hospital, were not evident in West Hospital. All the nurses in the 'community psychiatric nursing team' considered themselves 'community psychiatric nurses;' none of the community psychiatric nurses of West hospital were involved in 'day centre' work. Four of West Hospital's community psychiatric nurses were chosen, one community psychiatric nurse per geographical base (see p91). Of the total of ten community psychiatric nurses: three were excluded from the study: one away on a course; a second about to go on maternity leave and a third was about to retire; of the seven remaining, two were chosen by process of elimination, two randomly.

### *Selection of the patients*

#### **East Hospital**

##### *1. Record keeping and the community psychiatric nurses*

The community psychiatric nurses kept two kinds of records relating to patient contact: they filled in 'statistical returns' (which were hospital forms requiring quantitative details for administrative purposes); these recorded 'actual' attendances of patients at the day centres. The traditional format of the nursing 'kardex' (a loose-leaf holder containing a running record of details of the nursing contact which took place with patients) was also used: this in comparison included any contact which the community psychiatric nurses had had, to do with the patients: this included direct contact at a day centre, or home visit, or out-patient appointment; it also included more indirect contacts e.g. telephone calls by or about the patient, and contact with family, GP or carers; entries were also made if a patient had missed an appointment. Comparison of the statistical returns with kardex entries did not necessarily tally; there were more recorded attendances in the statistical returns. This suggests therefore that not all attendances at the day centre were recorded in the nursing kardexes. From cursory examination of the kardexes (by scanning the content of the entries), entries tended to be made if the community psychiatric nurses were actively engaged in problem resolution; patients who had been on the books for a long time had fewer entries than 'newer' patients.

Contrary to my expectation each community psychiatric nurse did not have his own 'caseload'. There was a 'communal' caseload: different nurses therefore visited the same patient (on different occasions) although it was noted that a few patients were visited by one community psychiatric nurse if consistency of input was required. This finding had implications for the choice of patients to be included in the main study. Based on the assumption that all the patients knew each community psychiatric nurse, random selection of patients would produce feedback about all the community



psychiatric nurses. However, conversation with individual community psychiatric nurses suggested that each did, in practice, seem to have their own patients, and different community psychiatric nurses specialised in certain types of work (see p88-89). The nursing kardexes were therefore examined to find out if the caseload was truly 'common'.

## *2. Examination of the nursing records*

To establish a sampling frame, the signed entries in the nursing kardexes were examined by the researcher; this took one month. This examination showed that more than half the patients were in contact with one community psychiatric nurse, suggesting that the nurses did not have a common pool of patients. Patients however, who attended the day centres had contact with three or more nurses. It was decided, therefore, that the sample of patients would be related to contact with individual community psychiatric nurses. The entries for each patient visited or in contact with more than one community psychiatric nurse were examined more closely, and the nurse who had written *most* kardex entries (over a six month period) was identified and considered to be the 'key worker'. (The Nursing Officer had few patients for whom he could be described as the key worker: he had hospital and weekend administrative work leaving limited time for direct patient care; the nurse seconded on the community psychiatric nursing course, working on a reduced caseload, also had fewer patients with whom to be identified as the key worker).

## *3. Visiting frequency of the community psychiatric nurses*

Another factor noted during examination of the nursing kardexes was the wide variety of 'frequencies' of contact with patients. This of course was not a totally unexpected finding, for two reasons: firstly, on a clinical level, varying patients' needs dictate varied community psychiatric nursing input; secondly, Sladden (1979) commented that the community psychiatric nurses in her study were reluctant to discharge patients from the books; the



fact that some patients on the records were not seen at all for six months suggested that this may also have been the case in East Hospital.

#### *4. The patient sample*

To examine this aspect of the 'process' of community psychiatric nursing the subjects for inclusion in the main study were chosen on the basis of frequency of visits. This decision was influenced by the work of Bloch (1975), who suggested that examination of the 'process' of nursing activity should be linked with examination of 'outcomes'. It was hoped that frequency of visits of the community psychiatric nurses ('process') in the present study could be linked with the outcomes of the service (evaluation by the carers).

Another major factor which affected the choice of sample was that previous evaluative research into the work of the community psychiatric nurse has tended to focus on specialist patient populations, defined by diagnosis (see p52). This research intended to focus on the whole range of patients visited by community psychiatric nurses. From personal experience in clinical work frequency of visiting is related to the condition of the patient (the more acutely disturbed patients tend to be visited more frequently) and what the nurse is doing during the visit (intensive family work may demand more frequent visits than routine assessments). Based on this rationale, it was assumed that a sample which covered patients with a range of frequency of visits would provide a sample of patients with varied conditions, illnesses, and needs and also reflect a range of inputs and therapies on the part of the community psychiatric nurses.

Seven patients were chosen for each community psychiatric nurse. The patients were listed in order of frequency of visits: the most and least frequently visited patients were selected, plus five others, evenly spaced throughout the remaining list. This sample reflects each nurse's input, and could broadly be described as that of a stratified sample, based on frequency of visiting of

the community psychiatric nurses (as recorded in the nursing kardexes).

## **West Hospital**

### *1. Examination of the nursing records*

As in East Hospital, the community psychiatric nurses completed statistical returns and patient contacts were recorded in a 'nursing Kardex.' Examination of the records to work out a 'key worker' was unnecessary in West Hospital, because each community psychiatric nurses had a personal caseload. To facilitate comparison of findings, selection of patients here was as that described above, based on examination of the individual nursing kardexes and frequency of visiting.

### *Selection of carers: East and West Hospitals*

For each patient chosen for the main study, the name and address of the Next of Kin, as recorded in the nursing kardex, was noted. Using the guidelines suggested by Platt et al (1980) the patient (unless he was demented) was asked to identify the carer with whom he was most in contact; this coincided with the next of kin given in the nursing kardex, the exception being couples who were separated.

### 3:5 THE METHODS

This final section of Chapter 3 focuses on the two methods used in the present study. An overview of each method is provided and the rationale given for these choices; the advantages of each are summarised and the techniques of data analysis are presented. Each of the methods were the subject of pilot studies which are also detailed.

#### *Methodology*

Various methods were explored prior to the decision to use those described below. In attempting to think back to the other methods considered and the reasons for their rejection, the comments of Kratz (1974) became particularly relevant. This author stated:

Literature of particular relevance to one's chosen field is scarce; because of this, one casts one's net wide, in an effort to find something, anything which might be useful in throwing light on the vast emptiness by which one is surrounded. In the end, one's reading becomes so wide as to become almost unconnected with one's point of departure. Some of it is forgotten, the relevance of much, which at the time seemed central to the theme under investigation becomes dimmed. Other material grows from relative insignificance to become the focal point of one's thinking. Yet somehow all items, whether only dimly remembered, superceded by events, or growing in importance, have contributed to one's thinking and to the finished work. (Kratz (1974), p9).

These comments reveal that doing research is a 'process' and that it is almost an impossible task to recollect the details of the process which shaped any piece of research. This study is no exception, and the shortfalls in the recall and reporting of this process must be acknowledged. What is remembered were various methodological landmarks which signposted the direction and which were responsible for the study taking its present form. These are summarised below. The retrospective nature of this summary gives the path a more organised appearance than that which was actually experienced and does not give credit to the influence of the researchers' informal



contact with peers and fellow students which also affected the emergent study. Other factors like the time, skill and labour available also had a bearing on the study methodology.

At the outset it was envisaged that the way the nurses worked and the effect this had on carers, could be examined simultaneously. Observational methods which had been predominantly used in the past to study the work of psychiatric nurses (Oppenheim and Eeman 1955, John 1961, Altschul 1972a, Towell 1975 and Cormack 1976) were reviewed and considered for use in the present study. The review showed that an observational approach to psychiatric nursing had failed to identify crucial components of the work, which were not amenable to direct observation; some researchers, notably McIlwane (1980) supplemented direct observation, by using a radio microphone to record patient / nurse interactions. Nevertheless, observational techniques examine behaviour as it occurs and are therefore less effective in explaining behaviour. This study was conceived with the aim of finding out the goals, assumptions and values of the community psychiatric nurses and to evaluate nurses' performance in the light of these goals; the observational method did not seem to offer opportunity to explore these aspects of the nurses work. Examination of what the nurses did and said to carers in the domiciliary setting would also provide little information on the 'outcome' of any interaction. Previous attempts at attempting to use 'observation' of patients and clients in the home situation (documented by Sladden 1979) were unsuccessful, because clients tried to engage the 'observer' in the interaction.

The survey method, sometimes called "the poor man's experiment" (Oppenheim 1983), was then considered but rejected on the grounds that this aimed at gathering census-like data and was essentially a fact finding exercise. It seemed, initially at least, that previous studies had provided enumerative data; both on the work of community psychiatric nursing (CPNA 1985b) and on the experiences of carers of the mentally ill (see p62) and that using this approach in the present study would add little to current knowledge.

Consideration then moved towards examination of less descriptive and more analytical methods using more tightly controlled designs. These initially seemed attractive as regards

evaluating community psychiatric nursing services (see Paykel and Griffith 1983 and Brooker 1984b), because they offered the opportunity to look at the relations between variables and allowed for inferences and predictions to be made. Somehow, this move from looking at survey design to experimental methods guided me into focusing on the literature which compared taking a qualitative with a quantitative approach.

This in turn resulted in the search for appropriate methods being taken in the direction of Grounded Theory (Glaser and Strauss 1967) which has been focused on recently as a useful research method for nurses (Simms 1980, Melia 1981, Powell 1982, Field and Morse 1985 and Chenitz and Swanson 1986). The reservation of the Grounded Theory approach was that previous researchers had found that psychiatric nurses find it difficult to talk about their work (see Altschul 1972a); further, I was somewhat daunted at the thought of using a method which would generate two large amounts of data which required transcription and analysis (data of the nurses and carers).

Brown (1973) and Norris (1981) discussed the interpretation of qualitative data; the latter author referred to Repertory Grid Technique and hence introduced me to the method which had a formative influence on the aims of the study. Repertory Grid Technique was a method which combined a qualitative and quantitative approach and seemed particularly attractive for this reason. The method also seemed to provide the structure which would direct the focus of the study and produce specific data on the goals of community psychiatric nursing work. At this stage, it was decided to take a separate approach to the 'outcome' of community psychiatric nursing.

The Personal Questionnaire Rapid Scaling Technique (PQRST) was chosen to explore 'outcome'; this method was recommended by researchers using Repgrid methods (Slater 1978) as a structured means of obtaining individualised information. This seemed to be suitable in this study, interested in the carers' view and the data obtained from the PQRST could be linked back to the nurses' data.

The two methods of data collection used in the study are described below. These are:



(1) Structured interviews were carried out with the community psychiatric nurses in an attempt to investigate the 'process' of community psychiatric nursing and explore the goals of the work as expressed by the nurses. These interviews were conducted in accordance with the format of the repertory grid technique (Repgrid) outlined by Fransella and Bannister (1977) and the 'laddering' procedure detailed by Hinkle (1965).

(2) The Personal Questionnaire Rapid Scaling Technique (Mulhall 1971) was used to examine 'outcome' in terms of the families' view of the helpfulness of community psychiatric nursing contact and the family's view of the 'process' of community psychiatric nursing.

### *The Repertory Grid Method*

A step by step guide to the method of Repertory Grid Technique, which was published by the researcher in the Journal of Advanced Nursing (Pollock 1986), is provided in Appendix 3, after p304.

Repertory grid technique was developed as a methodological component of a theory of personality (Personal Construct Theory) proposed by a psychologist, George Kelly (Kelly 1955 and 1963). Kelly believed that humans develop predictive hypotheses which are tested, modified or discarded in order to survive; he considered this an active process which influences and conditions how individuals see the world, and he believed that individuals build up a network of hypotheses (based on unique experiences) which is called a 'construct system'. Repertory grid technique offers the opportunity for an individual's 'construct system' to be elicited.

'Constructs' are treated as if they are bipolar dimensions of judgment, a description which always has an opposite: Light is nonsense without a sense of its opposite, which could be heavy or dark; this opposite may not always be the dictionary opposite but the semantic opposite which conveys individual meaning and understanding.



Repgrid has been used for management, educational and clinical purposes (See appendix 3, after p304: Pollock 1986). The merits of the technique for use in research are summarised below:

#### Advantages of the use of the technique

(1) The individual focus of the technique provides an effective means of exploring an individual's perception.

(2) The discipline involved in the application of the technique ensures that each interview is structured and the conversation is controlled; the technique is constructive as it facilitates listening and the collection of pertinent material (compare this with the unstructured interview situation; when there are times when both interviewer and interviewee are talking over each other; sentences may be finished off by the researcher and (mis)interpreted or suggestions made; the interviewer may not be so much 'listening' to what the other person is saying, as preparing the next remark. The conversation can transgress from the topic at hand, to irrelevant issues). Using Repgrid the interviewer is forced to keep quiet, and the rigour of the comparing and contrasting technique ensures that the interviewee gives uninterrupted elaborations.

(3) Observer bias is reduced almost to zero and objectivity is maximised because the input from the interviewer is minimal (Stewart and Stewart 1981).

(4) The conversational format of the technique recommends its use (Smith and Kendall 1963). According to Watson (1970) the format is not anxiety provoking and the respondent is reassured that there is no right or wrong answer.

(5) The method makes it difficult for the interviewee to interpret its aims and to introduce and maintain a systematic bias in the responses (Rowe 1971).

(6) The method systematically obtains qualitative data: the vocabulary of individual members of a group can then be examined or the descriptions analysed using a hermeneutic approach. This method has been used in pilot studies to help develop questionnaires which are meaningful to the respondents (Stewart and Stewart 1981).

(7) The results can also provide quantitative data which can complement the qualitative findings. These data can be analysed by principal component analysis (see below), the results of which can be presented visually and diagrammatically, as well as mathematically (Slater 1976).

Many of the advantages listed above e.g. the lack of experimenter bias, the constructive use of time and the fact that the results are analysable would be pertinent to any research study. Altschul (1972, 1973) found that it was difficult to get the psychiatric nurses in her study to talk about their thoughts, feelings and perceptions behind their work. In light of these findings, the individual focus of the repertory grid technique, and the conversational format of the method particularly recommended its use in the present study. It promised to be an ideal method which could help the individual community psychiatric nurses verbalise their perceptions of work. Using 'typical psychiatric patients' as 'elements,' the method was used to investigate the constructs which individual community psychiatric nurses produced.

### **The Repertory Grid Technique**

The technique has been described as a type of structured interview, the format of which enables the collection of individuals' descriptions ('constructs'); this elicitation of constructs is triggered by a sorting procedure (triadic elicitation), where the topics of interest ('elements') are written on cards. The technique involves three distinct stages: element choice, construct elicitation and grid construction. Each of these stages is explained below and each was piloted (see p113 for details of and reasons for the pilot study of Repertory Grid Technique).

### *The Laddering Procedure*

This is a procedure, described by Hinkle (1965), for eliciting increasingly superordinate constructs, that is, constructs of a higher order of abstraction than those initially elicited. It is a conversational technique developed from Repertory grid, and is aimed at systematically obtaining information from an individual to explore the meaning of one given construct. McCall and Simmons (1969) have stated:

In exploring for possible factors affecting some given variable, or for chains of causes and effects constituting a 'process' there appear to be two basic techniques...the second is to ask people themselves to explain what happened and to give their reasons for acting as they did. The basic question is always why?  
McCall and Simmons (1969)

In the laddering procedure the interviewer repeatedly asks the question 'why'. Wright (1970), demonstrated the clinical use of the technique by using it to explore the meaning of psychological symptoms, necessary he argued for behaviour change. The laddering procedure has had limited use in research application: Allsop (1980) and Hazelden (1981) used the procedure with teachers to explore the reasons for reading difficulties and truancy respectively.

According to Landfield (1971) the 'laddering' procedure provides a tool for documenting the conversation. This was used by Allsop (1980) and Slater (1976). Hinkle's procedure has been called laddering 'UP' from a construct. The laddering procedure is explained clearly and at length by Judkins (1976); Fransella and Bannister (1977 p16-19); Stewart and Stewart (1981, p20-28); and Wright (1970). Constructs can also be explored by 'laddering down', where the respondent is asked 'how' one side of the construct differs from the other (also see Appendix 3 for a summary of this procedure and see figure three, p111, for an example of the procedure 'laddering up' - as used in the present study). All the laddered conversations were taped, to allow for qualitative analysis of the interview data (see p124).



Figure 3: Showing excerpt from 'laddering procedure'

LP: What we are going to do today is talk through some of the things you told me about last time and really it will be getting you to state the very obvious about your work. I want you to tell me in your own words about your work, what you do and why. I've taken the descriptions you gave last time and we'll go through them.

LP: Family support - not

Tell me how someone with family support differs from somebody who doesn't have, just to give me an idea of what you are talking about.

F: If someone has family support you are getting a more objective picture of what is going on and you are getting somebody other than the patient's views. If someone has family support you'll find out quickly if there is anything going wrong, if there is adverse change in the situation. You may find the family tend to over react and you are called to crises that are not really, in the crisis situation you are more likely to be able to keep them out if they have family support.

LP: OK, lets take these separately. Why do you like to get a more objective picture?

F: To get a broader picture. Most of the information you get is subjective. You get a broader view if you speak to the family - of what is going on and what you are dealing with.

LP: Why do you want to do that?

F: Because we are not treating an illness, we are treating an individual and the only way to get to know them as a complete person is to get to know them.

Figure 3 continued: Showing excerpt from 'laddering procedure'.

LP: You want to get to know them as a complete person - why?

F: To provide a better standard of care, of comprehensive care.

LP: Why do you want to do that?

F: To give a good service. An illness and symptoms cannot be just treated, they have got to be looked at as an individual in his or her entirety.

LP: Why would you want to hear if there was something going on?

F: Sometimes you do and sometimes you don't. We can maybe take action to prevent further crisis and prevent an admission or any further trauma to the patient

LP: Why do that?

F: That is difficult; The nurses job is not just treating people, we owe it to our patients to give as good a service as we can, part of this is preventative medicine, primary care.

LP: Why is it useful for you to know if someone doesn't have support?

F: The CPN's information gathering processes would be more difficult. We would have to look for other sources of information, like neighbours which would have ethical implications. Or we may have to visit relatives who live a distance away.

LP: Why do that?

F: To get more information...

Using the Repertory Grid Technique it was hoped that from the data provided:

(a) Examination of the constructs would help answer the following questions:

(i) What patient information do individual community psychiatric nurses perceive as relevant to their work?

(ii) Do individual community psychiatric nurses select different pieces of information?

(b) Analysis of elements and constructs would provide information on the questions:

(i) Do individual community psychiatric nurses have different perceptions in relation to patients?

(ii) Can individual community psychiatric nurses be identified as using specific models of care?

Using the laddering procedure would help answer the following questions:

(i) Are individual community psychiatric nurses aiming for the same goals as regards treatment? What are these goals?

(ii) How do the nurses view work with carers?

(iii) Do the community psychiatric nurses as a group have a united philosophy of community care?

(iv) How do the community psychiatric nurses make community psychiatric nursing work? Is there a pattern to community psychiatric nursing action?

### *The Pilot study of the Repertory Grid Technique*

#### **Description**

Ten community psychiatric nurses were approached and invited to complete repertory grids. These community psychiatric nurses were either members of the community psychiatric nursing' professional organisation (The Community Psychiatric Nurses Association) or colleagues and friends of the researcher (community psychiatric



nurses, not in contact or involved with the community psychiatric nursing services in the main study); they lived in different areas of Scotland, some had specialised others generic caseloads, and reflected a variety of experiences of community psychiatric nursing and lengths of service.

### The reasons

A pilot study of Repertory Grid was necessary for the following reasons:

(a) To provide myself, as the researcher, with the opportunity to gain confidence and competence in the Repertory Grid Technique and the Laddering Procedure.

(b) To provide the researcher with the opportunity to analyse some of the data obtained and gain an understanding of the computer programme and possible results.

(c) To gain practice in the use of tape recording.

(d) To enable feedback about the frequency of sessions with community psychiatric nurses in the main study to be estimated and the programme schedule to be planned.

(e) To create the opportunity for methodological aspects of the interview situation to be revised prior to the main study.

The first three reasons centred around the needs of the researcher:

#### *1. The practicalities of the Technique*

As recommended by Allsop (1980), I needed to gain confidence in the practicalities of the technique. This involved discussion with other researchers who had experience with the method, followed up with practice using the method with both the experienced researchers and community psychiatric nurses.

#### *2. The Analysis*

One of the grids from the pilot was analysed: this confirmed that quantitative analysis, using the 'Ingrid' package (see below:

p121), was possible with the University mainframe computer; advice and help was also available to help with this.

### *3. Tape Recording*

Pilot work with the tape recorder allowed me to develop a checklist of activities which ensured that the tape recording of interviews in the main study was uneventful (see appendix 4; p305) and showed that this, or my note taking, did not upset any of the community psychiatric nurses.

The remaining two reasons had implications for the main studies:

### *4. Frequency of Sessions*

Information was needed about the demands of Repertory Grid Technique for example, the length of the procedure and toleration of the subjects, in order firstly, to plan and organise the data collection in the main study and secondly, to maintain the goodwill and cooperation of the community psychiatric nurses. The pilot work demonstrated that the time needed for the elicitation, laddering and rating (see p116-21 for explanation of these terms) was lengthy. As a result of this, each community psychiatric nurse, in the main study, was seen at least four times:

(1) to acquire the names to be used with the elements (each nurse was asked to choose someone who was typical of each 'patient type': these names were written in pencil on the back of index cards).

(2) to elicit constructs.

(3) to ladder the constructs.

(4) to complete the rating grid.

### *Co-operation of interviewees*

A most important consideration addressed by the pilot study was the co-operation of the interviewees. Scott (1962) said: Repertory Grid Technique is "a relevant task for describing people..." but

continues: "it is cumbersome to administer and score and it is doubtful that a non-captive population of adults would submit willingly to it..." . Taking account of these comments, it was necessary to use the technique with a group of community psychiatric nurses, to find out if they would be willing and able to do the technique (comply with the sorting procedure, produce constructs and use rating scales to build up the grid itself). Mair (1966) emphasised the importance of giving a clear indication of the context within which grid data are to be collected and pointed out that failure to do so would result in the respondent flicking from one context to another while constructing a grid. The pilot was used to make sure that respondents understood the instructions and were able to carry out the procedures without confusion.

The community psychiatric nurses in the pilot study, understood the instructions and enjoyed the technique. They were initially slow to sort the cards and provide constructs and were anxious to know if they were carrying out the procedure correctly; in the introduction of the main study, subjects were told there were no right or wrong answers and were given positive feedback during the procedure. By the sixth sort, of the pilot, subjects found eliciting easier; Repetition of constructs caused worry to some of the community psychiatric nurses. Shubachs (1975) commented that repeated constructs indicate those most relevant to the subjects, therefore this was encouraged in the main study.

### *The format of the Repertory Grid Technique*

#### **Element choice**

Elements may be persons, objects, activities or concepts and they define the content of the structured interview. Elements should cover as wide a range as possible of topics to be discussed, in order that the elicitation procedure is meaningful and succeeds in procuring a variety of constructs.

Stewart and Stewart (1981), p30 -36) outline "rules for selecting elements". In summary, elements should be: discrete; nouns or verbs; homogeneous (i.e. all people, all objects or all



activities); and non-evaluative. They emphasised that:

.... Elements really should be as precise as you can get them. An imprecise element, struck against another imprecise element or two to produce a construct, will not produce much clarity of contrast and therefore will not produce good clear constructs...a rough scatter over the element area is acceptable.  
(Stewart and Stewart (1981), p29).

Elements also must be meaningful and relevant to the subjects being interviewed; according to Yorke (1978), this is a crucial methodological consideration. Stewart and Stewart (1981) comment about strategies open to the researcher for selecting the elements:

you can supply elements, you can get them by free-response; or you can use eliciting questions. Either of the last two strategies puts you within reach of the interviewer-bias-free interviewing procedure that was one of our original goals. There is nothing stopping you mixing strategies, either, though you should be clear about why you do it; if you do mix strategies then *it is probably best to begin with any eliciting questions you want to use, then go on to free response, and finish with supplied elements, making sure you check that the interviewee knows them.*  
(Stewart and Stewart (1981), p35). (My italics)

In this study the elements were descriptions of patients. The choice of 'patient types' as elements fulfilled the first three 'rules' outlined. The pilot study (see figure 2, p95) ensured that the elements were not evaluative and that they were relevant and meaningful to community psychiatric nurses. The format outlined in italics above was tested in the pilot and used in the main study.

The choice of elements is related to the purpose of the interview; the purpose of this study was to look at the process of community psychiatric nursing. By using 'patient types' as elements, it was hoped that constructs would emerge which gave an insight into the types of patient information that community psychiatric nurses found relevant to their work and that from this, constructs could be explored (see the laddering procedure p110) to give details about the goals community psychiatric nurses used in their work. One of the major aims of the pilot study was to find out if use of the technique, as proposed, did in fact elicit the predicted data. This aim was successfully achieved.

In the pilot study, a meaningful list of elements (patient types), was achieved by asking the community psychiatric nurses to describe the work they did and with whom (cf the 'free response' strategy detailed above by Stewart and Stewart 1981). 6 - 10 elements resulted; the list varied markedly between nurses (for example some community psychiatric nurses used diagnostic groupings to describe their patients, other used 'nursing diagnosis', like chronic, acute, able to help, unable to help, old, young); the list was salient to the individual nurses. In the main study, to aid comparison across the community psychiatric nurses, 'supplied elements' were used for the triadic sorts; these arose from individual interviews and a 'free response' session, but checked for relevance with the whole group of community psychiatric nurses.

#### Construct elicitation

Six methods of eliciting constructs are presented in the literature. These methods are concisely presented in Fransella and Bannister (1977, p14-15). In the present study, the 'triadic' (also known as 'minimal context form') method of presenting elements was chosen to elicit the constructs, because it was the simplest and least time consuming method available. This means that the elements are presented to the subject in threes; the respondent is asked to say how two are similar but different from a third.

Several difficulties with the 'sorting procedure' emerged during the pilot study:

(a) The introduction given was - "what I am interested in, is the sort of information that you like to know about patients, that is useful for your work." The question then asked was: "I'd like you to tell me an important way in which two of these patients are alike and different from a third". The word 'important' seemed to cause difficulties and the community psychiatric nurses asked "important for what?" Interviews without the word 'important' caused less difficulty and did not lead to irrelevant descriptions



being given of the patients, e.g. red hair - blonde hair. This format was used in the main study.

(b) In the pilot the community psychiatric nurses selected cards/elements at random. This caused repetition of some elements, omission of others. In the main study pre-determined triadic sorts were presented to the community psychiatric nurses (see appendix 5, p306). Kasper (1962) recommended systematic presentation of elements for research purposes of Repertory Grid; this also avoided tedious repetitions, and ensured that all elements were sorted.

(c) The similarity description (the emergent pole: see figure 4, p120), arises spontaneously from the sorting procedure; the implicit pole in comparison, requires to be prompted. Epting (1971) evaluated the elicitation procedure to do this and recommended asking directly 'what is the opposite' or using the prompt 'as opposed to' to obtain the implicit pole. These alternatives were tested in the pilot. Asking for an 'opposite' from the community psychiatric nurses in the pilot tended to produce dictionary opposites. The 'as opposed to' prompt caused no difficulty and gave a more accurate insight into the descriptions used by the community psychiatric nurse: this was therefore used in the main study.

### Grid Construction

Constructs and elements can be integrated into a 'grid format' - elements are listed along the top and constructs, along the side of a matrix (see figure 4, p120). The interviewee, is then asked to allocate constructs to elements. Insertion of the information into a 'grid' format, with each element rated in terms of the construct, allows the primary data to be clearly presented, and available for discussion. The ability of the technique to provide quantitative information which could be analysed using statistical packages (see p121) seemed an advantage of the method.



Figure 4: an example of a grid matrix (taken from the present study)

ELEMENTS USED

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### *1. Use of the rating method for Grid Construction*

The subjects are asked to rate the elements according to a specified scale. Roth (1976,) has argued that language categories are not simply bipolar: he believes that there is a relativistic quality in language descriptions, a dimensional quality which suggests a range of statements rather than a choice of two; the precise relation to language of our perception of people is not necessarily one of clear cut dichotomies. This suggests that the use of a rating scale would be more appropriate in handling choices on a continuous scale, rather than the mutually exclusive traditional dichotomous choices (Kelly 1955).

Using a rating scale, the subjects have freedom to allocate the elements as they wish and fine discriminations are possible. In the words of Bannister and Mair (1968), the use of a rating scale has the aim of giving:

the subject as much freedom as possible to express his judgements and to throw the onus of formalising and quantifying onto post test statistical processing.  
(Bannister and Mair (1968), p68)

The community psychiatric nurses were asked to compile a Grid using a 6 point rating scale.

### *The data analysis*

#### **The Quantitative Analysis**

##### *1. Computer Analysis*

Traditionally, the most common method of analysis of the data derived from the Repertory Grid Method is quantitative analysis of the material in the grid matrix (see figure 4, p120). There are numerous techniques open to facilitate analysis of the numerical data of the repertory grid. These consist of sophisticated and complicated analysis by computer packages (see Pope and Keen 1981, and Thomas and Harri-Augstein 1985 for an overview of the methods).

In the present study the quantitative data derived from the grid matrixes was analysed using the 'Ingrid' programme (Slater 1978). There were two reasons for this choice of analysis: firstly, in published studies, 'Ingrid' was the most popular method of analysis (Beail 1985); secondly, this programme was available locally on the mainframe computer, using the Statistical Package for the Social Sciences (Nie et al 1975).

Ingrid analysis provided correlational data on constructs; scores indicating the relationships between elements; and a principal component analysis of the construct and element data. This analysis indicated the dispersal of constructs and thus their relationships to each other in terms of all of the elements that were rated, and also the dispersal of the elements in terms of the constructs used to rate them. Slater (1978) states that the principal component analysis was developed:

merely as a method for simplifying the records of a large number of correlated variables... by reducing them to a possible smaller number of independent measurements, ordered from largest to least according to the amount of variation they recorded.  
(Slater (1978) )

This analysis, although undertaken, did not illuminate the data: each nurse chose his own elements and constructs, so 'Ingrid' produced a number of personal profiles from which no trends emerged which seemed to have more general application. The 'Ingrid' analysis proved to be less helpful than expected and did not provide additional information to that gained from the 'laddering' interviews. Interpretation of the Ingrid analysis goes beyond the bounds of the data and should, according to the seminal work on Repertory Grid technique, be negotiated with the respondent (see Appendix 3); lack of time meant that this was not possible in this study.

The constructs gained from the Repertory Grid technique were also quantitatively examined using a method of categorisation, based on subject matter (see Chapter 4:4, p264) and Content Analysis (Berelson 1952: see below).



## 2. Content analysis

Content analysis is "a research technique for the objective, systematic, and quantitative description of the manifest content of communication" (Berelson 1952, p. 18) Berelson (1952) discusses Content Analysis in depth. He makes a distinction between 'what' is analysed and 'how', and outlines seventeen uses of content analysis. One of these uses is, "focusing on the substance of the content, where the primary concern is with the referents of symbols " (Berelson 1952, p. 27); this is relevant to the present study where Content Analysis was used to look at the differences and similarities between the community psychiatric nurses. Berelson states that:

Content analysis can be no better than its system of categories ... and should employ categories most meaningful for the particular problem at hand ... relevant categories are limited only by the analysts' imagination in stating a problem.

(Berelson (1952), p. 147)

Nine 'types' of categories are suggested by Berelson. The first of these, related to subject matter, is the most general category for use in content analysis studies and was used in the present study (see Chapter 4:4 for details of the process of finding a framework of analysis for the categories).

Berelson defined Content Analysis and said this should be:

**Applied only to the syntactic and semantic dimensions of language.**

The analysis then, is limited, to the 'manifest content' of the communication, rather than in terms of intentions or responses.

### **Objective**

The categories should be defined so precisely that different analysts can apply them to the same body of content and secure the same results.

### **Systematic**

All the relevant information is to be included, to eliminate partial or biased analysis of data; where data which doesn't fit the analysis this is excluded from

analysis. Additionally, the analysis should have a measure of general application.

#### **Quantification**

This is the most distinctive feature of content analysis, which distinguishes the procedure from ordinary reading. Of primary importance is the extent to which the analytic categories appear in the content, that is the relative emphases and omissions.

This definition of Content Analysis helped to guide the present analysis, the findings of which are presented in Chapter 4:4 (a summary of the experience of complying with Berelson's requirements is also detailed, p262).

#### **The Qualitative Analysis**

##### *1. Use of laddering diagrams*

The constructs, and data gained from the laddering procedure were presented in diagrammatic form (after Allsop 1980, and Hazelden 1981: see p261).

##### *2. Use qualitative data cards and the development of a theory*

The taped transcripts of the laddered interviews were also subjected to qualitative analysis. Glaser and Strauss (1967) discussed the value of identifying conceptual categories and properties (elements of a category) which "help the reader to see and hear vividly the people in the area under study"; they advocated use of this approach "in non-traditional areas where there is little or no technical literature". Community psychiatric nursing falls into this latter description and as such it was opportune to subject the accounts given by the community psychiatric nurses, during laddering, to this type of analysis.

A review of the early texts and papers on managing qualitative data [Barton and Lazarsfeld (1969), Becker and Geer (1960), Sieber(1976)], devote little attention to the problems of data analysis; this situation has been rectified in more recent papers



[see Norris 1981, Turner 1981, Field and Morse (1985) and Chenitz and Swanson (1986)] which have been especially helpful.

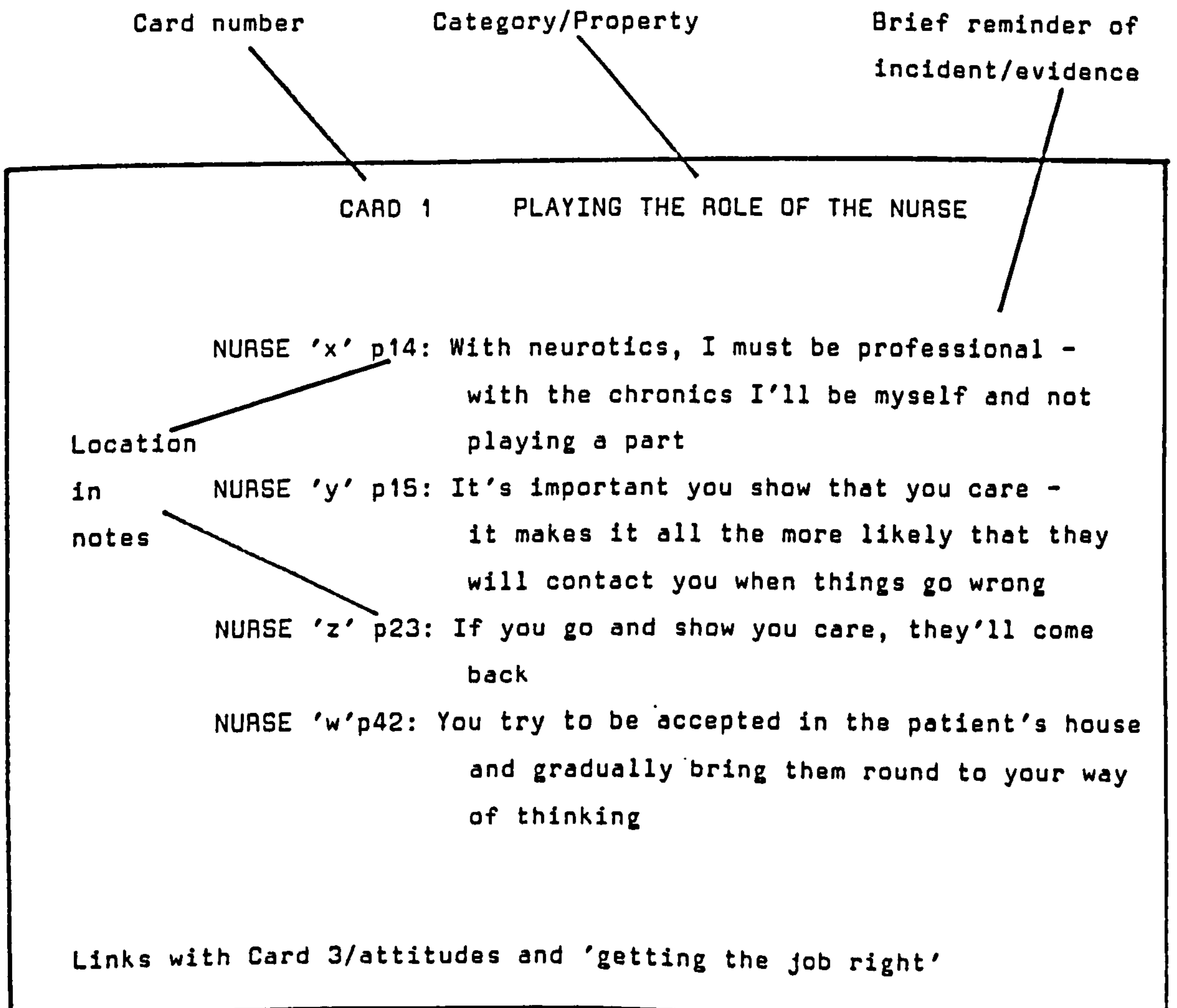
The strategy used to handle the qualitative data in this study, followed that suggested by Turner (1981) [see below, Figure 9 (a), p126], who used qualitative data category cards to sort the data into categories. Turner (1981) also elaborated a meticulous and systematic method of handling the practical elements of managing qualitative data, which consisted of a framework of nine stages [see Figure 9 (b), p128]; it was aimed specifically to be used in the development of grounded theory. The design of the present study was not faithful to a grounded approach; nevertheless, using this framework served the purpose of disciplining the researcher to examine the data closely in order to develop a theory which explained the 'process' of community psychiatric nursing. The method outlined by Turner was therefore followed in 'spirit' rather than to the letter. The first stage is elaborated at length, as the most opaque step in the analysis. From transcription of taped material, Turner (1981) tentatively labelled the phenomena he was perceiving. He describes the process thus:

I deal with the material paragraph by paragraph numbering the paragraphs for reference purposes. Starting with the first paragraph of the transcript I ask 'What categories, concepts or labels do we need on order to describe or to account for the phenomenon discussed in this paragraph?' When I think of a label I note it down on a 5"x8" file card, together with the number of the file and file the card. I then check whether further cards are needed to note significant phenomena referred to in this paragraph. I generate cards with titles of categories, until I am satisfied with my coverage of that paragraph, until I seem to have noted all of those features which are of significance to me, and then move on to the next paragraph. The labels used in this categorisation may be long winded, ungainly or fanciful at this stage and they may be formulated at any conceptual level which seems appropriate, but it is important that they should possess one essential property: as far as researcher is concerned the label should fit the phenomena described in the data exactly. If the fit is not perfect, the words used should be changed and rechanged and adjusted until the fit is improved, for the value of the whole approach depends upon this goodness of fit as the basis of subsequent operations.  
(Turner (1981), p232)



Emphasising the use of techniques to handle the analysis of qualitative data tends to underplay the part of the researcher in the understanding of the data: the researcher brings her own theoretical and personal perspective to bear on the analytical process. As already mentioned the community psychiatric background of the researcher will have influenced the study in different ways (see p94), and this comment is relevant to the interpretation of the interview data. The findings of this analysis are presented in Chapter 4:1) and details of these have been accepted for publication (Pollock: in press).

Figure 9 (a): Example of qualitative data category card, showing types of information noted



The qualitative analysis was based on transcriptions from audio-tape recordings of the 'laddered interviews' and undertaken personally by the researcher. No resources were available to meet the heavy cost of professional help. Transcribing is considered a pre-requisite to qualitative analysis (Field and Morse 1985). Transcribing is a lengthy process and took at least ten to twelve hours to transcribe a ninety minute tape. This aspect of the analysis then involved a considerable investment of time.

The data from the first area was analysed before that of the second area, the reason being that data from the second site was used to confirm the findings of the first area.

#### **An innovative approach in the use of the method and data reduction**

The laddering procedure has been little used previously in research, but provides a useful means of exploring the initial constructs. I had expected the nurses to give quite concise details about their work, but in fact they often gave lengthy details, volunteering plenty of information and examples to back up what they were saying. Often the nurses would give two reasons together for being interested in particular information; these were both explored separately. Sometimes the implications of the implicit pole came up spontaneously and it was unnecessary to repeat the question why. Often the implications of the 'implicit pole' were not opposites of the other side of the ladder. Positive comments were made by the nurses about the procedure: "It makes you think about things. You do this job and you do it normally without thinking what you are supposed to do. You've made me think why and I've been surprised at some of the answers". Continually asking why caused some nurses to wonder if they were unclear in their responses. Overall the nurses enjoyed talking about their work.

The laddering procedure took 3-4 hours on average, although with some of the nurses it took longer. The laddering interviews were divided into two sessions depending on the demands of the nurses' work. I took notes, which were summaries of the content of

Figure 9 (b): showing Turner's nine stage framework of qualitative analysis: (Turner 1981, p244).

Stage	Main activity	Comment
1	Develop categories:	Use the data available to develop labelled categories which fit the data closely
2	Saturate categories:	Accumulate examples of a given category until it is clear what future instances would be located in this category
3	Abstract definitions:	Abstract a definition of the category by stating in a general form the criteria for putting further instances into this category.
4	Use the definitions:	Use the definitions as a guide to emerging features of importance in further fieldwork, and as a stimulus to theoretical reflection
5	Exploit categories fully:	Be aware of additional categories suggested by those you have produced, their inverse, their opposite, more specific and more general instances
6	Note develop and follow-up links between categories:	Begin to note relationships and develop hypotheses about the links between the categories
7	Consider the conditions under which the links hold:	Examine any apparent or hypothesised relationships and try to specify the conditions
8	Make connections where relevant to existing theory:	Build bridges to existing work at this stage, rather than at the outset of the research
9	Use extreme comparisons to the maximum to test emerging relationships:	Identify the key variables and dimensions and see whether the relationship holds at the extremes of these variables



the discussion; these did not distract the respondents and helped me clarify what I was interested in exploring. On occasions my notes were my interpretations of what had been said rather than exact details; this inaccuracy, of recording what was actually said, was responsible at times for my asking clarification about the wrong details. This shows how the demands of the interview situation affected the conversations and at times this meant that all constructs were not fully explored; overall, the impression gained by the researcher was that the constructs were examined more fully than could be achieved in normal conversation.

Taking a qualitative analysis to the data has shown that this method can be used more productively than previously (Allsop 1980 and Hazelden 1981); this approach to the analysis was more fruitful than using the more traditional quantitative analysis. Future research should exploit this method.

#### *The Personal Questionnaire Rapid Scaling Technique (PQRST).*

The Personal Questionnaire Rapid Scaling Technique, (PQRST), was the method used for the 'outcome' part of the study. Personal questionnaires were designed by Shapiro (1961) to measure patients' experiences, particularly symptoms and their improvement. The original method was revised by Mulhall (1971 and 1976).

PQRST is capable of measuring beliefs, feelings and attitudes and is specifically designed for evaluation of subjective experiences. PQRST is a type of questionnaire where, instead of questions being answered, a series of personalised statements are presented which the subject is asked to rate. The format differs from traditional questionnaires; a booklet with answer sheets is used. The design of this booklet structures the answers and ensures that what is being measured is rated on an ordered metric scale (this is explained further below and illustrated in figures 5 - 7).

### Advantages of the use of the PQRST

- (1) The procedure has been validated in previous work (Ingham 1965 and Mulhall 1976).
- (2) The design is considered beneficial in reducing response bias
- (3) The logic of PQRST is that, in normal conversation feelings are quantified by adjectival phrases and that these are closer to the normal process of describing quantity than the necessary abstraction of using numbers or length of lines.
- (4) The adjectives used in the procedure have been extensively tested (Mulhall 1978). The adjectives used are: absolutely none, very little, little, moderate, considerable, and very considerable.
- (5) All possible pairs of adjectives are used ensuring that the whole scale is used and the central bias of traditional questionnaires is hence avoided.
- (6) The questionnaire is simple and rapid to use.
- (7) The scoring is similarly simple and expeditious, by use of a scoring key.
- (8) The adjectives are considered to be on an ordered metric scale; this is advantageous to the analysis and permits certain statistical manipulations to be undertaken on the data collected.

All of the listed advantages positively influenced the choice of PQRST for use in the present study. Advantages number three and six were particularly relevant in this study which involved psychiatric patients and relatives, some of whom were also psychiatric patients.

Figures 5 -7 illustrate the PQRST procedure. Figure 5 (p131) shows the answer sheet; the concepts being assessed are listed on the right hand side. These answer sheets are placed inside the





PQRST booklet and respondents are presented with pairs of adjectives and asked which member of each pair comes closer to the concept being assessed. Figure 6 (p133) shows this stage of the procedure - using an example from Mulhall's work measuring symptom change.

#### The construction of PQRST

Several methods are available for measuring psychological variables. For example if the aim were to measure levels of anxiety experienced by a patient any of the following might be used:

(a) A numerical scale from 1 to 7 in which 1 represents 'no anxiety' and 7 represents 'extreme anxiety'. In this case the patient selects a number which characterises his present level of anxiety. The range of such a scale might be greater or less than seven.

(b) A straight line, with the absence of anxiety at one end and extreme anxiety at the other. The patient marks the line at a point which indicates the amount of anxiety he experiences.

(c) A list of adjectives conveying degrees of anxiety, again ranging from absence to high intensity. The patient selects the adjective which seems appropriate.

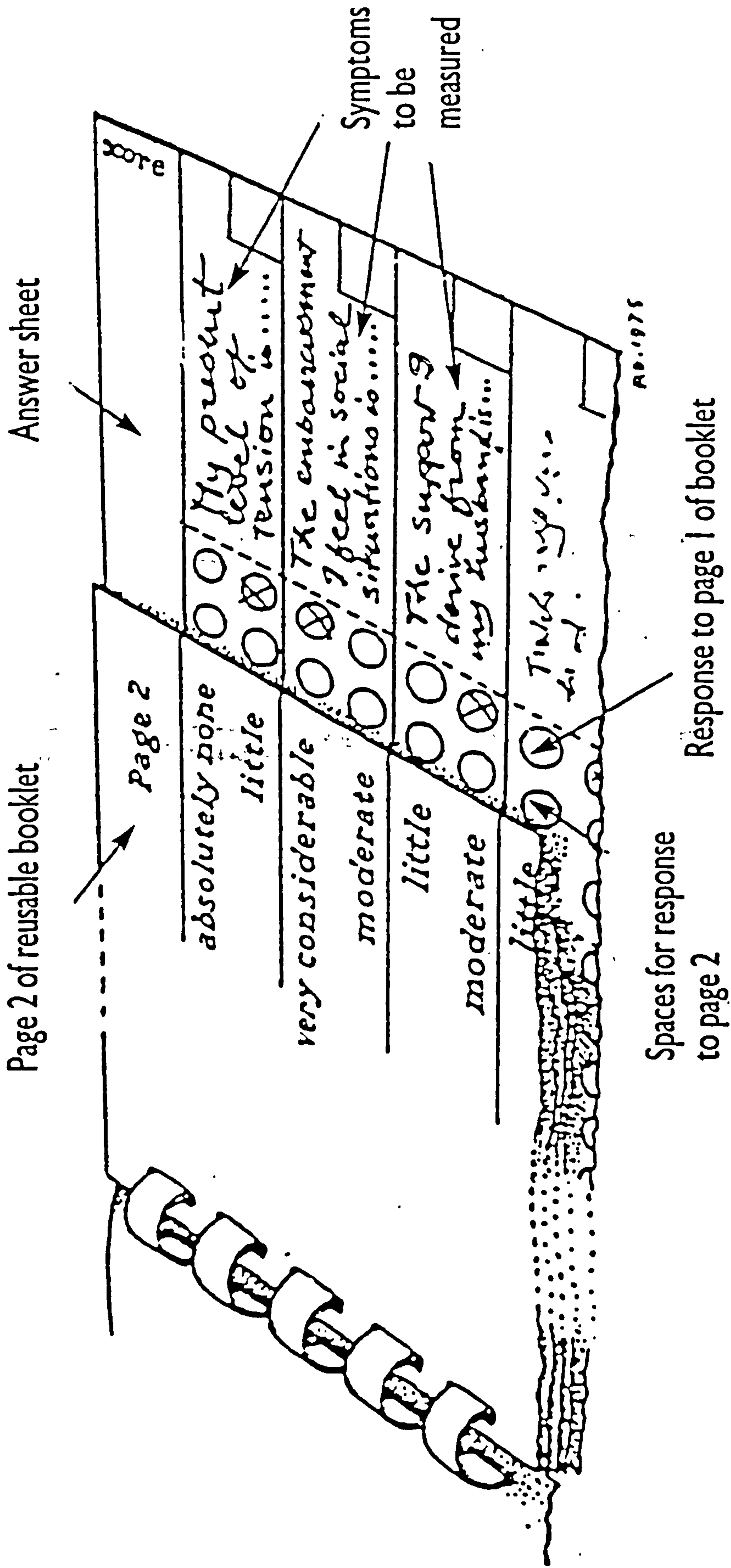
These, and other related techniques, share the common assumption that there is an underlying continuum, in this case, of anxiety. Whilst such methods are quick and easy to use they are unlikely to:

(a) reduce response bias, whether this is deliberate or inadvertant (see Cronbach 1950),

(b) allow an assessment of reliability to be made, or

(c) make allowances for the difficulty some patients have in making abstractions which require an analogy to be made between the subjective intensity of the symptom and a numerical value or a length.

Figure six: Illustration showing the PQRST booklet and answer sheet using Mullhall's (1968) format of symptoms





The PQRST is designed in such a way as to ensure that the whole of the scale is used; this is achieved by pairing each adjective with the adjacent one and to the one next to that:

ADJECTIVES	PAIRING
A Absolutely none	A } B }
B Very little	
C Little	C } D }
D Moderate	
E Considerable	E } F }
F Very considerable	

This arrangement of adjective pairs (nine in total) ensures that all possible discriminations are used, therefore eliminating bias. Each adjective location is ascribed a score:

0	1	2	3	4	5	6	7	8	9
A	B	C	D	E	F				

Each set of adjectives used can be considered to form an ordinal scale. The interval between them is unknown and may in fact be different for different people, therefore the scale cannot be assumed to be an interval scale. The procedure assumes that the scale is ordered metric. Within each pair of adjectives presented to the respondent, one implies greater magnitude than the other; an overall score is derived by counting the number of pairs in which the more intense adjective is chosen. If the lesser adjective is always chosen the score is nothing, if the greater is always chosen the score is nine.



### PQRST and its use in the present study

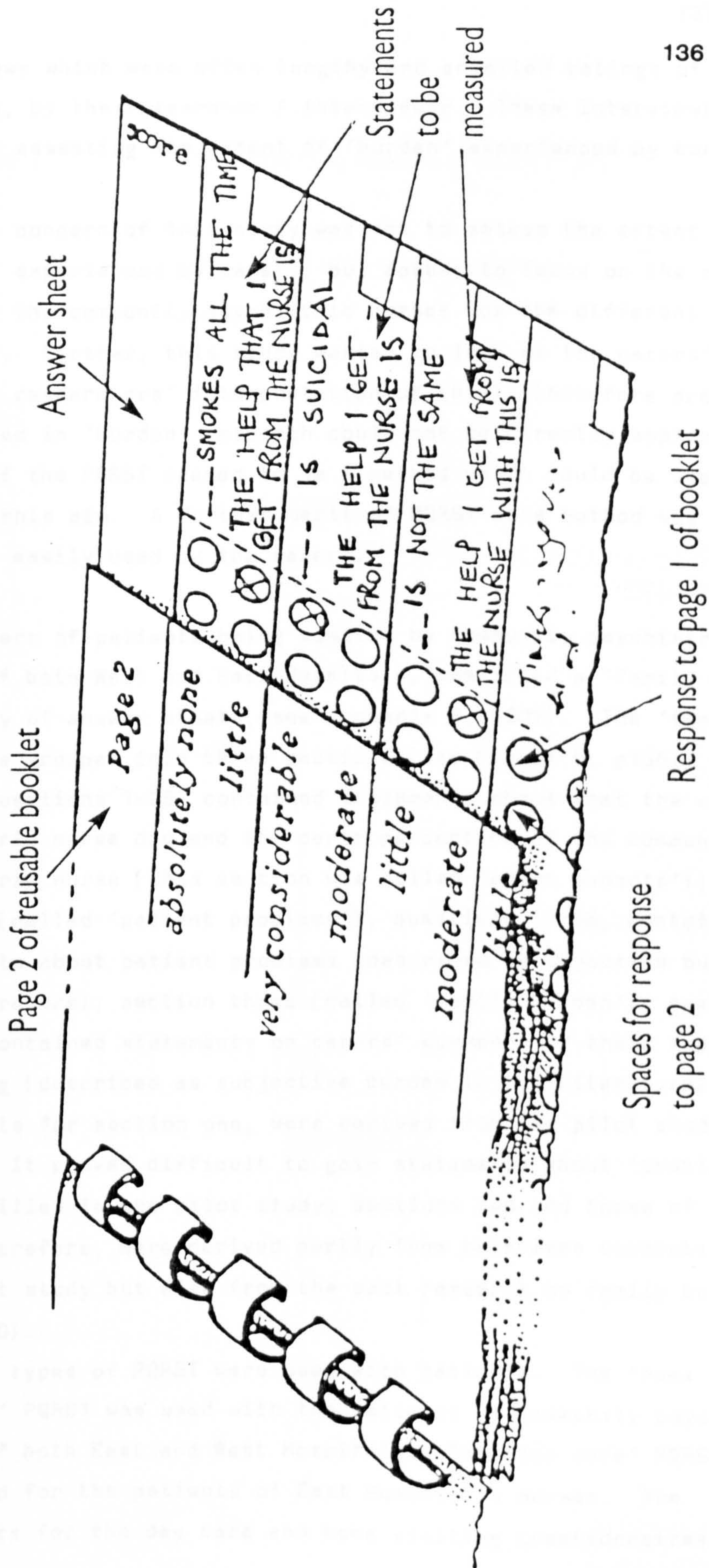
The intention of the PQRST part of the present study was to examine the outcome of community psychiatric intervention. The main focus of the study was to firstly, to find out how families of patients being visited by community psychiatric nurses perceive that community psychiatric nursing contact and secondly, to see if, and to what extent, carers' problems and experiences of caring for a mentally ill relative were helped by community psychiatric nursing intervention. Information about the patient's experience of the community psychiatric nursing contact was also collected.

Therefore, in the present study, instead of symptoms being listed (as referred to above), statements about the community psychiatric nurse, the service received or statements about patients' problems and carers experience of caring were inserted (see Appendices 6, 7, 8 and figure 7: p136). Details about how the statements were derived, are detailed on p140 onwards.

Platt et al (1980) reviewed the research instruments which have been used in 'burden' research and commented that the only single instrument which assessed the patient's disturbed behaviour and altered social performance, as well as burden, was the Family Evaluation Form (FEF) developed by Spitzer et al (1971). Platt et al (1980) commented that this FEF was "overly general and simplified". Another researcher who used the FEF (Kennedy and Hird 1980) commented in a personal communication to me, that this instrument was cumbersome to use. Platt et al (1980) proposed an alternative instrument be used to investigate 'burden': the Social Behaviour Assessment Schedule (SBAS); the main advantage of this, over previous techniques, being that it allowed for clear separation and assessment, in one instrument, of patient disturbed behaviour and social performance and the adverse effect of this on the household. This tool, and those of other researchers investigating 'burden' (see p62, Grad and Sainsbury 1968, Hoenig and Hamilton 1969, Spitzer et al 1971, Pai and Kapur 1981, Platt et al 1981, and Mangen and Griffith 1982b) took the form of semi-structured



Figure seven: Illustration showing the PQRSST booklet and answer sheet with the statements used in the present study.





interviews which were often lengthy and entailed ratings of carers' comments, by the researcher / interviewer. These interviews were aimed at assessing the extent of 'burden' experienced by carers.

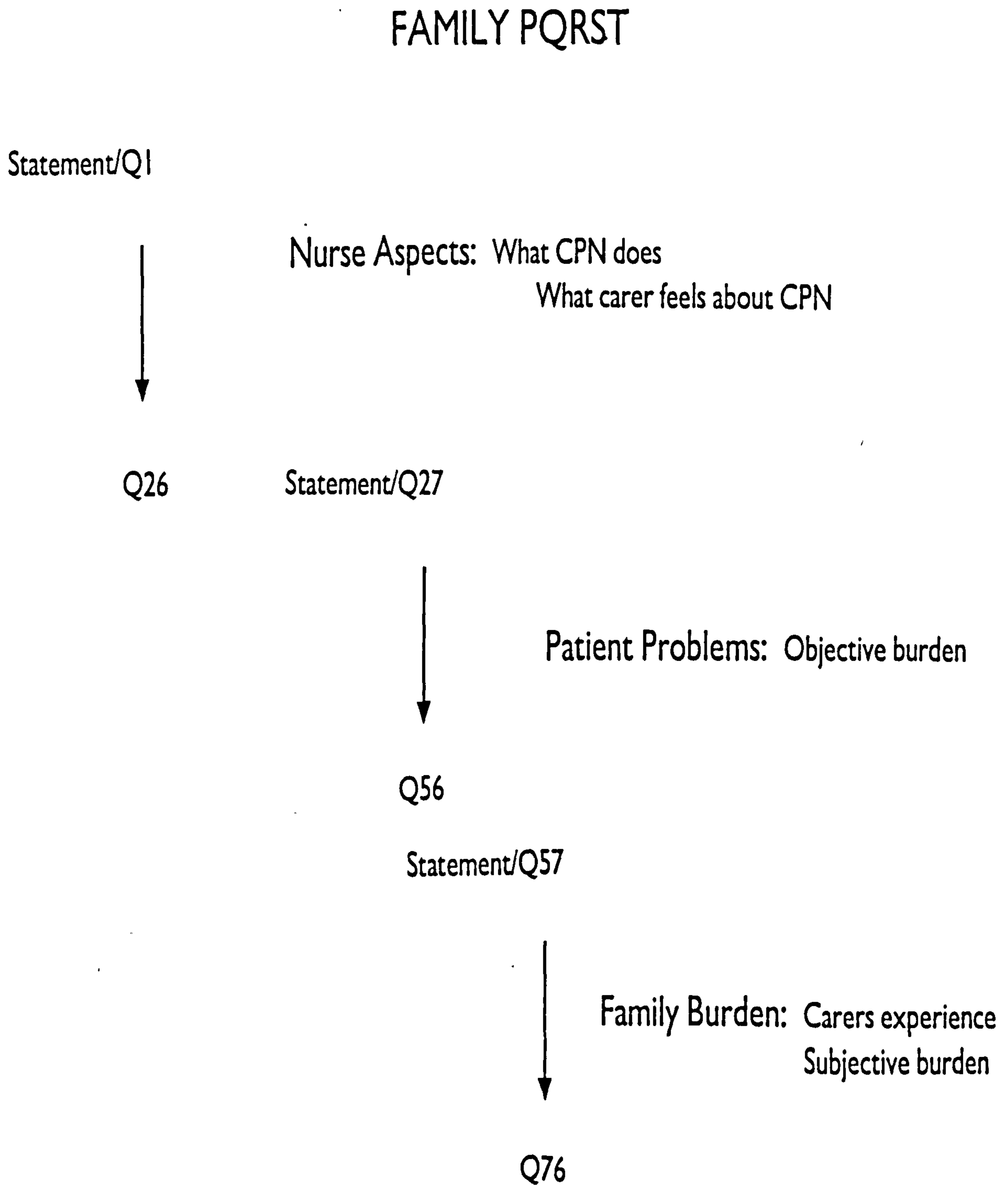
The concern of this study was not to assess the extent of 'burden' experienced by carers, but rather to focus on the relief given by the community psychiatric nurses for the different types of 'burden'. Further, this study wanted to look at the carers' view (not the researchers' interpretation of this), therefore previous tools used in 'burden' research could not be directly applied. The format of the PQRST seemed to be a method which could be used to achieve this aim. A further merit of PQRST as a method was that it could be easily used by the carers.

Carers of patients being visited by community psychiatric nurses of both West and East Hospitals, completed a 'family PQRST' (for copy of answer sheets, see Appendix 6, p307). The 'family PQRST' is grouped into three sections (see Figure 8, p138): the first, questions 1-26, contained statements about what the community psychiatric nurse did and the carer perception of the community psychiatric nurse (this section was called 'nurse aspects'); the second, (called 'patient problems'), questions 17-56, contained statements about patient problems (described as objective burden in the literature); section three (called 'family burden'), questions 57-76, contained statements on carers' comments of their experience of caring (described as subjective burden in the literature). The statements for section one, were derived from the pilot study (see below). It proved difficult to gain statements about 'problems' from families in the pilot study; sections two and three of the PQRST therefore, were derived partly from relatives comments during the pilot study but also from the past research on family burden (see p140).

Two types of PQRST were used with patients. The 'home visiting' PQRST was used with the patients of community psychiatric nurses of both East and West Hospitals. The 'day care' PQRST was only used for the patients of East Hospital's nurses. The statements for the day care and home visiting questionnaires were



Figure eight: Diagram showing sections of 'family PQRST'



all derived from the pilot study (see p140). Copies of the answer sheets can be found in Appendices 7 and 8, pp315 and 319 .

Respondents were asked to agree or disagree with the statements and then rate the community psychiatric nursing intervention on a scale of 'helpfulness'. In answer to each question the respondents commented on how 'helpful' the nurses had been, choosing one of the range of adjectives: absolutely none, very little, little, moderate, considerable, and very considerable. As explained above, for each question the respondent was forced to make a choice between two adjectives, and asked to tick the adjective that came nearest the 'true' rating (see figure 7, p136).

Patients or families who were unable to complete the questionnaire on their own were asked the questions verbally. In these circumstances, the personal questionnaire therefore, became a focused interview. As described by Denzin (1970), this is when "certain types of information are desired from all respondents, but the particular phrasing of questions and their order are redefined to fit the characteristics of each respondent." Lofland and Lofland (1984), call this focused interview, a "guided conversation". The spontaneous comments about the community nursing service, voiced by patients and families, during or after completion of the PQRST, were noted. As Blum (1970) has commented, conversation can be more relaxed and additional information gleaned after the more formal stage of interviewing and questionnaire completion. The information so collected, contains both 'direct' and 'volunteered' statements. As elaborated by Becker and Geer (1960), the volunteered statements can be assumed to be representative of the patient's preoccupations and true feelings, whereas the directed statements arose as a result of the researcher's questions and biases. No attempt has been made to separate these comments, although in retrospect this would have been a valuable exercise.

### *Pilot study of the PQRST*

#### **The Reasons**

The PQRST is a research tool which has been previously used in research. The purpose of the pilot was not to refine the research tool itself but rather, to test its use in the present study.

There were two main stages of this pilot study. The first was to acquire the list of statements to be used in the PQRST Procedure. The second was to integrate these into the PQRST Procedure and pilot the method with community psychiatric nurses' patients and respective carers (see Figure 2, p95). Each of these stages is described below.

#### *1. Stage One: Statements to be included in the PQRST.*

#### *Description*

The aim of this stage was to gain statements which could be integrated into the PQRST format. In the first instance, members of self help groups, concerned with care of the mentally ill, were approached to see if they were able to talk about their experiences and difficulties of caring for a relative. The groups included were: Scottish Association for Mental Health, Scottish Action on Dementia, Alzheimer's Disease Society, Schizophrenia Fellowship, and Manic Depressives Association. Members who were approached were organisers of these associations, all of whom were carers of mentally ill people; they were informed that my research interest was the effect on relatives of caring for someone who is mentally ill, and that I would like to interview them about their experiences. In this way it was hoped to acquire statements on objective and subjective burden (see p62). The respondents were able to talk about their difficulties and especially focused on practical difficulties with which they were faced: the patient wandering or keeping self to self, not coping with DHSS / money or smoking too much were commonly mentioned.

Secondly, twenty four patients and their respective carers, of East Hospital's community psychiatric nurses, were interviewed in



their own homes. These patients/carers were not included in the Main Study; they were chosen after the subjects in the Main Study had been selected (see pp100 and 103) and on the basis that they reflected a variety of frequency of contacts - three from each community psychiatric nurse (see p100 for selection criteria). The aim of these interviews was to gain information about the 'process' of community psychiatric nursing from patients and families. Patients and carers were asked to tell me about their contact with the community psychiatric nurse; the carers were asked to describe how the nurses helped with particular problems. In this way it was hoped to generate statements which could be included in the PQRST answer sheets, for use in the Main Study.

Only four patients in the pilot refused to be interviewed. Of the remaining, patients were either seen by the community psychiatric nurse at a day centre (n=8), at home (n=12); 8 had had contact at the day centre but were presently seen at home. Comments about the community psychiatric nursing contact varied depending on the setting in which this took place. On this basis two different types of PQRST were devised: one for patients who attended the day centre and one for patients visited at home. Patients in the Main Study would fill in the PQRST which described the present contact with the community psychiatric nurse; if patients were receiving both home and day care the 'home visiting PQRST' was completed.

Interviews took place with fourteen carers, three others refused to make comment. Seven patients refused me permission to contact their relatives. Information about the carers view of 'process' was obtained, but it was difficult to gain information from the relatives about problems or how the community psychiatric nurses helped them with their experiences. The carers who did provide descriptions of the reality of caring, did so in the terms most meaningful to them (for example, "I can never tell what so and so will do next"); these descriptions used less jargon than those found in the literature (using the previous example, the literature would have said the patient was 'unpredictable'). As far as was possible statements in the PQRST used a minimum of jargon in an attempt to make the exercise as meaningful as possible to the carers. Having failed to elicit an extensive list of 'problems'

from the carers, the literature on burden (see p62) was consulted again, in order to gain a comprehensive list of 'burdensome' factors which could be used in the PQAST (see references above). The resulting 'family PQAST' therefore included comments from the carers in the pilot interviews, plus items from literature sources. The final list of statements was endorsed by the members of the Voluntary Organisations mentioned above, to check that no major 'problem' had been missed out.

## *2. Stage Two: Use of the PQAST Procedure by patients and carers.*

The second stage of the pilot, consisted of using the proposed PQAST and answer sheets with patients and carers. Included in this stage of the pilot study, were ten of the patient/carer pairs who had been previously interviewed. The procedure was successfully completed by patients and carers; it took longer than expected and the repetitious nature of the procedure was commented on by some. On the answer sheets, beside the statements, there is a square for the score (see Figure 5, p132): this was distracting to respondents, as was the fact that previous responses became visible as progress was made through the booklet (see figure 6, p133). Feedback from this stage of the pilot about the specific statements resulted in some of these being omitted from the Main Study. A major modification, was a clearer separation of the activity of the nurse, or problem experienced by the carer (the statement) and the question to be answered (the help that the visiting nurse gave me was...).

Although the purpose of the pilot was to gain information for use in the PQAST, the pilot work highlighted other issues surrounding 'doing research.' In particular it made me focus on aspects of the process of interviewing patients/carers in their own homes and my role as a researcher. These interpersonal factors are mentioned here, because it is acknowledged that they may have had a biasing effect on the study.

### *3. The process of interviewing*

#### *Introduction*

I introduced myself, in the pilot, as a University student, learning about research by doing a study on community psychiatric nursing; I said that I had got the patient's name from the community psychiatric nurses in East Hospital. I deliberately intended to be seen as separated from the parent hospital service. This seemed to cause two problems:

Firstly, the effect of my introduction was that respondents asked me various questions: some respondents asked about my employer, why I was doing the study and what was I going to do with the resulting information. I said that I would be writing the project up as part of my degree. Other respondents were explicitly worried about whether or not the community psychiatric nursing service would be adversely affected as a result of the study. This of course, was an extremely difficult question to answer as no researcher can predict the effects of the research. All that I could reply was that my intention was to examine community psychiatric nursing because this was a developing speciality.

Secondly, my introduction seemed to cause respondents to reply to my questions in vague terms e.g. 'her type of problem' or 'nerve troubles' and there was a general reluctance on the part of respondents to discuss details of difficulties or community psychiatric nursing contact. Because of this, I decided to tell respondents (after the fifth interview) that I had a community psychiatric nursing background. This seemed to help patients and relatives verbalise their problems: maybe they made (positive) assumptions about my reactions and professional understandings. This may also however, have had the (negative) effect of making some patients/carers less critical of a service about which (they assumed) I had sympathies. I also did this in the main study.

The lack of flow of discussion may have been compounded by two other factors. First and foremost I arrived at the patients/carers unannounced and without any warning. This may have resulted in a general suspicion about my credentials and motivations which reflected in a reluctance to talk to me. This could have been



remedied by my explaining the study and returning when respondents had time to think; lack of time, on my part prevented this (also see below p144). I wrote to two people in the pilot study, giving warning that I was going to visit on a certain date and time and gave a phone number to contact me if this was inconvenient. These two respondents were extremely anxious about my mode of contact and I therefore decided that it was better to deal with these anxieties at the time rather than to let people worry.

The second factor which may have discouraged communication (particularly that of a sensitive nature) was that on arrival at houses I immediately started questioning and note taking. This of course reduced eye contact and did little to encourage communication and rapport.

#### *Confidentiality*

Some respondents specifically said that they did not want their names mentioned anywhere in the study and stated that they did not want their case histories identified.

Others were concerned about how I had gained access to their names and addresses: they were alarmed that I had also gained information about their illness or personal details. I in fact only needed and used details of names and addresses for this part of the study, and informed the respondents of this. (I actually did have access to casenotes and kardexes which contained personal information which I did not access: I did not share this with the respondents). I told these respondents that the names and addresses had not been given readily: that, permission to do the research had been given by Hospital Management Committee, the Area Ethics Committee and the parent hospital's consultants and community psychiatric nurses. I decided to inform all participants in the Main Study about these details, and to stress that all questionnaire answers would be anonymous.

#### *Combined or separate interviews of carer and patients*

In the pilot there were three occasions when both carer and family were in the house together. I had intended to interview patients first, and ask if I could approach the relatives as well,

but in reality to do this would have imposed an artificial separation on the situation; there were also practical difficulties when the carer was the more vocal and outspoken of a couple. I decided therefore to 'play it by ear' and answer whichever questions came up and to cover the specific research questions to each as intended. I acknowledge that the presence of the other person may have inhibited the respondent's replies.

This experience did however raise the question of whether or not I would give the PQAST questionnaires to both, together, if this situation arose in the Main Study. I decided to do so, especially as the written format of the PQAST made it less inhibiting to the carer or patient.

#### *Practicalities involved in visiting homes to collect the data*

Visiting patients and families at home was extremely time consuming; often I had to make return visits, either because no-one was in or to see the relative. Commonly addresses were difficult to find and in some cases the addresses were out-of-date. The pilot made me aware of all these difficulties, many of which could not be resolved. For reasons of economy in relation to money and time, patients and carers in the same areas were visited on planned days;

#### *Role as researcher*

As mentioned above, I told respondents of my community psychiatric nursing background. Whether or not as a result of this, some patients and relatives mentioned their mental health or situation to me and asked advice e.g. one lady said she felt shaky and was it her drugs? Another said the community psychiatric nurse was trying to get her to go to the day centre and did I agree? A relative asked if 'the patient' would get better.

This is a situation similar to that described by other nurse researchers using the method of 'observation' (Pearsall 1965). Pearsall talks of interviewing as a major ingredient of participant observation and commented: "tensions may be expected between some of the norms associated with research and their almost opposite counterparts in nursing practice - between disinterested observation and interested action....". I was faced with this dilemma - should

I respond to the interviewees and PQRST respondents in my 'nursing' role or as that of 'researcher?' I decided to avoid slipping into the 'interested action' role of the nurse; if, wearing my 'nursing hat,' I was worried about a patient or relative, I would contact the parent hospital.

Also, in an attempt to maintain the role of researcher, that described by Blenkner (1950) as the "investigative role" rather than that of "primarily helping," I tried to make the interviews formal. I refused to have coffee for instance - I found that 'having coffee' made the situation less formal and respondents not only asked more questions about me personally and professionally, but also about what I thought of 'East Hospital,' the treatment and the community psychiatric nurses there. This is a small point but one which I considered: I tried to be as consistent as possible in my approach to all patients and carers, in an attempt to reduce any bias into the interviews; this stance was taken throughout the Main Study.

#### *Analysis of the data derived from the PQRST method*

Using a scoring template, the method of PQRST enabled conversion of the adjectives used by respondents into a score of 0 (absolutely no help) to 9 (a very considerable help): see p134. The number of responses in each horizontal row of the answer sheet were counted and checked to see if they were consecutively numbered; if so, the score was written in the box of the answer sheet. This method was fast and facilitated by the format of the answer sheet. Scores were then inserted into a data file (see Appendix 9, p322-8).

The numerical information obtained from the PQRST was subjected to statistical manipulation using the non-parametric statistical packages available on the University Mainframe Computer (Siegel 1956); the Statistical Package for the Social Sciences mentioned above, had been updated by the time of analysis of the PQRST data; the updated version, called SPSSx (Nie et al 1983), was used for this part of the study.



The responses to each statement on the PQRST were examined using descriptive statistics. This gave an indication of the types of problems which the families had to cope with, gave an indication of the families' experience of the community psychiatric nursing service and provided a measure of how helpful the nurses actually were. Standard Chi-squared tests of association were also used, to see if there were specific aspects of the nurse or carers that affected helpfulness. Variables examined included the sex and age of the carers, the caseloads and the visiting frequency patterns of the nurses. Scattergrams were compiled and Multiple Regression Analysis was attempted.

The PQRST proved to be a useful means of exploring nurse helpfulness. There were difficulties ultimately in interpreting the scores (see pp139, 209, 218-9, 221, 252-3 and 255). If a nurse was rated as 'helpful' it was unclear why this was the case (and vice versa). The scores would have been more meaningful had they been linked with other data, patient history or illness, or age of carer for example.

# **CHAPTER**

# **4**

## **The results**

#### 4:1 THE NURSES' VIEW OF COMMUNITY PSYCHIATRIC NURSING

The Repertory Grid Technique and Laddering Procedure provided the opportunity to explore the work of the community psychiatric nurses [see Chapter 3:4 for more information about these methods]. In this section the findings of this part of the study, which focused on the process of community psychiatric nursing, are presented. First of all the 'elements' used by the nurses are detailed and discussed. Most of the section (p151 onwards), is devoted to presentation of the results of the qualitative analysis [see Chapter 3:5, p124, for the methods used] of the laddered interviews. It was hoped that this analysis would provide qualitative data on the way in which a small number of community psychiatric nurses work and in particular focus on the nurses' work with carers. Details of the goals of community psychiatric nursing work are presented in Chapter 4:4.

##### *The element lists produced by the nurses*

During the preliminary periods of observation, the community psychiatric nurses in each study area were interviewed and asked to describe their work. Each community psychiatric nurse produced a list of patient types with whom they were in contact and activities which they specifically did; e.g. I run a self help group for depressed women; I organise an injection clinic for schizophrenic patients; I liaise with other professionals and attend hospital kardexes. These descriptions could be summarised as 'task centred' definitions of community psychiatric nursing (see p29). Carr et al (1980), for instance defined six aspects of the role of the community psychiatric nurse, and Butterworth and Skidmore (1983) proposed various 'treatment approaches' available to psychiatric nurses dealing with the mentally ill in the community. None of these frameworks was described by the nurses when initially asked to describe their work.

Before detailing the results of the qualitative analysis, the differences in the 'element list' (see p116 and Appendix 10, p329)



used for the two study areas will be examined and commented on. Although the work patterns of the community psychiatric nurses were not systematically studied differences in the work patterns of the nurses can be deduced from the varied descriptions given in the 'element list'.

Nine out of the fifteen patient descriptions were similar: depot patient, consultant referral, at risk patient, depressive patient, demented patient, new referral, GP referral and chronic patient. 'Home assessment' visits described by the nurses attached to West Hospital coincided with the East nurses' description of 'requested visits', although the nurses attached to West Hospital would do a home assessment at the request of other professionals apart from hospital staff. There were therefore, in total ten elements produced that were similar in the two community psychiatric nursing services.

The other elements described by the community psychiatric nurses differed. The East nurses had two labels describing patients in terms of medication given; this reflected an emphasis, evident in East nurses' work, on administering and delivering medication; East nurses also took bloods for 'lithium' levels, an activity not undertaken by the nurses attached to West Hospital. This preoccupation with provision of medication was less evident in West nurses' work.

Both areas saw patients in terms of GP referrals but West nurses also described patients in terms of 'which agency' referred e.g. Health Visitor or Social Work referral; this reflects the open referral system operated by the West nurses. The East nurses only accepted consultant referrals; this, combined with the descriptions of out-patient, requested visit (request from wards or day centre staff to visit at weekends), physically ill and in-patient, could suggest that this reflects a hospital and medical orientation in the practice of the East nurses. The West nurses were GP-attached and less involved with the parent hospital (see Chapter 3:1); examination of the constructs produced by each community psychiatric nurse (the findings of which are summarised in Chapter 4:4) suggest that the West nurses also had a more 'problem orientated' view of patients.

The West nurses described anxiety management patients, crisis calls and social visits descriptions; these were not as relevant for the East nurses' work. It could be deduced that West nurses see themselves more as a crisis and anxiety management service than the East nurses. Chapter 4:4, Figure 25 shows that West nurses produced more 'descriptions of treatment' constructs than the East nurses. The element list also mirrors this difference, and the West nurses described patients in terms of treatment offered, e.g. home assessment, crisis call and social visits.

The element lists resulted from discussions with the nurses, and the final list is representative of agreed descriptions of the community psychiatric nurses as a group. This does not reflect the range of descriptions used by the nurses in practice (see p180). Each element list gives descriptions used by all the community psychiatric nurses. Some of the East nurses described 'emergency call outs' and 'patients on support and maintenance only' which appear comparable to the elements 'crisis calls and social visits' respectively, described by the West nurses. There was almost total agreement by the West nurses of the element list; this could suggest that the West nurses' work was more similar to each other; the different grades and work settings of the East nurses may have produced this variety.

Although beyond the scope of the present study it would be fascinating to find out what is responsible for the differences in the emphasis of the community psychiatric nursing services. Why are the nurses attached to the West Hospital more 'problem orientated' and those in the East, more medication orientated? Why does the West accept referrals from a wide range of agencies and East only from doctors. These questions arise out of the present study and were not explored further.

### *The work of the Community Psychiatric Nurses*

#### Summary of the qualitative analysis

These data explain how community psychiatric nurses make community psychiatric nursing work. The work of community psychiatric nursing can be usefully compared to that involved in making a theatre production. In the theatre, there is a play with a plot which is conveyed through the parts played by characters. In the face of production limitations (size of theatre, costs and time constraints, for example) and the demands of sponsors, audience, theatre critics and others in the Company, the characters make use of the stage props and 'get the show on the road'.

The community psychiatric nurses can be likened to the characters in a play, whose title is 'the provision of a community psychiatric nursing service'; the plot being the provision of individualised care. Similar to the production limitations in the theatre, the community psychiatric nurses have limited care options and resources and are faced with the varied demands of patients, carers and situations, other specialists and the bureaucracy. Yet the nurses have to produce the best match of needs to resources. Maintaining the theatrical analogy, the nurses have to use what props they have on the stage, not to 'get the show on the road', but to make the community psychiatric nursing service work.

Unlike a theatrical production, however, community psychiatric nurses do not appear to have an overall director controlling the work; neither are there guidelines which limit or define practice. This results in individual community psychiatric nurses establishing their own *modus operandi* and defining their own work practices.

Two major themes pervade this account of the work of the community psychiatric nurses. Firstly, the nurses 'juggle resources'. Secondly, they continually seek to legitimise their work and justify the care given. Both of these aspects of the work emerged because the nurses' expressed ideology of providing 'individualised' care, (care tailored to the needs of individual patients and their carers), was impossible to sustain in the face of finite resources.



### The ideology of individualised care

Traditional psychiatry, psychiatric theories and models (Chapter 2:2), have been criticised because they focus on the 'individual'; this approach renders individually experienced difficulties as individual problems, regardless of cause [Penfold and Walker (1983) and Banton et al (1985)]. Penfold and Walker, for instance, have stated that psychiatry takes:

the 'individual' as both the *unit of study* and as the *unit of meaning*. This can be characterized as merely an extension of the Western ideology of "individualism." It is more accurately understood as a function of the way that "the social and economic organization of society generates typical situations for people to endure as *individuals* because they have no power to change them and do not see them as matters which can be changed". It is this assumption that results in the further assumption that individually experienced difficulties are indeed individual problems, regardless of cause.  
(Penfold and Walker (1983), p49)

Despite this criticism, the principle of respect for the 'individual' is widely described as the central principle of the caring professions (see Downie and Telfer 1980). Further, in recent years, the trend in nursing has been away from telling the patient what is best for him and what he should do, toward involving him in the decision making process. The 'nursing process', an approach to care which emphasises that each person is an individual who has needs and problems peculiar to him, and that the patient has a right to have a say in what is done for him, is testimony to the importance placed on care on the 'individual' in contemporary nursing (Aggleton and Chalmers 1986). Community psychiatric nursing is no different in this respect, and one of the notable aspects of the data was the expression of an ideology of 'individualised' care by the community psychiatric nurses.

The work as described by the community psychiatric nurses and the resources used (and often created by), the community psychiatric nurses, were 'patient focused'. The nurses claimed to plan care on an 'individual' basis and talked about getting to know the patients as 'individuals'. They emphasised that this was intrinsic to the

implementation of therapy and a pre-requisite to any activities of the community psychiatric nurses. The importance of this became apparent, because before they committed themselves verbally to the researcher, about what they would do in relation to specific situations or patients, the nurses stressed the need to 'get to know the patients'.

Psychiatric nurses obviously have 'to get to know the patients', they have to talk to patients and gather information in order to do their jobs adequately. This is the initial data gathering or 'assessment' stage of the 'nursing process', the prevalent prescriptive model used by many nurses (Chapter 2:2). In addition to this, the community psychiatric nurses had to 'get to know the carers'. This is particularly important in the community setting as the nurses have less control of the situation than they do when caring for patients in hospitals. All the community psychiatric nurses constantly referred to 'getting to know the patients' and 'getting to know the relatives'.

#### *1. The nurses' work of developing and building relationships*

Three other references in the data lent support to the notion of the nurses providing 'individualised' care. Firstly, the nurses spoke at length of 'building and developing relationships' with 'individual' patients, and referred to this as part of the process of 'getting to know individuals'. 'Building relationships' is a generally accepted premise on which psychiatric nursing is based (Chapter 2:2), as Burgess and other authors have commented. Burgess (1981), for instance, has stated:

Feeling responsible for a person in terms of being involved with his well-being and by helping him to reach for mutually agreed upon goals is in reality caring for the patient. As the patient works with the nurse on goals for recovery, he will use the nurse's humanness and strength to build back his own resources. In giving of oneself, through one's own uniqueness, coupled with an attitude of being genuinely interested in the patient and trying to understand and help him, the nurse will find developing the fundamentals of relating with the patient.  
(Burgess (1981), p57)

The comments of one community psychiatric nurse summarised that of many others:

We can't really help unless we know what is going on. We build a relationship with them and get to know them. They get to know us and trust us.  
Hamish p22

The 'getting to know' behaviours of the individual nurses varied from having cups of tea, "to break down barriers", talking to patients, giving medications and collecting specimens of urine or bloods (East nurses only). As Adam explained:

If we have taken someone on in the community, we have a fair bit of work initially, just the main investigations for one thing - going in and out the house, and you find out who is who, just because you are doing the creatinine clearance, lithium levels or different things - you are still getting to know them, no matter which way it goes.  
Adam p27

Schwartz and Shockley (1956) also found that the nurses undertook activities along with the development of interpersonal relations between patients and nurses; they said:

We believe this aspect (interpersonal relations) to be crucial in bringing about patient improvement. Whatever a nurse is doing with the patient - bathing him, feeding him, giving him medication, playing games with him or sitting talking with him - she is maintaining a relationship with him. We need to know more about these nurse patient interactions and their effects on patients.  
(Schwartz and Shockley (1956), p16)

Chapter 4:2 provide some information on the patient's perception of the community psychiatric nurse interaction and suggest that different patients found different activities helpful.

'Getting to know the relatives' was also acknowledged by the community psychiatric nurses as an important part of their work. As one nurse said:

You've got to get on good terms with the relatives. If they don't like you, you won't even get into the house. That will be it. I wouldn't want that. After all I am the visitor going into the home.  
Jock p6



## 2. *The nurses' use of the strategy 'showing care'*

This brings us to the second reference in the data which supports the notion of the community nurses holding an ideology of individualised care: that is the nurses spoke of 'showing that they cared'. This was a specific strategy used by the community psychiatric nurses which enabled them, as shown in the above quotation, to gain access to patients' homes.

Unlike the hospital situation, provision of care in the home environment allows patients to maintain social roles (Chapter 2:3). In the community situation, patients are not the passive recipients of care (as have been described in the hospital situation by Freidson 1970, Penfold and Walker 1983, and Banton et al 1985), and nurses are the guests of patients. The roles of the patient and the nurse are much more equal than when care is provided in the institutional setting. This affects the work of the community psychiatric nurses in that they have to work at 'getting accepted' in the patient's home. The nurses referred to the work of gaining access at different levels: to gain acceptance in the home in the first place; secondly, to make it clear why they are there and what they can offer, and finally, to maintain that acceptance in order to be allowed to continue gaining entry to the patient's house. Examples showing each of these levels is listed below:

With recent contacts you are trying to be accepted and you have to establish rapport.

Adam p23

It's important to ask patients about aspects of their daily life; that makes sure they know you are trying to help and are sympathetic to their problems.

Colin p7

You want to bring people round to your way of thinking but you've got to play it carefully and not tread on anyone's toes: they'll just not have you back.

Bert p17

'Showing that you care', then, was a strategy used by the nurses to 'gain access'. The nurses talked about the importance of 'showing you care' by 'playing the role of the nurse'. Both of these notions were inextricably linked, and repeated mention was made by the nurses about expectations held both patients and carers

of their behaviour as nurses and professionals. This is illustrated in the following extract:

I have to be on guard to remain constructive, keep my feelings to myself, I get superconfrontive and very irritated and that is no way to be - I've got to play the caring role.

Frank p30

The idea of playing the role of the nurse may suggest that the nurses are in some way putting on an 'act'. This behaviour could alternatively be interpreted as a crucial part of the work of the psychiatric nurse. Nurses are taught about the importance of using empathy, warmth and a non-judgmental approach in order to develop relationships and facilitate communications (Rogers 1957 and Chapter 2:2). 'Showing you care' and 'playing the role of the nurse' may be the nurses' umbrella term for the activities which are evidence of the theory proposed by Rogers being put into practice.

The nurses had to demonstrate that they cared, this was despite being able to offer little help in some cases. They seemed to be successful in achieving this, by asking questions, listening, showing interest and simply by 'being available'. The nurses considered these behaviours, at times combined with provision of what could be described as a 'gesture of concern', as sufficient action to 'show that they cared':

I'll always say I am a phonecall away, get in touch. We have a card saying community nursing services. I'll leave that on my first visit - it's fairly standard practice

Kevin p6

Caring is not necessarily regular visits, it is being available isn't it? It can take the form of a phonecall or having someone call and ask for a visit every three or four months. Time and time again you find the relatives have not been dealt with or told things. What we are really into now is not following up but going along and introducing ourselves, leaving a phone number, being a known face.

Lester p11

By using the strategy of 'showing that they cared' the nurses were able to manage crisis, provide early treatment and prevent hospitalisations. This strategy was used by the nurses to achieve desirable outcomes and was advantageous to the nurses at a practical

level. Preventing hospitalisation was a frequently cited goal of the work of the nurses and one way of achieving this was to 'manage crisis' and 'implement early treatment'.

'By showing that they cared' the nurses were able to keep the channels of communication open to ensure that the nurses could be contacted in the event of crisis:

You want to turn up if you know something is going on (an illness or bereavement), to show you care. That makes it all the more likely that they will come to you when things go wrong.

Adam p15

Crisis management is considered to be an ideal type of treatment for psychiatric patients (Caplan 1964) and 'Crisis intervention' (Chapter 2:2), has been described as an approach to care which is especially useful for community psychiatric nurses (Pullen and Gilbert (1979), Ratna (undated) and Simmons and Brooker (1986). This approach is clearly discernible from the data, as evidenced by the following excerpt:

The sooner we get there the sooner we see the patient in crisis, and they are more likely to tell us what happened to them, and be more aware of their own feelings and how they cannot cope. It is important for us to see them like that...we want to keep people at home. Home is best. They'll have a crisis at home, and hopefully they can get over the crisis and stay at home, that is part of our job.

Graham p3-4

'By showing that they cared' the nurses ensured that they would be called to patients should there be a crisis of any kind; this in turn was preferred by the nurses because they considered this time to be vital as regards patient change and improvement. This approach also enabled the nurses to provide early treatment.

The community psychiatric nursing literature underlines the importance of 'implementing early and quick treatment', where the term 'early' treatment refers to treatment of mental illness at an early stage before admission to hospital is indicated (MacDonald 1972 and Leopoldt 1979a and b). This was relevant to the nurses in the present study. Kevin (p2), for example stated: "if someone is 'going off' or 'going down' we want to know about it. If we can



stop them it will avoid re-admission and starting all over again. I would prefer to be contacted". The community psychiatric nurses also talked of 'situational crises' as incidents which were handled in a particular way which focused on stress management and aimed at avoidance of hospital admission.

Reduction in hospital admission rates has been accredited to the work of community psychiatric nurses (Warren 1971, Corrigan and Soni 1977 and Pullen 1980) and the community psychiatric literature suggests that preventing admission to hospital is considered desirable (Stobie and Hopkins 1972a and b and Harker 1976). There was some suggestion from the data that the nurses were judged by their ability to prevent re-admission, and this in itself was evidence which proved that the nurse 'cared', as the following extract shows:

From the patient's point of view it (hospitalisation) sets them back...for my own credibility if they (the patient and carer) are going to have faith in you, you have to show some results. If you can, avoid anything like that (hospitalisation). You have got to rely on the patient having confidence in you; if you establish that sort of rapport they will get in touch as they trust you and I will work to prevent readmission - I show I care.  
Kevin p3

Keeping patients out of hospital however, depends on many factors, not just community psychiatric nursing contact. Goldberg and Huxley (1980) have shown that GPs play a vital role in the identification of mental illness and referral to the psychiatric services. West nurses' close links with GPs and acceptance of direct GP referrals, suggest that this factor is acknowledged by that service.

Society's ability to tolerate non-productive persons visible in the community has an important bearing on whether admission is considered (Hawks 1975). The nurses referred to this influencing their work:

I want to prevent readmission especially if there is a 'neighbour problem' - they may be a bit wary of the chap next door. The more admissions the patient has the more social pressure there is to result in long term care.  
Jock p3

The families' ability and capacity to continue caring for a mentally ill relative also influences the decision of admission to hospital. The nurses of both services referred to the latter two factors as having a bearing on the decision to admit or not, and stated that they would not "prevent admission to hospital *at all costs*."

Psychiatric hospitals of course, in the past, have been called 'asylums' (meaning sanctuary or place of safety), reminding us that the institution has qualities that recommend its use. A benefit of hospital admission has been pointed out by Cumming and Cumming (1957): they found that admission serves the purpose of 'preservation of the sane'. This was also the finding of Tizard and Grad (1961) who found that the domestic life of families was improved as a result of admission of a mentally ill relative to hospital. Both East and West community psychiatric nurses used hospital admission in this way; demented patients, in particular, regularly came into hospital for 'holiday admissions', to give carers' relief. Another reason given by the nurses for admitting patients was to allow 24-hour assessment, which would enable more information to be gained about patient behaviour (and hence more appropriate care could be given); day and night care was considered desirable, by the nurses for some patients who were considered 'at risk'. These were usually patients who lived on their own and were 'at risk of neglecting themselves' or patients described as "impulsive who may do something silly, like taking tablets...they create anxiety in ourselves; we look at how they have coped with crisis in the past, if they have taken an overdose we would be extremely anxious".

Most of the work of the nurses however was to do with preventing hospitalisation. The avoidance of producing 'institutionalised' patients was the most common reason given by the nurses for preventing hospitalisation. Other reasons given by the nurses in the study, included avoiding disruption of family life (see above), and avoiding labelling and stigma (see p160). Caring reasons then were given by the nurses to account for the emphasis of the work being on prevention of hospitalisation. These reasons



supported the notion of the work being focused on individuals and reinforced the nurses' approach of 'showing that they cared'.

### *3. The nurses' strategy aimed at promoting patient independence*

A third theme in the data lent support to the nurses carrying out 'individualised' care. This was the emphasis in the nurses' comments on helping individuals be autonomous and capable of planning their own lives without professional help. The nurses talked about 'getting the patient independent'. The adoption of this rationale was central to the work of the community psychiatric nurses and emerged as a major reason for community psychiatric nursing intervention. The nurses referred to this using different phrases: patients must "stand on their own two feet"; "run their lives for themselves"; "act like adults"; "make their own decisions"; "have a realistic sense of responsibility"; "be helped to cope with everyday aspects of living"; "learn to adapt to change". These phrases appear similar to lay attitudes to mental illness, where sufferers are told 'to pull themselves together'; one could conclude therefore, that nurses used a 'lay' or common sense approach to patients (as also found by Altschul 1972). An alternative interpretation of the nurses' rationale is that 'getting the patients independent' is seen as a crucial aspect of their 'caring' function and intrinsic to their professional ideology of 'individualised' care. (It is perhaps at one remove from analysis of the data, but it is worth commenting in passing that this sentiment of 'maintaining independence' closely mirrors one strand of contemporary political philosophy: see Chapter 2:1 for a discussion of how this is influencing the development of 'community care'. The data do not suggest that the nurses were taking this specific approach out of any particular political allegiance - rather because of their concern for the welfare of the patient. However, the ambiguous nature of the approach is noteworthy).

The varied vocabularies used by the community psychiatric nurses suggest that different stances were taken with different patients; these ranged from a dictatorial prescriptive role to a facilitative supportive one. 'Getting patients independent' was a



'caring' way of describing work that was aimed at getting patients' deviant behaviour, to conform to that sanctioned by society.

#### 4. Individual nurses developed a *modus operandi*

The notion of providing 'individual care' was confirmed by the finding that similar situations appeared to be treated differently by individual community psychiatric nurses within the same community psychiatric nursing services studied. The following excerpts show the differing interpretations::

Isolation - I feel this is really a curse of this age; there are too many people without good neighbours; I feel with all the people out working there is not as much caring, many people are totally isolated and I am the only person who looks in. I can be the only person that the people see. My job is to try and rectify that if I can, try to encourage them to get out or at least offer some social stimulation and company...

Ivan p1

Those that are lonely and isolated for instance - I know (a colleague) visits them, she has some she has seen for ages and she has some she has cut down; but its the weekly cups of tea that make me feel bad and angry. I don't think that is what you are paid for. And it is not an ideal world - there are a lot of people that you could be visiting occasionally, but the reality of it is that there are an awful lot more acute and distressed people around...

Jock p14

The examples chosen deliberately cover the same topic in order to facilitate discussion of the relevant issues. Other topics could have been used for example, bathing patients, giving depot injections, or transporting patients to name but a few. These demonstrate the conflicting views even within the same services, about the specific work of community psychiatric nursing.

It was apparent from the data that each community psychiatric nurse developed his own *modus operandi*. The nurses emphasised that each patient's and family's needs were different, that each therefore had to be assessed and programmes developed to cater for specific needs. Many descriptions of care demonstrated that the nurses considered 'assessment' to be a prerequisite to care provision, yet no formal assessment tools were used (e.g. see Barker 1986 ). One of the nurses in the study stated:

If they were asking for an assessment I'd do it on a 'one off' basis but I would not get involved unless you had the GP's OK. It may be just a discussion and I'd say the approach that I would take.

Kevin p8

Some of the nurses talked of 'goal setting', 'target setting' and providing 'time-limited' packages of care. These strategies helped the nurses structure the work, as demonstrated in the following excerpt:

I'd set limited goals about keeping his health making sure that physically and mentally he was as well as he could be, not at risk in his environment. I would not aim for employment for psychotics. I don't like setting too high a goal because if I don't reach it, I feel bad within myself.

Kevin p11

Each nurse developed his own strategies and set of guidelines; there was considerable variation in the treatments which the nurses offered and each nurse had particular preferences for certain tactics. Comparison of the following comments make this point:

I'm not for tapes. Most of my colleagues use the relaxation tapes. I'm not for them - a busy mum with kids has not got time to set aside to relax. I'd just talk. I'd maybe set small targets, going to the shops say. I would not give tapes. The information sheet is OK. I'll give it to them to read - if they do I may give them a tape. It often makes the nurses feel better giving tapes over - it is an instant cure.

Kevin p12

I have a guideline for people with panic attacks. I do four visits for assessment and background, that sort of thing, then we both (patient and nurse) decide if it is worthwhile. That is my way of trying to avoid the long term dependency thing and also my feeling that I have to cure everyone. I think everyone should have that sort of 'whatever' - when they look back and say where we are going, otherwise it is a waste of time.

Lester p8

Although the nurses talked about working out care on an individual basis, and gave the impression of carrying out individually tailored programmes it might also be argued from the data that lack of resources was an important factor in care provision. The data showed that concern for the individual (patient

and/or carer) was not necessarily the guiding premise, and much of the way the community psychiatric nurses go about their work is to do with using and stretching the available resources to the limit.

### Juggling Resources

The nurses saw themselves as specialists and a scarce resource; at times, the nurses felt 'pressured' to take action, as evidenced by the following comments: "We are supposed to be a specialist type of nursing and able to give a diagnosis back to the GP of whether the person is psychiatrically ill or not" (Bert p2). Sometimes they felt they had no choice but to respond to the demands made of them, as shown in the next comment:

The non psychotics are easier to work with because the work is time limited. Because there are no other facilities the organics become ours. It is OK to be realistic, but at the end of the day there may be no-one but us.  
Lester p12

The nurses spoke of 'only having so many hours in the day'; 'having to cut down the work rate'; 'making sure they did not waste time because there are too many people to help'; 'gauging their input'; 'having to use the resources that we do have'; 'we must be cost and time effective'; 'it's all to do with economy of visiting'. The community psychiatric nurses clearly demonstrated that they were aware of 'juggling with resources' as can be seen in the following extracts:

If a patient has local support it helps us to decide the frequency of visits, the length of visits, how much input that person is going to need from us...time is precious; it's all to do with economy really.  
Adam p8

I only visit if I have something to offer. We don't visit psychogeriatrics on a regular basis. They are low priority. I'll do an assessment, maybe offer day care or support services and we leave a card to say we have called. Unless we can offer a bed you are just a middle man for the consultant and get all the abuse. You can offer to put them on the waiting list but that is a lie - you can say it is for 3 months but you know it will be 3 years...  
Kevin p14



There were numerous examples given by the community psychiatric nurses which demonstrated how the availability or lack of resources shaped the possible scenarios of care between the community psychiatric nurses and the patients. The therapy was very subtly constructed according to, and constrained by, the available resources rather than the patients' needs.

What resources were available to the nurses? There was some evidence that the community nurses developed their own new resources, especially group therapy situations: e.g. a self help group for lonely women with a history of mental illness was started by one nurse. There were other resources that were targeted as necessary developments e.g. the creation of purpose built day units, but the development of these was restricted by financial considerations. The nurses used other professionals as resources:

I do like to refer on but that is not always possible and you have to be realistic and take each case individually. That is another reason I see for working with social workers ... we cannot cope with all the problems and we should not try.  
Adam p10

The facilities and resources in the two study areas differed (see Chapter 3:2). Regardless of details about actual resources the nurses had to make decisions about who got what resources.

*1. The nurses' work at 'fitting in' patients to resources*

Patients, despite the nurses' claims to provide care which catered for each individual, were not in reality offered 'individualised' care at all. They were 'fitted in' to the available resources. As several of the community psychiatric nurses noted, it was easier for the nurses if they were able to gain information which they could then use:

It's easier for both staff and patient if we can talk quite freely; the community psychiatric nurse can get to the root of the problem...he has more to work on  
Eddie p1

The nurses all had a clear idea of what help they could offer for

specific problems: difficulties with money led to offers of help with budgeting; for problems of isolation and loneliness the offer of attendance at the day centre or groups aimed at offering social stimulation were made; problems of low self esteem and lack of confidence led to offers of group therapy; one to one therapy was offered for marital, family or relationship problems. As a nurse listened to a patient's description of difficulties the nurse would look for solutions to the problems from the stock of problems and related actions that the nurses carry around in their heads. This is similar to doctors' behaviour as described by Illsley (1980):

Doctors spend many years acquiring a comprehensive compendium of knowledge about physiological, biochemical and psychological facts and events and a distinctive method of organizing that knowledge into states, processes and syndromes. At the end of their training they have learned how to obtain data from patients about their symptoms, to conduct physical examinations, to supplement the patient's report with other visible and tangible information and to request investigations about internal substances and processes invisible both to them and to the patient. They then organize the available data to correspond with learnt patterns signifying specific diseases and physiological processes. Their objective is also specific, *to link data patterns with acquired knowledge of causes and treatments.* (Illsley (1980), p45). (Italics mine).

It is plausible to assume the nurses act similarly to doctors because many of the community psychiatric nurses had a hospital based training, influenced by the medical model (Chapter 2:2).

Nurses talking to patients therefore, had a dual purpose: in addition to facilitating the development of relationships with individual patients, referred to earlier, the information so gained, helped make extremely complicated situations and distress intelligible and manageable. Situations became manageable because the information given by the patient was 'fitted in' to a framework which the nurses had learned and could use.

The frameworks referred to by the nurses suggested they use conceptual models of nursing (see Chapter 2:2). Like doctors, the nurses make the patients' dialogue fit their knowledge base. Do the data suggest that community psychiatric nurses like the doctors, take a 'medical model' approach to patient care and fit the

patients' comments into a framework of physiological processes, causes and treatments of diseases? Some of the nurses do appear to use a 'medical model' framework in their practice, as evidenced by some nurses' comments that the aim of their discussions with patients was to 'get to the causes, roots of or precipitants of illnesses'. There is also evidence from the data of the East nurses, that much of the nurse activity was related to medication giving and actions relating to the monitoring of this treatment (in relation to the production of side effects or symptom relief). The 'medical model', however, was not used exclusively. The 'social model' of care was taken by some nurses, who took a problem solving approach to patients:

It is my job to stop someone harming himself and improve their mental health. I want to get a comprehensive assessment to 'treat'. I don't like the word 'treat', to help them look at the problem...if you use the word 'treat' it is like you are going to cure them, but you are not, you are going in to help them.

Jock p4

A 'psychological model' was used by some nurses (see example of Frank, p40, detailed on p187). The 'behavioural model' was also used, although minimally (see reference to target setting: p162). Individual nurses seemed to take an eclectic approach to the use of models, and one model was not used exclusively by one service.

The data suggest that the nurses controlled and manipulated conversations so that they were in a strong position of not in fact responding to expressed needs, but responding to those which could be met by the available resources at the community psychiatric nurses' disposal. This point is illustrated in the excerpt below:

Some folk don't like you prying into their personal lives. It takes longer to do an informal interview, in getting the information out, but I find it an awful lot better. I no longer do a formal interview...if I get my toes stood on, I just have to assess the situation and find out how they react to me; some people just automatically blather and give information away that they think you want to know, others you've got to ask...I change my conversation and technique with the person and draw the information that is most relevant.

Dick p25



There were marked similarities in the thinking of the community psychiatric nurses as regards 'fitting in' patients to the available treatment:

If someone has been in hospital, they get out of the habit of talking to people, they feel different and don't want to join in normal social life. We'll get them to come to the group, otherwise all they do is sit in the home, do nothing and worry. We all do that, there is more time to think about how bad they feel. We want to try and stimulate them, to stop them brooding, becoming depressed. We don't want re-admission to hospital.

Ivan p3

There were also however, some differences of opinion about 'fitting in' patients to available treatment (see below).

Talking to patients appeared to be a reassuring activity in itself. This is graphically illustrated by the comments of one of the community psychiatric nurses:

The more we know about patients, about how they react, the better control we have over situation and the less anxious we are about individuals.

Graham p41

It is also worth commenting that the talking/gathering information may also have had the function of relieving the *client's* anxiety and distress through ventilation and sharing of feelings. This ventilation through discussion, is referred to in the community psychiatric nurses' accounts, particularly in relation to crisis work and is referred to in current literature (Oldfield 1983). Further the nurses' conversations will have also had the effect of indicating to patients what to ask for, so here again we see how the nurses controlled the interactions with patients / carers. Closer examination of the business of 'getting to know patients' revealed that 'developing relationships' was the nurses' shorthand for describing conversation which appeared free flowing, but in fact had the purpose of gaining particular information:

...we actively encourage pill taking; the only way that we can monitor this is by assessing their mental state: we talk to patients; we encourage them to talk about themselves. You can assess their mental state by talking

to them. The patients themselves will tell us what we know all the time.

Graham p27

This was also the case for 'developing relationships' with the relatives. 'Getting to know the relatives' was useful to the nurses because again they may find information which they could use. Some examples from the community psychiatric nurses serve to illustrate this process:

Married people have I feel a lot more stress on them, than single people, because of the stress of living with someone and the stress of children, perhaps; they have the stress of dealing with parents and in-laws; a lot will have money worries, sexual problems...if someone presents with a psychiatric disorder these are the most common reasons for frictions; this may be the reason that causes the illness. We'd want to try and change the way they functioned, the way they operated together; you can lower the level of anxiety maybe relieve the psychiatric disorder. There may be non-therapeutic things going on in the family that would make your job difficult. So you'd want to know about it so that you could rectify any false views the patient has. Also when you plan your programme, you'd plan it so that these people don't have access to intervention  
Bert pp8 and 24

Developing relationships and getting to know patients served the purpose of acquiring information which allowed the nurses to fit patients and carers into available treatments. The nurses did not seem to be aware that they 'fitted in' patients to treatment. This may well be because they strenuously attempted to keep faith with the ideology of 'individualised' care. The nurses however had a very real problem in maintaining the ideology of care focused on the individual, especially in the face of limited resources.

Symptomatic of this difficulty was that the data demonstrate that the community psychiatric nurses continually sought to legitimise their own actions and different ways of working.

### Justifying the care

#### *1. The nurses use of the notion of 'avoiding patient dependency'*

The rationale of 'getting patients independent' fitted in with the philosophy of providing individualised care. The opposite

notion of 'avoiding getting patients dependent' was also used by the nurses. This not only fitted in with the ideology of 'individualised' care, but also allowed the nurses in a caring way to withdraw services and, in effect, helped the nurses 'juggle resources'. This rationale was also used by the nurses to justify the care given.

Use of this rationale was vividly described in the following comments:

You have to avoid setting up a dependency in people. You must look at that every few visits, right from the word go. Using contracts helps: I don't come over as 'I'm going to cure you' but it is 'I will help you. We will work together, and after so long we will evaluate'. It is including them and allowing them to take responsibility. Sometimes we have to bring the dependency thing out in the open.

Lester p13

This 'avoidance of dependency' rationale enabled the nurses, in a caring way, to withdraw services:

Attendance at the day centre is gradually reduced, they are weaned off and their dependence lessened. We want to encourage them to be independent, and keep them at home, for the quality of life, for their own self esteem. Nobody wants to attend the centre for a long time and we encourage that. Another reason is to reduce the numbers of people attending and make room for others.

Graham p32

Patients 'getting dependent' on the community nurses was seen predominantly as something to be avoided. One reason given was that a 'dependent patient' could not be weaned off treatment (the implication being that this person would be a long term demand on resources). The logic of this stance would suggest that the nurses would be reluctant to offer prolonged care. The practice situation did not bear this out, the reality being that long term care to patients was a feature of the work of community psychiatric nursing (see details of how the nurses described patients, p182).

Some of the nurses described 'dependency' as "becoming too emotionally attached" to the nurse: another reason given for 'avoiding dependency' was that if a patient became "too attached"



(ie dependent) to any one nurse, it would make the nurse's successor's job difficult. This is an instance again of how present work is affected by consideration of (nursing) resources. The reference to patients being 'over-involved' is interesting. The nursing literature on caring relationships (Chapter 2:2) warns against nurses becoming 'over-involved' with patients. It could be argued that if a *patient* is considered to be 'over-involved', that this reflects badly on the nurse. Alternatively, the emphasis on avoiding dependency / emotional attachment could arise out of the nurse being unable to deal with the emotionally charged nature of some nurse/patient relationships. In other words the nurses dealt with the emotionally charged relationship by curtailing it.

It could be argued that the nature of the 'caring relationship' (Chapter 2:2) places the the patient in a 'dependent' relationship with the nurse (because of a requirement for help), and hence dependency cannot be avoided. The nurses did not comment on dependency as being the result of the nurse / patient relationship and did not see this as a legitimate part of the work.

The nurses talked about 'promoting independence' and 'avoiding dependence' in tandem but clearly this was a much more complex notion. The nurse did not speak openly of denying independence but rather they referred to 'keeping a watchful eye' on some patients; 'providing limited support or contact'; 'providing constructive follow-up'; one of the services described 'on call' patients who were unofficially 'kept on the books' because they were especially liked by particular nurses: these patients were not discharged. Denying independence was therefore considered legitimate in certain situations, usually in patients at risk of relapse.

Dependency was usually but not always considered to be a bad thing. Some of the nurses spoke of wanting to create a 'therapeutic dependency'. This described situations where the nurses considered long term care or commitment (from the nurses) justifiable:

You try and create a therapeutic dependency - so much attendance at a day centre, and we would make them do social skills, cooking, shopping...set out some sort of a programme so they would be able to talk about how they manage.

Bert p18

This description of care given mirrors that of the action involved in trying to 'promote independence'. The nurses tried to make patients independent by creating a 'therapeutic dependence', a link not focused on by the nurses themselves.

It was unclear from the data what criteria were used to determine the limits of therapeutic dependency, for example when the dependency became 'untherapeutic'. There was some suggestion that if the nurses felt they had nothing to offer, or if the patient was not progressing, changing or developing 'as expected' by the nurses, then the dependency would be seen as untherapeutic and the nurse would take action to wean patients off treatment:

I'd make out a programme and if they did not work at it, I'd drop them a letter and say if you require further visits please contact. I'll have called and they will not have stayed in, wasting everyone's time. There is no point. I'd tell them the reason why that they are not willing, If they changed their mind, I'd try again.  
Ivan p10

'Dependency' was also considered to be acceptable if this prevented a patient being admitted to hospital as the following excerpt illustrates:

There is nothing constructive about dependency unless it is the psychotics, mostly it is a non-constructive thing. It is very difficult to get out of once you are into it and it is not cost and time effective. Some people argue with this and say that if the community psychiatric nurse visiting keeps so and so out of hospital it is effective, and I can see that. But my view says something about my priorities not necessarily the service.  
Lester p13

## *2. The nurses' reference to 'in the patient's interest'*

The nurses referred to the actions they took as being 'in the patient's interests': the benefits to patients for example, of 'being independent' were frequently referred to by the nurses, for example:

We want to instil in them a realistic sense of responsibility, not just socially but for themselves,

allowing them the opportunity to be resourceful, so they feel better in themselves.

Graham p18

They continually argued that using the rationale of 'promoting independence' and 'avoiding dependence' was in the patient's interests (in the long term). This phrase, 'in the patient's interest', arising out of the ideology of 'individualised' care, could almost be described as a catchphrase which was used to legitimate whatever action the nurses wanted to do: any and all of the stances taken by the nurses were justified as being 'in the patient's interests'.

That the positions taken by the nurses were indeed 'in the patient's interests' is an assumption which can be challenged. Using the rationale of 'promoting independence' and 'avoiding dependence' clearly benefited the work of the nurses: helped them structure and organise the work and make demands more manageable. There were practical reasons for making a patient independent; for example, the patients would not longer need the help of the community psychiatric nursing service. 'Denying independence' also had practical advantage in that taking this stance allowed the nurses to cope and avoid making unpleasant decisions - for example, discharging someone who may relapse. 'Avoiding dependence' allowed the nurses to reduce service provision and in effect share and stretch out the resources, whilst maintaining a caring disposition. The way the nurses work was not just 'in the patient's interests' but in the interest of 'other' patients. The data suggest that using the caring rationale served the interests of the nurses themselves, other patients and overall was in the interest of 'service provision'. By using this caring rationale, then, the nurses were in fact able, consciously or otherwise, to give an acceptable face to the lack of resources. Some patients' interests were clearly not served by this approach: some were willing to be dependent on the nurses and they would have benefited from this had the nurses been obliging. This can be seen from the following account:

I thought how sad it was a young woman having to ask a visiting professional to walk her dog when she lived in a



private housing estate with neighbours. The social worker did her a favour not us...there was an opportunity there to push her towards interacting with others that was lost...it depends on the age circumstances of the patient, everything comes into it...

Kevin p9

This excerpt from the data shows that the dependency need of the patient was met by somebody else, in the above example a professional. This in effect means that use of the 'getting independent' rationale resulted in what could be described as 'transferred dependency'. Patient dependence on the nurse was transferred to dependence on another professional.

Dependency could also be 'transferred' to the carers. This interpretation is supported by examination of the data on the occasions when the community psychiatric nurses talked about the relatives, carers or families. The nurses did try to share the dependency with the carers, as the following excerpts show:

One patient is so demanding that the children are getting quite fed up...we try and take some of that dependency off them, take some of the support from them, try and relieve them

Hamish p6

You would have a chat with the families and try and sort out the problem. And often having a chat about the patient, and getting out the anger towards a relative is enough to maintain the situation for longer - it relieves the frustration and anxieties. ..It helps the family to know that somebody understands and cares that they are not by themselves. If they are having difficulties, to talk about them and to know that somebody cares about their situation - this helps anyone.

Colin p19

It is unclear when it was considered legitimate to 'share the dependency'. It seemed far more likely that the nurses would 'transfer dependency' to the carers. The data in fact strongly suggest that 'patient interests' were maintained at the expense of the carers' interests as shown below.

### *3. The nurses' use of carers*

Scrutiny of the nurses' accounts suggests that the families were involved to help the nurses in the business of community

psychiatric nursing. At the very least families were involved in order that the community psychiatric nurses could obtain background information. As stated in the following extracts:

If someone has family support you get a more objective picture of what is going on, a broader picture. Family are part of the information gathering process  
Frank p1

You see the relative to find out their side of the coin, to see how they find the patient...  
Eddie p5

This was particularly so for the families caring for patients suffering from dementia:

If there is somebody there, there is always someone there to get a good record, an exact record of that has been happening between visits. It is a near foolproof way to know if patients are taking the medication. We get a true history if there have been any falls, sleepless nights... Again you just want to establish what is going on - what in this case is appropriate to do. The more information you've got the easier it is to decide what is the best thing to do for the patient.  
Dick p40

Another reason given for 'getting to know the relatives' was to 'check up' on the patient's story:

Well, we see a patient, they say they are ill: we can find some biological symptoms, such as depression, there seems to be something there. But the patient doesn't always tell you everything that is going on in their life. A lot of people have court cases and if you don't know any of the background information, you're going to say this person is unwell for no reason, treat them, give them a psychiatric label, when they are really responding to stress in their lives. It could be sorted out in other ways than psychiatric intervention.  
Bert p1

This checking up activity, allowed the nurses to target treatment at the real problem (in the above case, the issues around the court appearance) rather than treating an illness which may be secondary (see Chapter 2:1 and Caplan 1964), and further was considered as crucial by the community psychiatric nurses in order to avoid giving someone a psychiatric label unnecessarily (see discussion below).

Gaining information was also vital to the community psychiatric nurses for giving them feedback about treatment and progress:

We try to keep a relationship going and develop a friendship with the family. They would be informed of progress or tell us if they see an improvement or deterioration.

Hamish p2

'Getting to know the patients and carers' was actually a fact finding exercise which helped the community psychiatric nurses determine care. It also became clear from the data that to know patients in their social context over a period of time was important. This was partly conveyed by the nurses talking about 'developing relationships'. Use of the word 'developing' suggests movement over time, and the community psychiatric nurses made it clear that they did not get to know patients and carers in a series of individual and separate meetings. Rather, each meeting was interrelated with others, and the experience of the community psychiatric nurse in one situation predicted future action in another:

If a patient is at loggerheads with the person with whom they live, the chances are, the community psychiatric nurse will get a lot of phone calls from the relatives complaining about the patient doing such and such. They'll complain of the slightest wee thing. I know they'll have had a fight or something the night before and I'll not race down: it'll have happened before; it's a case of making sure the relatives cannot manipulate you...with the folk that get on with the patient, you know they'd put up with an awful lot before they'd call: there must be something wrong and I'd visit straight away.

Eddie p6

The nurses, then, justified the care they gave by reference to information given by the relatives. Examination of the data revealed that 'Getting to know the relatives' had a reassuring effect on the community psychiatric nurses:

It makes us feel better, especially when they first come to the day centre if we know they have someone to go home to. If something does crop up, the family will tell us and let us know.

Graham p8



The information gained from relatives and involvement with the family, was aimed at improving or maintaining the *patient's* health, not aimed at helping the carers. Much of the help the relatives received however was coincidental. An excerpt from the interview data, illustrates this point well:

If family has little contact with the patient, it would be quite useful to know why, and if perhaps there had been a family dispute or something like that, we may be able to find out exactly what had happened, smooth things over, get them communicating which would alleviate the patient's isolation to a certain extent. There may have been problems in the family in relation to the dementia or paranoia, something like that - relatives may have found it difficult to cope with the patient, not really knowing what to do or what to say, because of the difference found in the elderly relative; we can discuss the problem with the family and explain the changes that are likely to occur and do occur with dementia and paranoia...help them to try and understand why the elderly relative simply does not understand... it can help, in that it can cause a less strained relationship: the relatives can be more understanding of the problems and therefore have a better relationship with the patient; it is less of a strain on them...it makes it easier for them to cope with the patients. It makes their coping ability greater.  
Colin pp1 and 14

'Supporting the relatives' has been stated in the literature as a reason for community psychiatric nursing development (Chapter 2:4); caring for the carers, in theory is part of the ideology of community psychiatric nursing. The above excerpt shows that the community psychiatric nurses, when pushed to explain why they are interested in specific information, appear concerned for the carer. The data also suggest however, that this is of interest, only inasmuch as it affects the care given to patients. The nurses were not interested in helping the carer cope *unless this in turn was beneficial to the patient, or to the nurse's management of the patient*. Carers, it seems, were not helped in their own right. Taken further, the interview data suggest that the nurses seemed to use the availability of carers to assist in making the community psychiatric service work. This is most obvious in the above excerpt, where the explicit aim of the work of the community psychiatric nurse was to 'increase the coping capacity' of the

carer; this of course, in turn had the effect of enabling the patient to remain in the home situation.

Care which the community psychiatric nurses could give to the carers was limited by two factors: firstly, the abilities of the community psychiatric nurses to be able to develop relationships with the carers:

It depends on personalities: I may not be able to communicate too well with some families but with others someone else could.

Colin p19

and secondly, by the availability of resources to the community psychiatric nurses:

Some families struggle on and its not until we are called in that we can put support in...I assess the situation and try and say to them I can understand why you do want to look after your wife, if you got a home help in to do the heavy work that would give you more time to look after her...some families will go round and make mum's lunch or whatever. If they are happy with that, fine, but it can become a bit of a burden so I would suggest meals on wheels...aids can be given, it all boils down to everything I've said is to make life easier for the person who cares, sometimes it isn't possible to relieve the situation. A lot of the time you can't.

Dick pp7 and 18

The data showed that the community nurses were concerned for the carers, but limited resources (including community psychiatric nursing manpower) restricted the help which could be offered to carers.

You always try and involve families but this would involve a considerably larger amount of work, if you wanted to involve the families in a constructive way. The family may not necessarily be part of the illness but with families with any pathology, we're treating a sick relationship not a sick individual. Most families have some pathology, they don't know that is happening, don't know what to do for the best, don't want to push too hard. That sort of situation is quite easy to deal with, but I'm talking about families that are resistive to the suggestions of the community psychiatric nurse. If the family is involved with the patient's illness the patient will not get better and stay better, if it is the family dynamics that are sick. So we

are looking for a compromise, modifying family attitudes so that the patient's illness can be looked after...to help the patient reach their optimum level of functioning. That is not necessarily my idea of 'better', it is to do with the patients idea of where they are going and how they are functioning.

Jock p8

Here again we see how the work of the community psychiatric nurses was influenced by resources and how the community psychiatric nurses 'juggled resources' to make the service work. The carers were not just sources of information but were used by the community psychiatric nurses to help plan the community psychiatric nursing input:

Knowing the support system affects our input, helps plan our involvement. We find out what goes on, and decide our approach, what to use what to encourage...time spent with one person could be cut down if we know there are people around that do certain things.

Adam p20

For one you know how much support you need to give - go in every day or whether you can share with a caring relative.

Bert p21

This aspect of community provision of nursing care was in some ways quite unexpected. The literature suggested that informal carers, most often female kin (Chapter 2:4) would be involved in care of the mentally ill in the home situation. That the community psychiatric nurses used the availability of carers to gauge the level of nursing input is an indication of how pressed the nurses are.

This is quite different from the role of relatives in relation to nursing in the hospital situation. Regardless of the availability of relatives the nursing establishment of wards is estimated on number and condition of patients. Involvement of relatives in hospital wards is encouraged or discouraged according to local management preferences; carer involvement in day to day care is not expected. If it was, this would doubtless raise questions about manpower deficiencies and about whether relatives would then be expected to do more and for more patients. Debates about the role of volunteers and workers on job creation schemes in the hospital situation are evident in the contemporary nursing press (Kratz 1987); the current shortage of trained staff (Chapter 1:2)



and proposals that future nurse learners are taught outwith the hospital situation (UKCC 1985) may mean that the role of carers in hospital will be prominent in future.

This brief excursion into the role of relatives in hospitals, illustrates the different expectation of caring relatives in contrast to the community setting. What has been or is responsible for these differences? What were the expectations of the community psychiatric nurses with regard to family involvement and what limited these? These questions were not explored in depth, but remain areas worthy of further investigation.

There was some evidence from the data that the community psychiatric nurses were unsure of how much to get involved with carers. The following nurse stated:

It is my job to be aware of the mental health of the family but I get involved to varying degrees. It depends who else is involved. I'm not sure how much we should get involved, but what happens is you don't usually have a lot of choice. We can't draw the boundaries.  
Lester p7.

The nurses seemed to be in a Catch 22 situation, where concern for the patient, learned during training, was reinforced by the existence and perpetuation of resources which catered for patients. This focus on individualised (patient) care compounded the lack of interest or ability of the nurses to care for the carers and conflicted with the expressed wishes of the nurses - 'to help the carers'; what resulted was that the nurses provided as much care as they could to the carers (by listening and being available) and for the most part enabled carers to continue in their caring role. The nurses' work with the carers appeared more to do with 'juggling resources' and making the system work, than helping the carers.

It will be remembered that the nurses by 'showing that they cared', were able to 'manage crises'; 'provide early treatment' and 'prevent admissions to hospital'. All three approaches were justified by the nurses because the patients could remain at home, which was considered preferable to institutional care. Hospital was considered by the nurses to be a resource which was only used as a

last resort, and 'avoiding blocking beds' was a justification for keeping patients in their own homes for as long as possible. The families' ability and capacity to continue caring for a mentally ill relative also influenced the nurses' decision to admit patients to hospital, and the nurses stated that they would not "prevent admission to hospital *at all costs*." It was unclear what 'costs' were targeted as being an indication of the limits to the provision of care at home by the carers. Taking an approach, of 'showing that they cared' however, detracted from the reality of service provision which was that limited resources were available. It could be argued, for instance that 'lack of resources' and inability to provide optimum care could produce 'crisis'.

#### 4. Labelling

Another effect of using the notion of 'promoting independence' and 'avoiding dependence' was that this had ramifications in the way the community psychiatric nurses described patients. Some comments of the community psychiatric nurses suggested that they wished to avoid 'labelling' patients: avoiding labelling was specifically discussed by the nurses, as the following excerpt shows:

Once you've labelled someone as psychiatrically ill it becomes an illness in itself. People look upon them as being ill and it is hard to get rid of that label whether the person has had any psychiatric illness or not. They are looked upon as a deviant in society, as being less than normal, as being socially inadequate.  
Bert p2

The evidence below suggests that the nurses, paradoxically did indeed 'label' patients. One cannot help but ask why the nurses did this and what purpose the labels had? Similarly, what effect the labelling had? These issues are explored below.

'Labelling' describes the use of short descriptive tags which describe individuals rather than objectively describing behaviour and which exert an effect on the individual's subsequent career. Labelling theorists argue that the most crucial step in the development of deviant behaviours is the experience of being publicly labelled deviant. Whether or not this happens depends 'not so much on what he does as on what others do' (Becker 1963).

Goffman (1963, 1964, 1974) and Scheff (1966) describe certain stages involved in the labelling process in relation to mental illness. Diagnoses are examples of such labels:

Putting a label on a patient can invalidate the patient - 'you are invalid, and what you say is therefore invalid. You are sick because your label says so.' Diagnosis can therefore become a way of restraining people and of rendering them even more impotent than they were when they started. To say someone is neurotic, psychotic or psychopathic or schizophrenic is not just a scientific statement. It can become a way of making a value judgement about the patient and putting him down. Mitchell (1973), p35).

Patients are not only labelled on admission to hospital; there is evidence to suggest that patients can be labelled in the community by professionals (Penfold and Walker (1983), and by society Mechanic (1968) and Page (1984).

Rosenhan (1973) has shown how normal people can be labelled 'schizophrenic' and how normal behaviour is then misinterpreted or overlooked. Kreitman (1961) conducted a study where pairs of psychiatrists independently interviewed 90 out-patients; they found that there was only a 50:50 chance of agreement about symptoms and diagnosis. Other authors have commented on the unreliability of psychiatric diagnosis (Bannister et al 1964 and Kendell 1975). More recent World Health Organisation - sponsored work has shown that the reliability of psychiatric diagnosis can be improved through the use of agreed definition of terms (WHO 1978). The application of psychiatric diagnostic 'labels', despite their imprecision is liable to have relatively powerful effects. (This fact was acknowledged in the present study, as demonstrated by the comments of Bert, above).

Rosenthal and Fode (1963) observed a strong association between 'problem' patients and the failure to establish an organic basis to the illness. Jeffery (1979) suggests that for his casualty doctors, the terms 'problem patient' and 'psychiatric patient' were virtually synonymous. These findings are similar to those of Becker 1963, Strong (1980) and Hughes (1981). There is research evidence to suggest, then, that doctors label patients. Research has also demonstrated that nurses use labels in their work with patients:



Stockwell (1972) showed that on general wards, nurses identify popular and unpopular patients; nurse/patient interaction was found to be related to this perception and psychiatric patients were overtly rejected or ridiculed. May and Kelly (1982) suggested that psychiatric nurses perceive patients as either 'chancers, pests or poor wee souls', each category legitimised a particular nurse interaction. These authors noted that:

Problem or disliked patients are those who call attention to the fragility of nursing authority by rejecting, implicitly or explicitly, the services - help, advice, treatment - that the psychiatric nurse stands ready to provide.

(May and Kelly (1982), p280).

In view of the above comments, and the fact that most community psychiatric nurses do not receive post-registration training (Chapter 2:5), it is reasonable to assume that community psychiatric nurses continue practices learned in the institutional setting. The evidence from the interview data clearly demonstrated that community psychiatric nurses do 'label' patients.

#### *The nurses' use of labels*

Getting to know the patient and carers over a period of time had a strong influence on the work of the community psychiatric nurses, and resulted in the nurses describing patients in terms of the length of contact with the community psychiatric nursing service. Descriptions of patients with lengthy contact with the psychiatric services, included: 'chronic, long term, old, known, regulars, having a long history or lengthy experience of psychiatric care or a psychiatric background, been on the books for years and professional patients'; in contrast, there were patients described as 'acute, short term, recent contacts, unknowns or an unknown quantity, and new referrals'. Visits to new patients were described as 'cold visits, first visits and initial assessments'. The influence these descriptions had on the community psychiatric nurses work is demonstrated in the following excerpt:

When notes are available, if someone has a history you use that for guidance. I'm less professional with the psychotics. You fall into the role of familiarity. That

is a particular danger with depot drugs - you give them the injection and maybe don't look so closely at them...first referrals you go into the house from scratch and spend a lot of time on that person.

Kevin p12

Work with new patients was more anxiety provoking for the community psychiatric nurses, and there was no information initially which they could work on (see p175). This anxiety may be related to the fact that the nurses had not yet legitimised their approach to patients. As the above excerpt indicates, work with a 'known' patient had its problems too.

The following excerpt demonstrates the linkage of 'new' and 'old' patients with the notion of crisis work and avoidance of care in hospital.

There are people who have been on the psychiatric roundabout, who have been seen by psychiatric doctors and have adopted the sick role...Those not diagnosed as psychiatrically ill are easier to work with, it's easier for them to accept that they have a problem: most of them are frightened of being diagnosed as mentally ill...things are more acute, the pain is still there...With those who have been diagnosed etcetera added on to that there is sometimes the idea of 'I must go into hospital to be made better', with them it is more difficult to prevent hospitalisation and work with problems.

Lester p9-10

A 'management of crisis' approach (see Chapter 2:2) tended to be taken with 'new' referrals and also with 'old' patients for whom hospital care had been unsuccessful. This can be seen from the following example:

...you do a little bit of digging about...it becomes apparent that all these people need is some outside intervention to help them through the stressful period, then usually you don't see them again. A great deal of psychiatry seems to be a bit of that now, especially the new referrals - a lot of new referrals you'll see them once and they are not really a psychiatric case but there is something needing...it is useful to know that for the next time something happens...it is a good learning situation. When we know the patient, we don't see the situation as a new crisis but as a pattern to the patient's life, they become ill in a certain way...If a patient is running about hallucinating, you would think that this person should be

in hospital, but from experience we know that this person is a gross hysteric. You could go out and give them some tranquillisers to calm them down. If you take them into hospital you are uprooting them from their families. You are disrupting all the supportive services that are there - it is better to go and do something at home.

Bert p28

Other researchers have found that the work of community psychiatric nurses varies depending on the length of patient contact. Sladden (1979) for instance, found (based on the nurses' interpretations of their contacts), that activities aimed at changing patients behaviour directly (using advice, persuasion, or warnings) or indirectly (using a cognitive approach aimed at developing insight and understanding), were more frequently used at initial contacts and in particular where community psychiatric nurses had noticed deterioration. It was surprising that the community psychiatric nurses' activities were significantly related to initial contacts, as one would have expected these activities to be related to the community psychiatric nurses' longer term work (with both patients and families).

The East and West nurses used other descriptions and labels. The patients were judged by the community psychiatric nurses, in relation to past responses to treatment and described accordingly. 'Dependent patients' were referred to by the community psychiatric nurses and described as 'a drain on resources'; 'a draw on the helping agencies'; 'demanding'; 'psychopathic manipulators'; 'getting secondary gain out of the sick role'; 'attention seekers'; 'professional patients'. The community psychiatric nurses had individual lexicons - a favourite range of descriptions, for patients who did not 'fit in' to, and co-operate with, the treatment offered. There was a common understanding as to the meaning of these lexicons, even across the two community psychiatric nursing services studied. Patients that did not 'fit in' to the available resources were variously described by the community psychiatric nurses as: 'unresponsive', 'difficult', 'irregular attenders', 'defaulters', 'resistant to therapy'; 'unmotivated'; 'lacking insight'; 'manipulators'. No mention was ever made by the nurses themselves about the deficiencies of the community psychiatric



nursing services offered.

These labels were used by the nurses to describe patients who they found difficult to help, in other words who were unable to be made 'independent'. There was an abundance of 'negative' descriptions (perhaps logically because those who would qualify for the positive range of descriptions, are by implication no longer in need of help; i.e. they are independent, therefore ready for discharge). These labels served the purpose of helping the nurses cope with failures; patients who failed to become independent and patients who failed to fit into the available services and resources. The labels were used by the nurses to legitimise the work, and helped the nurses decide who got what treatment. Further, the use of labels also helped the nurses cope firstly, with patients who did not fit into treatment, and secondly, with managing the nursing service. 'So here again we see the importance of 'justifying the care and juggling resources'.

The labels were meant for 'in-house' use: this was made quite clear to me because I was treated as 'in-house'. In both research areas, I was made to feel welcome because of my practical experience as a community psychiatric nurse; there was a feeling of camaraderie during the interview sessions; some of the nurses joked in a conspiratorial manner, about the 'labels' they used. This, combined with the comments of the nurses, suggested that the 'labels' were for the private use of the community psychiatric nurses. The data in fact suggest further that use of 'labels' facilitated communication between the nurses. This is demonstrated clearly in the following excerpt:

I don't go in with the idea that someone is chronic, I go in to help that person as much as I can. It is a term I would use with you, not with them. I don't really even look on them as chronic, they are a person to me. It's just a piece of shorthand to describe what they are like...  
Ivan p5

The above comments suggest that the nurses did not intend to harm the patients. Taking note of the above theory (p181), however, there are implications in describing patients as 'dependent' (or whatever), and this 'labelling' may have adverse effects on the

patients. The theory suggests that the nurses' use of negative labels to describe the patients will result in the patients being viewed in terms of these 'labels'. This could have several undesirable effects: patient improvement and changes for the better may not be observed by the nurses (who may pay more attention to aspects of behaviour which necessitate the use of the 'dependent' label); other professionals will pick up these labels and perceive the patients negatively, as difficult and demanding for instance; patients themselves may also begin to accept the labels and believe that they are in need, dependent, demanding, a drain on resources and begin to conform to these descriptions (an effect which works against the thrust of the nurses' therapy, which is to help individuals be autonomous, self sufficient and independent). This aspect of the nurses' work could mean that, for some patients, the nurses may be inadvertently perpetuating patient dependency.

#### *5. The nurses' view of patients*

The nurses' use of labels is more than a mechanism of communication. The labels demonstrate how the nurses viewed patients. The interview findings show that individual prejudices or preconceptions may affect the work of community psychiatric nurses. This is contrary to what might be expected of nursing work, where an assumption of the nurse / patient relationship is that the nurse should adopt an 'objective and impartial' attitude (Chapter 2:2).

As discussed above, several authors have noted that psychiatric nurses can have prejudiced views of patients which can in turn determine treatment. The following example shows this process is evident in the work of the community psychiatric nurses:

It depends on the condition of the patient as well. I know someone who we would have no difficulty going shopping or getting her chocolate because she was a pet patient and she also had a terminal illness. That changes how you behave; there is someone else, youngish, just neurotic who wanted us to do things like walk the bloody dog...

Kevin p9

In this excerpt from the data, the terminally ill patient was seen as a 'poor wee soul' and the other, as a 'chancer' (see above comments; also May and Kelly 1982). The second patient was



described as neurotic. McIlwaine (1980) demonstrated that neurotic patients are viewed negatively by psychiatric nurses (in the hospital situation). The data here suggest that only some of the community psychiatric nurses held these negative opinions of 'neurotic' patients; an extract from the data illustrates this:

Neurotics and hysterics tend to act how they feel...you know they're not acting in a bizarre way, its not because they are mad. It's because they are distressed about something and you want to push them to look at it...you want to relieve the distress...reflect back on them what they are doing and at the same time reassuring them saying how they feel is a more effective way of getting what they want and if they did this it wouldn't be the end of the world.

Frank p40

The example shows that this nurse, far from being negative was prepared to take a constructive approach to management of the neurotic patients in his care. The data show overwhelmingly, however, that how the nurses viewed and described patients affected their work. The nurses were aware that their views of patients may be judgmental. This was most obvious during some of the interviews, when the nurses stopped describing their work and commented that they treated all the patients 'just the same'. This was clearly contradicted by elaboration of different types of treatment being offered to different patients, as shown in the following excerpt:

We would offer the same sort of thing for someone who was isolated and for someone with family support. But you tend to be more aware of just how they are managing and ask more about how they are are coping. With a family around patients will be attended to...but really we do try to treat everyone the same.

Colin p15

An explanation of this reaction maybe that the nurses felt discomfort at the realisation that they carried out 'patient triage' in relation to offering treatment. The exercise of discretion is considered to be one of the prime attributes of professional work, but it may be that the nurses found it difficult to acknowledge the extent to which they sorted out patients and decided who should be given what resources.



At times, the nurses acknowledged the influence of their personal judgments and stated that their opinion may be wrong. Nevertheless the judgments did affect the way the nurses managed patients, as is shown in the following excerpt:

I'm thinking of neurotic hysterics who would go to a GP and for the sake of peace and quiet and tranquillity, to keep cases at bay, he'll put people on anxiolytics or sleeping tablets when they really shouldn't. They are putting them on it because the patient demands it, not because the patient really needs it. That is a very subjective thing. It is my opinion that they shouldn't be on it. If I feel someone is on medication and doesn't need it I would be looking closely at their symptoms and get a mental approach to their symptoms. Try to deal with their feelings instead of hiding behind valium, with the ultimate objective of getting them off it, not taking it away from them, but getting them to see that they don't need it, let them see that they can manage without it...Because you can't hide behind valium for years. You're just putting off the evil hour. The GP is treating symptoms not treating the person as someone with problems. They are treating the objective complaint like without looking at why. Without looking at why they feel tense. Part of our remit is to look at why people feel tense not just pour valium down their throats...some patients need a prop and can only deal with their feelings if they have medication. It is very much an emotive subject. We're talking about my opinion. I'm not sure whether my opinion should come into it, but it is very difficult to keep your opinions and feelings out of it..we want to get away from producing chronic invalids who've been on valium for years and this is compounded by their unresolved feelings and they are addicted to the stuff...  
Frank p8-9

This excerpt from the data shows clearly how the nurse's judgments determined treatment and provided a rationale for the nurse's management of patients. It is obvious too that concern for the patient is central in this account.

The fact that the community psychiatric nurses hold prejudiced views of patients and carers is not necessarily bad. Hume and Pullen (1986) consider that the varied opinions of psychiatric nurses about patients are an important facet of treatment in the multi-disciplinary setting. Burgess (1981) talks of the concept of 'stalls', including 'judgmental feelings', which are unavoidable factors that impede the therapeutic process. Peplau (1952) emphasises the importance of the nurse assessing his own

interpersonal behaviour as it affects the therapeutic relationship, the work roles of the psychiatric nurse and the phases of the nurse/patient relationship. There are also particular difficulties for psychiatry and hence in the work of the work of community psychiatric nurses in particular, in maintaining a balance between subjective perception and objective data in psychiatric practice.

The work of psychiatry, has less scientific rigor to control its practice, than traditional medical practice. The seminal work of Zola (1972) and Illich (1975), and others since, e.g. Illsley (1980), have clearly argued that medicine is a 'system of social control':

Persons who cannot, by reason of illness, carry out their normal responsibilities require some form of legitimation, and in a famous statement of the obligations of the sick role Parsons (1958) stipulated as one obligation the need to seek technically competent help and to co-operate in trying to get well. Given the position of medicine as the sole definer of sickness this makes the medical profession one of the arbiters of deviant behaviour...the obligation upon doctors to provide sickness certificates to employers and the social security system is the most common embodiment of the doctor's position in the system of social control.

If all diseases were clear-cut and organic, medicine's role in social control would be limited. Sociologists have noted however that the increasing acceptance of behavioural disturbance as illness has brought many other forms of potentially deviant behaviour within the medical orbit (Zola 1972). Mental retardation, insanity, neurosis, homicide, suicide, shop-lifting, sexual behaviour, aggression, drug and alcohol 'abuse', and baby and wife-battering, for example, have each come to be regarded to varying degrees and in certain circumstances either as illnesses or as problems susceptible to medical advice and treatment. The boundary lines between what is socially undesirable and what is sick behaviour in a medical sense are difficult to draw. The uncomfortable suspicion has been frequently voiced that some forms of medical diagnosis and labelling, particularly those relating to mental illness or insanity, are convenient means of locking away individuals whose behaviour is uncomfortable for society. Psychiatrists themselves are concerned about its uses in the USSR as a means of silencing political critics. The situation is exacerbated by the fact that decision-rules for the diagnosis of illness are not so strict as those for determining criminal behaviour; nor are they so open to public view and judgement. It does not, however require such extreme cases to make the point that the more medicine moves from technological intervention in organic conditions



to the surveillance and modification of everyday behaviour, the more likely it is that it will be involved in controversial issues on which its motivation and authority can be challenged. This is an uncomfortable position for a profession which has based its claim to status and autonomy on scientific principles, and which has emphasised its freedom from political and social values.  
 Illsley (1980) p74-75

The community psychiatric nurses in the study were clearly aware of their role in this 'system of social control', as shown below:

Some of the work is to do with getting people adjusted to retirement...getting them advice, there are pamphlets you can pick up. Getting voluntary workers to pop in, or getting them involved in the church....I want to improve their quality of life, improve their outlook, get them accepted...

Jock p9

We have seen so far, that the community psychiatric nurses made decisions about who should receive what care and that they used various devices to justify the care: using the avoidance of dependency rationale and referring to the work as being 'in the patient's interest'; the nurses also legitimated the work by using labels. Another way by which the nurses legitimated their practice was by seeking legitimacy from the group: they justified their less than impartial attitude by seeking group consensus and approval at meetings of their peers.

#### *6. The nurses' use of group consensus*

The community psychiatric nurses talked about 'playing it safe'. This in effect was a phrase which described a range of activities the nurses engaged in which put limits and checks on their behaviour. One way of 'playing it safe' was that the nurses did not exclusively rely on their own judgment: 'Second opinions' were sought. These sometimes involved the family:

You speak to the family to substantiate what the other person is telling you. You get another view: if someone has been married for ages, you've got to admit that that person knows more about the patient than you do, and can see changes that you are unlikely to pick up and miss.  
 Adam p3



'Pooling opinions' and coming to a decision based on the weight of opinion was another way the community psychiatric nurses made difficult decisions and discussed approaches to patient care:

You see the relative to find out their side of the coin, to see how they find the patient, so I can compare what I think, what the GP thinks, to what the relatives and the patient is saying.

Eddie p9.

The opinions of the patients, families and other professionals were pooled. Multi-disciplinary meetings also took place in the parent hospitals (more so in East Hospital) and these afforded opportunity to discuss patient management and approaches. Case conferences were also held if a situation was particularly problematic. Both community psychiatric nursing services had regular community psychiatric nursing meetings where opinions could be pooled and ideas shared:

Sometimes you find yourself a wee bit insecure in that you wonder if somebody could make trouble for you. I would discuss that with my colleagues and ask them what they thought. Provided everyone agreed I would stick with my decision and then speak to the consultant.

Kevin p8

The community psychiatric nurses had to make complicated and difficult decisions about patient management. The nurses were aware of the possibility that things may go wrong and talked of creating 'safety nets' which was how the nurses referred to the letters written to GPs if a patient was discharged: these always offered the possibility of re-referral and future treatment:

We find that the ones that attend irregularly, are not motivated to get help. If its just a case of not being motivated, then there's no point in pushing them; you'd wait probably for another crisis really and pick them up again. But you would inform the GP, keep everyone in the picture - we'd be willing to take them on again.

Hamish p11

The nurses also talked about having 'contingency plans'. Often the nurses had alternative treatment plans which could be implemented if the first approach to care failed. In East Hospital these were

sometimes formally written down in an 'at risk' register in the admission ward (see example p197). It is unclear at what stage of therapy this was undertaken, but the name suggests that this was used when nurses were anxious about patients welfare.

There were instances cited in the data where nurses were challenged about their treatment decisions and actions (by relatives, other professionals and lay people in the community). This resulted in the nurses having joint meetings to compare opinions of colleagues and often this resulted in discussions with the consultant. There was evidence therefore that the service closed ranks to support the nurses' exercise of professional discretion .

My impression, based on limited attendance at staff meetings, was that the aim of multi-disciplinary meetings was formally to review progress and make decisions about patient care; the feelings of the nursing staff about patient management were rarely explored. An additional impression gained of these meetings (and based on the comments of the nurses) was that the organisation of the nursing services (particularly in East Hospital), was influenced by other professions, especially medicine. What Gouldner (1959) has called "latent social identities" may be evident in the work of the community psychiatric nurses. These are, identities which are not culturally prescribed as relevant to or within rational organisations - which intrude upon and influence behaviour in interesting ways. This is an area of study worthy of future investigation and separate detailed examination.

#### *7. The nurses' work and the bureaucracy*

The varied ways in which the nurses handled similar situations (see p161) and the fact that the nurses' attitudes influence practice lead one to ask how far do the individual nurses let personal feelings intrude on the work, and to what extent does the bureaucracy limit individual work practices.

The data suggest that there was a certain amount of bureaucratic control on the community psychiatric nurses which maintained a check on the individual scope of the work. The nurses felt their work was being monitored, as shown by the following

comments:

It (the work) is up to you. You don't get that many (wasted visits) anyway. If it went up to '50%' 'they' might be a wee bit wary. It is quite in order if you work that way. We keep a Kalamazoo, the record that the district nurses use.

Kevin p4

This nurse then, talking about his individual work pattern, the irregular nature of which incurred 'wasted visits', inferred that 'they', i.e. the organisation, would inform him if this was unacceptable practice. This assumption was based on the fact that individual community nurses were obliged to complete detailed day-to-day records of their work practices (statistical returns, kardexes or the kalamazoos). The controls exerted by the bureaucracy were few and these measures, with their quantitative focus (Chapter 2:5 and McKendrick 1981), do little to examine performance on a qualitative level.

The nurses themselves put checks and limits on their activities by working within self-made guidelines. Care was also legitimised by the use of agreed policies (see p197). The use of these policies and planned inputs portrayed the image of the nurses as 'being organised'. It will be remembered that no formal assessment tools (Barker 1986) were described or referred to by the community nurses (see p161). In the absence of undertaking 'systematic assessments' or using measuring tools to assess input and measure output, it could be argued that 'being organised' was a facade used by the community psychiatric nurses which obscured the reality of the effect of the community psychiatric nurses' attitudes, and which in turn may have served the purpose of offering some legitimacy to the work.

Murray has stated that the nurse alone is unable to assess the effects of attitudes and feelings. Murray commented:

Therapeutic treatment of patients is not something that can be left to the good will of the staff. Procedures should be devised which will help the staff deal with the stress and frustrations that arise in the mental hospital setting. Mental health professionals should regularly evaluate their attitudes and responses to patients. They should also attempt to examine objectively the social system in which



they work to discover the effects of the system's internal operations on the patient's behaviour and its effect on their own behaviour. In addition, they should examine their role in the behaviours that patients demonstrate...  
Murray (1974) p332

Although Murray is talking about hospital-based nurses the issues raised are equally pertinent to the community psychiatric nurses, and suggest that regular forums be available where patient management and the nurses' feelings are discussed.

Menzies (1960), has shown that general nursing is organised to contain the anxiety of staff. One cannot help but wonder how far the community psychiatric nursing' work patterns evolved to cope with the anxiety aroused from developing new and autonomous work patterns and from juggling resources. Previous studies focusing on community psychiatric nursing suggest that some of the activities and responses of the community psychiatric nurses could be to anxiety, rather than to a systematic assessment of need [Hunter (1978), Sladden (1979)]. These authors studied the work of psychiatric nurses in community settings. The finding of increased admissions (in Hunter's study), could be the community psychiatric nursing response to coping with anxiety. Sladden found that decreased frequency of visits followed detection of deterioration. It is possible that this response could be to anxiety, rather than to systematic assessment of the need for visits. Sladden also found that community psychiatric nurses 'held on to' patients. It could be argued that this finding is symptomatic of community psychiatric nurse' anxiety surrounding caseload management.

There is evidence of anxiety in the present accounts given by the nurses about their work, 'getting to know the patients and relatives' was partly undertaken because of this. The introduction of 'supervision' (see Chapter 5:2) into the work of the community psychiatric nurses may be a helpful strategy which could provide some support for the nurses. In the present study, existing meetings of the community psychiatric nurses were used to discuss business and administrative matters. Patient management was discussed regularly on an informal basis, by the nurses themselves and was most evident during a 'crisis' when urgent decisions needed

to be made. 'Supervision' sessions (CPNA 1985), which allow the nurses' opportunity to focus on attitudes and feelings about management and afford opportunity for insightful practice or staff development, were lacking. The managers of the services are in an ideal position to introduce an element of supervision into the practice of the community psychiatric nurses.

The findings in this study demonstrate that decisions about which patients receive care are made by the individual community psychiatric nurses. Kalkman (1974) says that nurses are not independent practitioners as they depend on doctor referrals and prescriptions of patient care. The CPNA Survey (CPNA 1985), however, suggests that community psychiatric nurses receive only 82% of referrals from GPs or psychiatrists; referrals are also taken from district nurses, health visitors, social services and direct referrals from patients and relatives. This could indicate that community psychiatric nurses are moving towards being autonomous practitioners. This move seems to be reflected in debate within community psychiatric nursing (CPNA 1985) and in nursing generally (RCN 1981) and suggests that this is an issue of concern. Clearly if the work of the community psychiatric nurse was broadened to include early detection of mental distress, then issues of accountability, responsibility and autonomy will increase. The West community psychiatric nurses operated an open referral system (Chapter 3:2) and the data suggest that individuals develop their own working practices. In this sense the community psychiatric nurses are operating autonomously and with very few controls. The checks and safeguards described by the community nurses, which they imposed on their work, is a way in which the nurses have evolved practice to preserve some sense of accountability and responsibility.

#### *8. The nurses' use of moral considerations*

There are moral aspects in the business of 'juggling resources' and 'justifying the care' and the community psychiatric nurses relied on moral considerations to justify their work. Similarly, bureaucratically-driven decisions, influenced by resources in

themselves, presented as moral questions. These moral considerations, which significantly influenced the nursing practices, are presented.

'Moral responsibility' is referred to by Rhodes (1986), as "consideration of one's obligations to act for the overall good of others and society". The nurses seemed to consider it preferable to help as many patients as possible. This was the rationale behind group work: "You can deal with eight or nine folk in an afternoon in a group. There is no way you could deal with that on your own" (Ivan p5). This choice, to help many rather than few, can be traced partly to the current emphasis in practice on 'efficiency' arising from Central Government's stress, since the early 1980s, on efficiency savings and the implementation of the Griffiths Management Structure (DHSS 1983). Additionally, the importance managers place on quantitative statistics (see p70) to evaluate community psychiatric nursing activities serves to combine to make the choice of treating many patients preferable to treating few.

To pursue a policy of maximising benefit to the community at large, however, it may be necessary to ignore the plight of others who may be expensive as regards resource use. Taken to the extreme this argument suggests that some individuals are expendable for the sake of the good of others. There is in fact some evidence of the nurses taking this stance as the following comments show: "We don't visit psychogeriatrics on a regular basis, they are low priority" (Kevin p14). This is a dimension of psychiatric work that is not as relevant for psychiatric nurses working in wards. Here demands for care are controlled by hospital or admission policies and limited by the work of others in the team. The solitary nature of the work and the variety of contacts in the community setting may mean that the community psychiatric nurses have to decide how to limit demands made of them.

There are alternative options open to the community psychiatric nurses. One alternative, discussed by Downie and Telfer (1980) is the notion of 'equal consideration' which is a demand for *consistent* treatment between individuals and the use of a rule which can be formulated as a guideline to practice. This demand for consistency



clashes with the personalised nature of the caring relationship which stresses the individuality of situations. Nevertheless there was evidence that the nurses used and applied some rules consistently. These rules, called 'policies', resulted from the community psychiatric nurses as a group agreeing to take a common approach to situations; as can be seen from the following excerpt:

If someone has had past suicide attempts and you thought that they were really ill, depressed and didn't want to come into hospital, you would think twice about leaving a person out and treating them in the community; in that case you would maybe think about whether they were certifiable - should they be in hospital and in care...If the past suicide attempt had been psychopathic type manipulation behaviour you have to find out what the policy was and what the last letter said, if this person had to be treated again or what. Are they to be given drugs? It all depends on what the policy is...The person may have presented with what seemed to be a psychiatric disorder, but on investigation it turns out to be a reaction to stress in their lives. People have said they are psychopathic, but lets see if we can help them, lets do A, B and C; and every time you do this and they wouldn't do anything, you would say there is not much more we can do for you. We would set up this network so that if it happens again we'll come and see you and if things have changed we'll try and help you. In our crisis list there are people at risk, but there are also information sheets for patients who are not to be admitted in any circumstances; but it is not quite like that, there is a little bit of information and we would go and assess the situation and if things have changed we can form a new treatment plan.

Bert p36

Agreed policies seemed to give legitimacy to care provision (see also p193). Consistency is necessary if care is seen to be fair, but this is not a sufficient condition for 'fairness': a consistently applied rule, for example, that all schizophrenic patients be refused hospital admission could still be thought of as unfair.

The provision of *equality* of treatment may be an option, but this not realistic, as it would be unreasonable to spend the same amount of time and money regardless of the problem. Again, the data suggest that the nurses tried to take this approach. The nurses spoke of 'treating all the patients the same': "You wouldn't treat patients any different but what you would offer them would be

different" (Jock p26). Close examination of the occasions when the nurses asserted that they 'treated the patients the same', however, not only belied the previous comments (of treating the patients the same), but also showed that some of the nurses differentiated between 'treating' patients and 'offering treatment'. This demonstrates two different usages of the verb 'treat' (I treat all my patients fairly and I am treating so and so for depression). Putting this more more analytically, the differentiation showed that the nurses were talking in the first instance about taking a general caring approach and manner to all patients. This relates to the earlier discussion of the importance of 'showing that you care'. In reality the nurses did not treat really treat everyone the same, and different patients were offered different treatments.

Downie and Telfer propose:

What is required is that all differences of treatment be based on a criterion which will group like cases together and distinguish unlike cases, for *morally appropriate* reasons. In this context the obvious criterion is *need*, since the aim of proffering help is to meet needs: those whose need is greatest should get more help than those whose need is less, and those whose need is equal should get equal help...We can call this requirement that any differences of treatment be based on morally appropriate reasons, a principle of *equity*. Equity is not the same as equality, since it says not only that like cases must be treated equally but also that unlike cases must be treated unequally.

(Downie and Telfer (1980), p 76-77)

As we have seen the nurses did not treat like cases equally and different nurses came to different decisions in relation to what appeared to be similar situations (see excerpts p161). These examples showed that there was disagreement amongst community psychiatric nurses about whether they should undertake 'social visits' to lonely individuals. Some nurses argued that it was legitimate for a community psychiatric nurse to visit patients to provide companionship, friendship and social stimulation on the grounds that the visiting prevented patients becoming depressed and mentally ill. The nurses therefore asserted that they had the moral foundation to continue visits. Other nurses argued that 'social visits' were not the legitimate work of the community psychiatric

nurse, when there were other patients in current need of 'therapy' from a skilled psychiatric nurse. Again we see how resource availability influences the views and actions of the nurses. Who receives what resources then became a moral question and the nurses justified their input by reference to their training and arguments which legitimate contact with non-mentally ill individuals (see below). The nurses had different ideas about what work should be done for payment and some of the nurses argued that to 'drink tea' was not 'therapy' and that helping loneliness should be taken on by someone else, presumably on an unpaid basis. These differences of opinion about who should receive what care are brought into sharp profile because the resources available to the nurses are scarce.

#### *9. The recipients of community psychiatric nursing work*

The community psychiatric nurses sought to justify their work by reference to their training. Some of the nurses argued that they are trained to deal with the mentally ill, not lonely individuals. The data show that the community psychiatric nurses had a clear idea of what they were trained to deal with. An excerpt illustrates this point:

I'd prefer not to take on injections. I don't mind psychotics but not injections. I don't find job satisfaction with them. It is still a fair amount of my work, a big part of my job. I find it boring. I prefer the 'vague referrals'. I feel I am working as a professional using my own skills to find out their problem areas. I am virtually deciding myself how to handle it and I come to the decision of when to discharge. From that point of view I am using my training properly. With the injections, it is just a procedure.  
Kevin p15

Few of the nurses in the study had specialised training for community psychiatric nursing work. This reflects the picture nationally, of a minority of practising community psychiatric nurses who have undergone specific training (Chapter 2:5). The interview data suggest that the nurses with specific training seemed to be less in favour of 'social visits'; it is unclear if their training accounted for this or provided them with skills which were better used with other clients. Regardless of possession of community



psychiatric nursing qualification, all the nurses had a clear idea of what they were doing and why.

The following paragraphs briefly present a theoretical discussion about the possible recipients of community psychiatric nursing care. Most community psychiatric nurses, by virtue of their hospital-based training, are trained to deal predominantly with diagnosed psychiatric illness which is severe enough to warrant hospital care. Skidmore and Friend (1984) offer support for this view and state that at present psychiatric nurses are not trained to deal with the less serious forms of mental illness. If legitimacy of work is defined by training, psychiatric nurses should, strictly speaking, only be working with hospitalised and recuperating patients with a diagnosis of serious mental illness.

This conclusion can be questioned. Many authors argue, for instance, that the psychiatric nurse may have a valid part to play in work, not only with designated patients, but also with carers and families of patients (Falloon 1984 and Orford 1987). Others argue that it is legitimate for psychiatric nursing work to be with non-nurse professionals, to transmit skills to other helping agencies (Goldberg and Huxley 1980).

There is also a body of literature which argues that psychiatric work (in order to benefit the mental health of the whole of society) should embrace primary, secondary and tertiary levels of prevention (Chapter 2:1). This latter focus of psychiatric work includes work aimed at health education (to prevent psychiatric illness occurring at all: primary prevention; early diagnosis and treatment of illness to prevent and reduce the duration of disability: secondary prevention; and maintenance of functioning despite incapacity or disability: tertiary prevention). Secondary and tertiary preventative work focuses on designated patients; primary prevention involves work with healthy individuals. Community psychiatric nurses can justify intervention with a variety of individuals by referring to any one of these preventative approaches.

These levels of intervention are not as clear cut as one would imagine, however, because of the confusion which can arise out of

debate about how the limits of 'mental illness' should be defined. Some examples demonstrate this confusion: should individuals in the community being given relaxation therapy by community psychiatric nurses for feelings of panic be labelled 'mentally ill'? What about in comparison, someone treated with valium for the same problem? This confusion is compounded by the emphasis in contemporary psychiatric care on avoiding hospitalisation and treating people at home if possible (see Chapter 2:1): is someone seen only once by community nurses 'during crisis' considered a psychiatric patient - they may not be diagnosed 'mentally ill', yet they may have case notes in the psychiatric hospital? What about an individual who has suffered a psychotic episode, been successfully treated and now is well on long term injections and attending day care - is this person mentally ill?

The question of whom community nurses are trained to help is not easy to answer and is the subject of debate and controversy in the literature. The differing views, evident in the interview data, reflect differences of opinion about more general areas of community psychiatric nursing work, and whether the job of community psychiatric nursing be that of 'primary prevention' or 'secondary prevention'. Bearing in mind previous comments about the work being aimed at the 'overall good' (of society), it could also be argued that the work of the community psychiatric nurses should be aimed at 'preventing' mental illness. Some of the nurses subscribed to this view and paradoxically (in the face of lack of resources) actually undertook 'work finding' activities. An excerpt from the data demonstrates this:

I'm trying to break down the image of the mental institution that the public have. I'll say look I could not help anyone in chains. I'll explain as the image is terrible, and mental illness is regarded with suspicion. My job is talking to and teaching the public. I was in a wee shop this morning and the girl asked what job I did. I said I was a community psychiatric nurse. It turned out that her daughter was psychiatrically ill and I said if she feels she needs me to get in touch.

Jock p6

In view of the limited resources available to community psychiatric nurses it is perhaps surprising that the nurses engaged in activities



which added to their workload.

Despite debates about whether it is legitimate that nurses work should be exclusively with individuals with, or who have had, serious mental illness, the fact remains that many community psychiatric nurses, including those in the present study, are involved in care of people suffering from minor emotional stress. In view of the above discussion on training, questions must be raised about how the nurses learn to care for these patients, if not in the formal nurse training school and colleges. This study shows that that the nurses have learned their own ways of dealing with patients.

There is evidence from the interview data that mixed caseloads ie with patients requiring primary and secondary preventative work, served the practical purpose of motivating the nurses.

I'd get bored with geriatrics all the time. I actually quite enjoy working with anxieties, that is one of the things I really do like to do, but if I have done two or three days of just anxious patients I like to do some psychotic patients who are not a lot of hard work.  
Ivan p11

This may be an important consideration as regards organisation of community psychiatric nursing services. Recent nursing literature on the concept of 'burnout' demonstrates that professionals working in stressful and emotionally demanding situations for prolonged periods can become 'spent', resulting in reduced work performance (Cherniss 1980). One way of avoiding this is to provide varied, interesting and supportive work situations (Hume and Pullen 1986). The above quote shows how the variety within individual nurse's caseloads can sustain interest and enthusiasm for the job.

Psychiatric nurse managers in the community, at service level, must address the issues of what the community psychiatric nurse should be doing and with whom, and they should be making joint decisions about service organisation and planning. The data here suggest that these issues are not being tackled at local level and that individual nurses are left to make their own decision about who receives care. DHSS (1975) recommended that local needs be used as



a basis for local planning, instead of national criteria and standards being set for community psychiatric nursing services. This study suggests that local (mental health) needs are mopped up in a rather hit-and-miss fashion by individual practitioners rather than being met by any planned strategy of intervention. Planning at local level seems vital, especially because staffing levels constrain or even determine the type of care offered.

The community psychiatric nurses in this study have clearly adopted many coping mechanisms and devices which enabled them to provide a community psychiatric nursing service, despite limited resources and infinite demands. These in themselves could be described as a defence against anxiety; devices which the nurses used to ensure that the service worked. These devices were learned in the practical situation, not formally in the nursing colleges, and were the means by which the community psychiatric nurses organised and planned work with the patients. Gouldner (1959) commented on the "informal patterns" of "organizationally unprescribed culture structures - that is, patterns of belief and sentiment" which develop amongst groups of workers in organizations. The community psychiatric nurses' use of labels could be described as one such informal pattern of behaviour. The nurse seemed to be socialised into what is legitimate by contact with colleagues and peers.

The major control imposed on the community psychiatric nurses was 'finite resources'. These in fact restrained the nurses from totally 'doing their own thing'. This, combined with the checking out behaviour of the nurses resulted in the nurses providing a service which was remarkably standardised and uniform. The interview data provided an illuminating study of how the nurses make an under-resourced system function and how they strove to make the service appear fair and uniform despite plenty of evidence to the contrary.

#### 4:2 THE PATIENTS VIEW OF THE SERVICE

The present study was motivated by a concern to find out whether the community psychiatric nursing contact helped families cope with the burden of caring for a mentally ill relative at home. The study focused on whether or not the community psychiatric nursing services met the needs of the carers. I would argue that the patients' needs should be the major rationale for developing services, but the involvement of patients in the present study was not to examine whether their needs were being met, but rather to gain feedback about their experience of the 'process' of community psychiatric nursing. This was valuable for two reasons; first, as an adjunct to the data received from the nurses who described their work - here the focus of concern was to obtain information on the 'process' of community psychiatric nursing; and second, in order to demonstrate an interest in community psychiatric nursing to the patients before asking their permission to approach a carer.

This section examines the patients' view of the community psychiatric nursing services. As described in section 3:5, patients used PQRST which consisted of statements on, and questions about, the helpfulness of the community psychiatric nurses; this procedure produced information on agreement or disagreement with the statements and obtained answers to questions on a scale of 0 (absolutely no help) to 9 (a very considerable help). The data collection took place in two different areas (see sections 3:2 and 3:3 respectively, for details of these, and the rationale for selection of the patients). There were two different questionnaires for patients, depending on the setting of the community nurse contact: day care or home visit (see section 3:5 for the reasoning behind this decision).

The section is divided into two parts. In the first, the results for the 'day care PQRST' and 'home visiting PQRST' are presented separately. Details of the number of patients who completed the PQRST are given and where appropriate, the findings for each area of data collection are displayed side by side; this enables direct comparisons and allows evaluation of the evidence of

material differences between the two sets. Patients of community psychiatric nurses based in East Hospital are referred to as 'East' patients; those of the nurses attached to West Hospital are referred to as 'West' patients. More complex relationships within the data are then explored: helpfulness in relation to specific factors of the nurse or carers, and helpfulness in relation to frequency of visits. The second part is a discussion of the results.

*The findings*  
*Day Care PQRST*

Appendix 3 contains details of the statements in the 'day care PQRST'. These statements were collected from patients during the pilot study (see p140). Looking at the questionnaire as a whole, the statements could be broadly described as either nurse, patient or situation focused statements (see Table 3, p206). Most of the statements were 'nurse focused'.

**The Respondents**

Only 'East' patients completed this questionnaire; all 'West' patients were visited at home, because no day centres existed outwith the parent hospital (see Chapter 3:2). Thirty-seven out of a total of fifty-six 'East' patients approached to complete a PQRST were attending a day centre run and organised by the nurses. More than half of the sample patients (p102) therefore, had contact with the community psychiatric nurses in the day care setting. Of these thirty-seven patients, twenty-nine completed the questionnaire. Further details about patients (e.g. type and length of illness, etc.) were not collected. Of the patients who did not complete the 'day care PQRST', four refused and four were unable to do so.

**The Results**

The answers to the statements were analysed using descriptive statistics. The patients were asked initially to agree or disagree with the statements in the PQRST (see Table 3, p206), examination of which gives an insight into how the care given by the community psychiatric nurses at the day centre was perceived (see text below).



Table 3: Percentage of patients who agreed with (in 'yes' column) statements in 'day care PQRST' and % with scores of four or less. Absolute numbers also listed in brackets.

Summary of PQRST Statements	% of 'East' patients	
	YES	Score of four or less
* I CAN PHONE THE NURSES ANY TIME	76 (22)	10 (3)
* THE NURSES TAKE AN INTEREST IN ME	93 (27)	14 (4)
* THE NURSES MAKE ME FEEL IMPORTANT	59 (17)	21 (6)
* THE NURSES GIVE ME SUPPORT	90 (26)	7 (2)
* THE NURSES GIVE ME MY MEDICATION	79 (23)	28 (8)
* THE NURSES TALK TO ME	90 (26)	3 (1)
* THE NURSES KEN ABOUT ME	93 (27)	21 (6)
* THE NURSES ARE CHEERY	86 (25)	3 (2)
* THE NURSES CARE	90 (26)	7 (2)
* THE NURSES HAVE TIME FOR DISCUSSION	80 (23)	6 (2)
* THE NURSES SAY THINGS THAT COMFORT ME	73 (21)	10 (3)
* THE NURSES DON'T TREAT ME BADLY	76 (22)	21 (6)
* THE NURSES ARRANGE TO SEE PSYCHIATRIST	69 (20)	3 (1)
* I TALK TO NURSE ...OTHERWISE COUDN'T	72 (21)	7 (2)
* THE NURSES LISTEN TO ME	86 (25)	10 (3)
* THE NURSES ASK YOU HOW YOU ARE FEELING	90 (26)	13 (4)
* THE NURSES HAVE SPECIAL QUALIFICATIONS	86 (25)	14 (4)
* THE NURSES LET ME SEE THINGS DIFFERENTLY	59 (17)	3 (1)
* THE NURSES TELL ME NOT TO GET DEPENDENT	34 (10)	10 (3)
* THE NURSES DELVE INTO MY PAST	41 (12)	17 (5)
+ THE DAY CENTRE IS A PLACE TO GO	76 (22)	3 (1)
+ THE DAY CENTRE IS LIKE A FAMILY	62 (18)	10 (3)
+ I ATTEND A GROUP	52 (15)	13 (4)
+ WE PLAY GAMES	40 (11)	17 (5)
+ THE CENTRE HAS A NICE ATMOSPHERE	80 (23)	14 (4)
+ I AM KEPT BUSY AT THE DAY CENTRE	52 (15)	17 (5)
+ THE DAY CENTRE BUILDS UP MY CONFIDENCE	65 (19)	6 (2)
+ I GET A MEAL AT THE DAY CENTRE	41 (12)	7 (2)
+ I MAKE MY OWN WAY TO THE DAY CENTRE	65 (19)	34 (10)
# I MADE FRIENDS AT THE DAY CENTRE	63 (18)	10 (3)
# PEOPLE THERE ARE WORSE OFF THAN ME	90 (26)	41 (12)
# I MEET OTHERS WITH SIMILAR TROUBLES	62 (19)	20 (6)
# I FEEL I AM HELPING OTHERS	60 (18)	17 (5)
# I CAN GET THINGS OFF MY CHEST	76 (22)	3 (1)
# I HAVE COMPANY AT THE DAY CENTRE	73 (21)	17 (5)
# OTHERS AT THE DAY CENTRE ARE DIFFERENT	51 (15)	20 (6)

n=29

KEY: \*: nurse focused statements  
 +: situation focused statements  
 #: patient focused statements

Looking at the frequency counts of the scores 0-9, the majority of scores for each question were high (see Figure 10, p208). Examination of Table 3 shows that the highest percentage of agreement was given by patients to statements that referred to the nurse taking an interest, giving support, talking to patients, caring, and asking about how the patients feel. Almost 60% of patients reported that the nurses helped them look at their situations differently; most patients found this helpful; 41% of patients agreed that the nurses 'delted into the past' and many found this helpful.

Two other statements were agreed by at least 90% of the patients: 'The nurses ken about me' and 'people there are worse off than me'. Looking at the scores for the item (see Table 3, p206), 'People there are worse off than me' suggest that this component of the day centre was seen to be of little or no help by 41% of the patients. 20% of the patients were not helped by 'meeting others with similar troubles'.

The agreement responses suggest that different patients receive different care at the day centre e.g. group work, playing games, or keeping busy. The day centre was seen by half the patients to have 'a nice atmosphere', to be a 'place to go', 'to be kept busy', and by half it was not. Most of the patients found these aspects of the day centre helpful, although some did not.

The interviews with the nurses suggested that the day centre was used to help patients increase independence and gain confidence, improve social interaction, and in order to enable patients to venture out of their houses (see p169). These factors were perceived by patients and found to be helpful: 70% reported they got company at the day centre; 63% made friends and 65% agreed that the day centre built up their confidence. 65% of the patients made their own way to the day centre, which was considered to be of little or no help by 34% of the patients.

Figure 10. Sample of SPSSX output file showing skewed frequency distributions

FILE: PATIENT DAY CENTRE QUESTIONNAIRE: EAST PATIENTS, AUTUMN 1984

Q8 The nurses take an interest in me

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.40 OCCURRENCES
2	2.00	*****	
1	3.00	***	
1	4.00	***	
2	5.00	*****	
2	6.00	*****	
1	7.00	***	
4	8.00	*****	
14	9.00	*****	

I	I	I	I	I	I
0	4	8	12	16	20

HISTOGRAM FREQUENCY

VALID CASES 27 MISSING CASES 2

Q10 The nurses give me support

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.40 OCCURRENCES
1	3.00	***	
1	4.00	***	
0	5.00		
2	6.00	*****	
2	7.00	*****	
2	8.00	*****	
18	9.00	*****	

I	I	I	I	I	I
0	4	8	12	16	20

HISTOGRAM FREQUENCY

VALID CASES 26 MISSING CASES 3

Q17 The nurses talk to me

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.40 OCCURRENCES
1	4.00	***	
1	5.00	***	
3	6.00	*****	
1	7.00	***	
3	8.00	*****	
17	9.00	*****	

I	I	I	I	I	I
0	4	8	12	16	20

HISTOGRAM FREQUENCY

VALID CASES 26 MISSING CASES 3

Q22 The nurses have time for discussion

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.40 OCCURRENCES
2	3.00	*****	
0	4.00		
2	5.00	*****	
2	6.00	*****	
1	7.00	***	
5	8.00	*****	
11	9.00	*****	

I	I	I	I	I	I
0	4	8	12	16	20

HISTOGRAM FREQUENCY

VALID CASES 23 MISSING CASES 6



As described p134, the outcome criterion used in the PQRST 'helpful/ not helpful' derived from a range of scores representing 'no help' via 'a little help' to 'very considerable help'. A score of nil means 'no help' and scores 1-4 therefore comprise the 'least helpful' end of this range. For the purpose of analysis the scores of 4 or less for each statement were considered to be 'unhelpful'. This distinction between helpful and unhelpful requires qualification, because it is not strictly accurate to characterise the less helpful end of this scale as 'unhelpful' for two reasons. Firstly, because un-adjectives like this tend to have a negative meaning, which implies the nurses were actively un-helpful (the data did not suggest this). Secondly, it could be argued that a little help is a lot better than no help at all (a point referred to by the carers). This reservation about the interpretation of the findings should be borne in mind as one reads the analysis.

#### More complex relationships within the data

In addition, therefore, to looking at the answers to individual questions then, scores of 0-4 were considered 'unhelpful' and scores of 5-9 as helpful; scores were also subdivided into three. The Chi-square technique was then used, to test for statistical significance of the frequency counts of scores within the above groups. In relation to these, male and female patients, attributes of the individual nurses and frequency of contact were tested to find out whether there were specific factors of the nurses or patients which affected helpfulness. Scattergrams were also completed for each item of the 'day care PQRST' to see whether frequency of contact was in any way related to helpfulness. In this study all associations below the .05 level of probability of occurring by chance (5%) were considered significant (different probability levels are therefore not cited in the text). The only associations that emerged as significant were in relation to the statements 'The nurses take an interest in me' and 'I made friends through the day centre' (see Figure 11, p210). No other significant associations were found.

Figure 11. Sample of SPSSX output file showing significant crosstabulations

FILE: PATIENT DAY CENTRE QUESTIONNAIRE: EAST PATIENTS, AUTUMN 1984

Q1 I made friends through the day centre BY EXPERIENCE PAGE 1 OF 1

COUNT	EXPERIENCE					ROW TOTAL
	Longest trained	2.00	3.00	6.00	7.00	
1 Unhelpful						
2	2	1				3 16.7
3		2	4	3	4	15 83.3
COLUMN TOTAL	2	3	4	3	4	16
	11.1	16.7	22.2	16.7	22.2	11.1
						100.0

CHI-SQUARE D.F. SIGNIFICANCE MIN E.F. CELLS WITH E.F.< 5  
 13.19999 5 0.0216 0.333 12 OF 12 (100.0%)  
 NUMBER OF MISSING OBSERVATIONS = 11

Q8 The nurses take an interest in me BY EXPERIENCE PAGE 1 OF 1

COUNT	EXPERIENCE						ROW TOTAL
	Longest trained	1.00	2.00	3.00	6.00	7.00	
1 Unhelpful	3						3 11.1
2	1	1		1	2		5 18.5
3	1	4	4	4	4	2	19 70.4
COLUMN TOTAL	5	5	4	5	6	2	27
	18.5	18.5	14.8	16.5	22.2	7.4	100.0

CHI-SQUARE D.F. SIGNIFICANCE MIN E.F. CELLS WITH E.F.< 5  
 17.73473 10 0.0596 0.222 18 OF 18 (100.0%)  
 NUMBER OF MISSING OBSERVATIONS = 2

### *Home Visiting PQRST*

The items in the 'home visiting PQRST', in Appendix 4, obtained from the pilot study (see p140), are predominantly nurse focused. Looking at the content of the individual items in the 'home visiting' questionnaire there are far more nurse focused statements than ones relating to the visiting situation. The 'nurse focused' statements relate to the patients' perception of: the nurse's manner, what the nurse does, and the effect that the nurse has on the patients. The patients saw the nurse visiting as a patient orientated service, as indicated by the absence of statements referring to family involvement.

#### **The Respondents**

Both 'East' and 'West' patients completed 'home visiting PQRST'.

Nineteen 'East' patients were approached and invited to complete the 'home visiting PQRST'. Eleven consented and the remaining patients were unable to respond because of dementia.

Of the twenty-eight 'West' patients approached, twenty three completed the 'home visiting PQRST'. Four elderly patients refused and one was unable to do the procedure. During the preliminary period of observation (see Figure 2, p95), it was noted that the community psychiatric nurses from West Hospital did not work from a day centre base. In view of the limited number of 'East' patients visited at home, it was thought that it would be useful to gain more data on the 'home visiting' and the community psychiatric nurses.

#### **The Results**

The answers to the statements were analysed using descriptive statistics, in the same manner as above (see p209). Table 4, p212, summarises the percentage of patients who agreed with the statements in the 'home visiting PQRST'. Examination of Table 4 gives an insight into how the care given at home by the community psychiatric nurses was perceived. This is elaborated on in the text below.



Table 4: Percentage of patients who agreed with (in 'yes' column) statements in the 'home visiting' PQRST and percentage with scores of four or less, for 'East' and 'West' patients. Absolute numbers in brackets.

Summary of PQRST Statements	% of patients			
	YES		Score of four or less	
	East	West	East	West
* SAME NURSE VISITS ALL THE TIME	72 (8)	78 (18)	0 (-)	8 (2)
* YOU GET TO KNOW THE NURSE	91 (10)	83 (19)	0 (-)	8 (2)
* THE NURSE TAKES AN INTEREST	91 (10)	87 (20)	9 (1)	8 (2)
* THE NURSE CRACKS JOKES	64 (7)	52 (12)	18 (2)	13 (3)
* THE NURSE IS PATIENT	73 (8)	91 (21)	0 (-)	17 (4)
* I'M NOT FORGOTTEN	91 (10)	87 (20)	18 (2)	4 (1)
* THE NURSE IS ATTENTIVE	91 (10)	96 (20)	0 (-)	8 (2)
* THE NURSE IS CHEERFUL	91 (10)	91 (21)	0 (-)	8 (2)
* THE NURSE CARES	100 (11)	83 (19)	18 (2)	13 (3)
* THE NURSE ASKS HOW I'M KEEPING	100 (11)	91 (21)	18 (2)	21 (5)
* A RELATIONSHIP HAS DEVELOPED	55 (6)	74 (17)	9 (1)	13 (3)
* I KNOW THE NURSE'S CIRCUMSTANCES	37 (4)	48 (11)	9 (1)	26 (6)
* I CAN TALK TO NURSE CONFIDENTIALLY	64 (7)	83 (19)	0 (-)	4 (1)
* THE NURSE HAS OTHER QUALIFICATIONS	91 (10)	91 (21)	0 (-)	26 (6)
* THE NURSE BRINGS THINGS I NEED	18 (2)	35 (8)	9 (1)	13 (3)
* THE NURSE TALKS TO ME	91 (10)	87 (20)	9 (1)	0 (-)
* I CAN TRUST THE NURSE	91 (10)	87 (20)	0 (-)	8 (2)
* THE NURSE HAS A CUP OF TEA	55 (6)	57 (13)	27 (3)	17 (4)
* THE NURSE LOOKS AROUND	18 (2)	26 (6)	0 (-)	17 (4)
* THE NURSE TAKES BLOOD	64 (7)	13 (3)	0 (-)	0 (-)
* THE NURSE GIVES ME MEDICATION	55 (6)	26 (6)	0 (-)	13 (3)
* THE NURSE VISITS REGULARLY	82 (9)	74 (17)	18 (2)	13 (3)
+ INFORMALITY OF HOME VISITS	82 (9)	56 (13)	0 (-)	8 (2)
+ THERE IS NO WAITING AT THE HOUSE	91 (10)	65 (15)	18 (2)	4 (1)
+ IT IS CONVENIENT AT THE HOUSE	100 (11)	78 (18)	0 (-)	4 (1)
+ I AM TREATED AS AN INDIVIDUAL	91 (10)	70 (16)	9 (1)	4 (1)
+ THE NURSE CAN CONCENTRATE ON ME	91 (10)	65 (15)	0 (-)	8 (2)
+ I CAN TALK MORE OPENLY AT HOUSE	73 (8)	65 (15)	0 (-)	0 (-)
+ NURSE VISITS ON A FRIENDLY BASIS	91 (10)	74 (17)	0 (-)	4 (1)
+ HOME VISIT BETTER IDEA OF ME	82 (9)	83 (19)	10 (1)	21 (5)

n=11 ('East' patients); n=23 ('West' patients)

KEY: \*: nurse focused statements  
+: situation focused statements

Table 4 also shows the percentage of patients who scored four or less for each statement i.e. considered that statement to be of little or no help (although bear in mind here the comments p209).

Looking at the frequency counts of the scores 0-9, the distribution of the scores was negatively skewed (see Figure 12, p214). All the items were viewed as 'helpful' by most patients, in both the areas studied.

**'East' and 'West' patients:**

There was 100% agreement by all 'East' patients that the nurses 'cared' and 'asked how the patient was keeping'; this concern for the patients' welfare was less unanimously agreed on by the 'West' patient respondents. A similarly high proportion of 'East' and 'West' patients agreed that the nurse's manner suggested that he was 'interested, attentive, and cheerful'. The nurse was also seen to 'crack jokes'; a large proportion of patients did 'not feel forgotten'.

The nurse being cheerful and cracking jokes was perceived as being helpful by a large number of patients. This suggests that the patients perceived the nurses as 'cheering up' the patients and this was experienced as beneficial.

A large proportion of patients agreed that in the home situation the nurse focused specifically on them and they considered the visits to be more convenient. The nurses were perceived as doing varied activities: 'talking, having cups of tea, looking around the house, taking blood and giving medication' and for similar proportions of patients. West Hospital was different in that the nurses did not take blood; the nurses based in East Hospital gave medication to a higher proportion of patients.

Figure 12. Sample of SPSSX output showing skewed frequency distributions

FILE: PATIENT HOME VISITING QUESTIONNAIRE:EAST PATIENTS, AUTUMN 1984

Q39 You get to know the nurse

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.10 OCCURRENCES
2	5.00	*****	
0	6.00		
1	7.00	*****	
2	8.00	*****	
5	9.00	*****	

I.....I.....I.....I.....I.....I

HISTOGRAM FREQUENCY	VALID CASES	MISSING CASES
0	10	1

Q40 The nurse takes an interest

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.10 OCCURRENCES
1	2.00	*****	
0	3.00		
0	4.00		
2	5.00	*****	
1	6.00	*****	
1	7.00	*****	
3	8.00	*****	
2	9.00	*****	

I.....I.....I.....I.....I.....I

HISTOGRAM FREQUENCY	VALID CASES	MISSING CASES
0	10	1

Q46 The nurse cares

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.20 OCCURRENCES
1	3.00	*****	
1	4.00	*****	
1	5.00	*****	
0	6.00		
0	7.00		
2	8.00	*****	
6	9.00	*****	

I.....I.....I.....I.....I.....I

HISTOGRAM FREQUENCY	VALID CASES	MISSING CASES
0	11	0

Q49 I know the nurse personal circumstances

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.10 OCCURRENCES
1	3.00	*****	
0	4.00		
1	5.00	*****	
2	6.00	*****	

I.....I.....I.....I.....I.....I

HISTOGRAM FREQUENCY	VALID CASES	MISSING CASES
0	4	7

Q50 I can talk to the nurse in confidence

COUNT	VALUE	ONE SYMBOL EQUALS APPROXIMATELY	.10 OCCURRENCES
1	5.00	*****	
1	6.00	*****	
1	7.00	*****	
1	8.00	*****	
3	9.00	*****	

I.....I.....I.....I.....I.....I

HISTOGRAM FREQUENCY	VALID CASES	MISSING CASES
0	7	4



Almost 40% of 'East' patients and almost 50% of 'West' patients reported that they 'knew the nurse's circumstances'. A high number of patients in both areas agreed that they 'got to know the nurse', a lower number of 'East' patients agreed that 'a relationship had developed' between the nurse and patient. A very high proportion of patients said that they could trust the nurse but it is unclear what the nurses could be trusted with; this proportion did not tally with the proportion that agreed that the nurse can be talked to in confidence. It is perhaps a surprising finding that these proportions were not similar; it is also surprising that 'talking to the nurses confidentially' was not considered to be helpful by 36% of 'East' patients.

The data of both 'home visiting' PQRSTs were examined to look at more complicated relationships in the data (see above p209). No significant associations were found using the Chi-Square Test. There was a definite pattern in the West Hospital data: the scattergrams of scores on helpfulness and frequency of visits (these were calculated by counting the number of kardex entries per patient: see p102) showed that the data tended to be concentrated in the top left hand corner of the plot (see Figure 13: p216).

*Patient perception of day care compared with home visiting.*

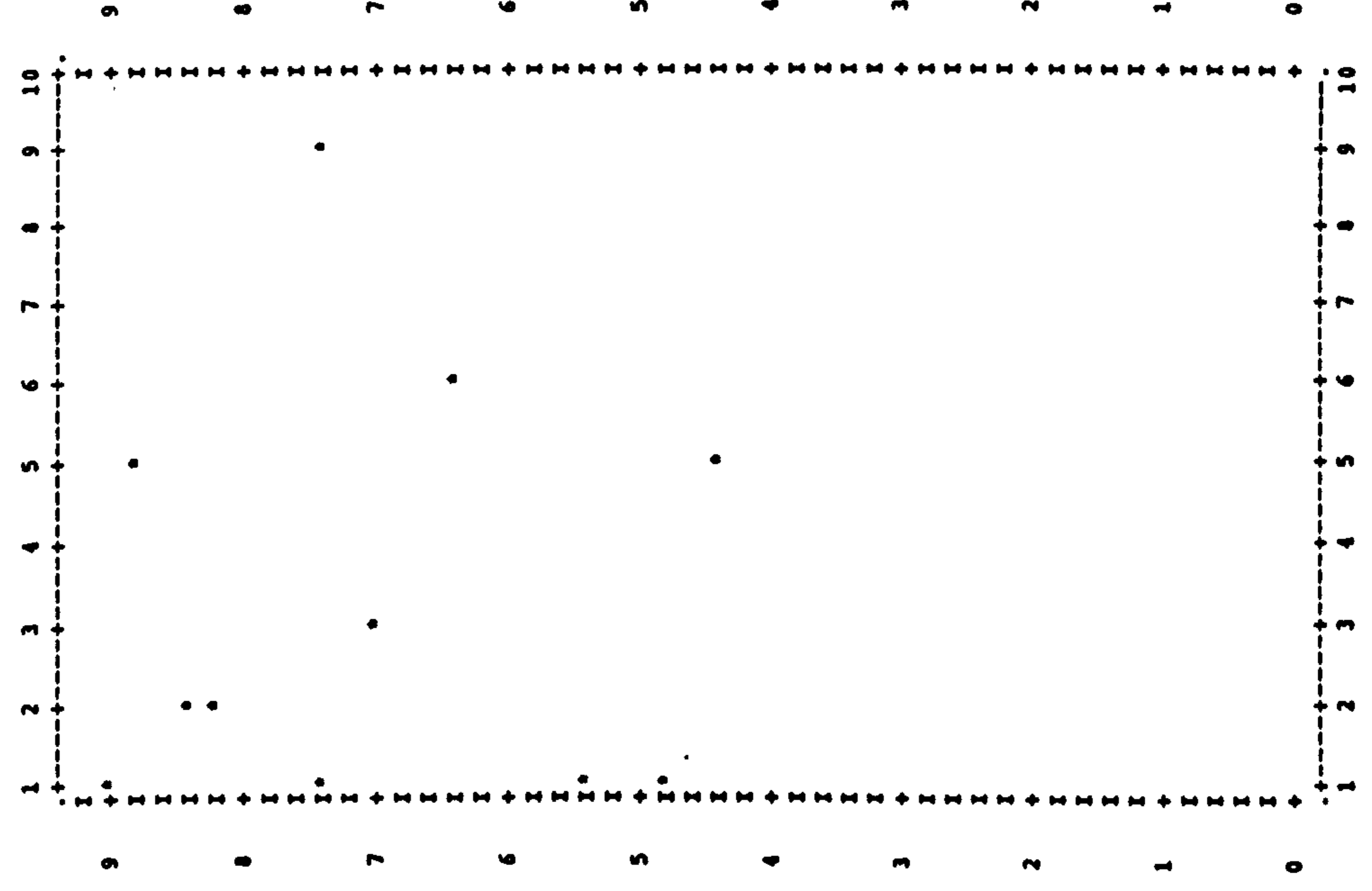
It is worth taking the opportunity to compare the contents of the 'day care' and 'home visiting' PQRSTs and making some comments on the statements used in them. The obvious difference of course is that the 'day care' PQRST contains statements relating to the patients, confirming the fact that the some patients find some of this contact helpful.

Nurses in both settings are perceived to take an interest and demonstrate care and concern. There is more emphasis in the 'day care' PQRST on statements which refer to helping the patient change, e.g. 'The nurses delve into the past' and 'The nurses let me see things differently'. The 'home visiting' PQRST emphasises the friendly relationship developed with the nurse e.g. 'The nurse visits on a friendly basis' and 'I know the nurse's circumstances'.

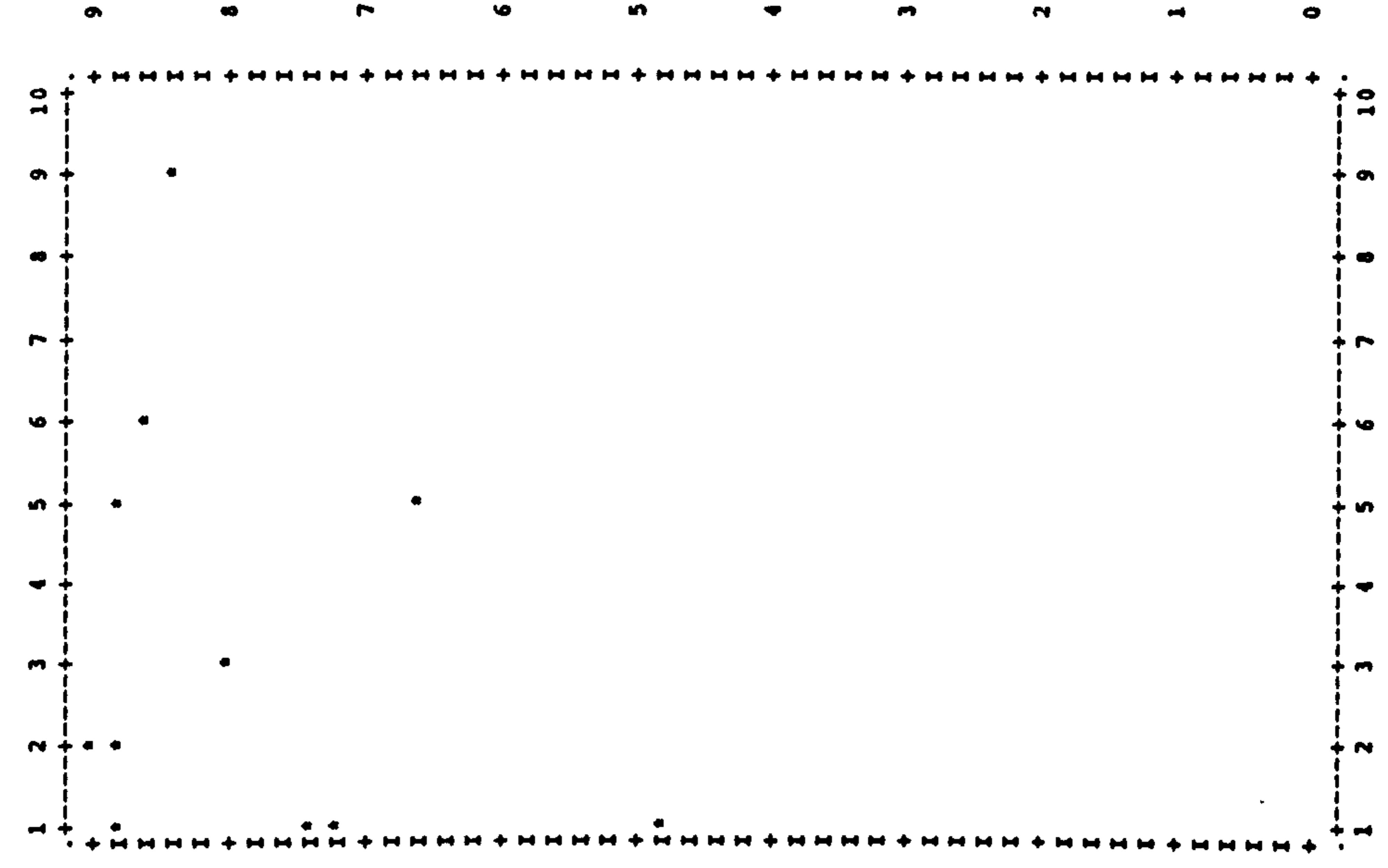
Figure 13. Sample of SPSSX scattergram output

FILE: PATIENT HOME VISITING QUESTIONNAIRE (EAST) AUTUMN 1984

DOWN: Nurse-focused statements ACROSS: Frequency of visits



DOWN: Situation-focused statements ACROSS: Frequency of visits



Each star represents the average score across all the questions for each respondent

## *Discussion of the findings*

### *'The Day care' PQRST*

Craig (1978) completed a study on day care and commented:

This data shed no light on the actual quality of care provided for any one patient, its appropriateness, the importance or otherwise of maintenance of family and community supports for a patient or the removal or non removal of burden on family or community agencies.

Craig (1978) p91)

In contrast, the responses from the patients in the present study using the 'day care' PQRST do shed some light on the patients' perception of care, and on the quality of care given by the East Hospital community psychiatric nurses who ran the day centres. These responses are now discussed.

The majority of the statements in the 'day care PQRST' were 'nurse focused'. Some of the statements classified as 'patient focused' could be judged as 'nurse focused', e.g. 'I made friends at the day centre' or 'I have company at the day centre': on first reading these appear to be related to the patients at the day centre, but it could be the case that the statements also related to the nurses. The items show that the patients talked about the community psychiatric nurses in the plural, not about specific nurses. It must be acknowledged that the answers refer to judgments about contacts with several community psychiatric nurses and may be undervaluing the helpfulness of individual community psychiatric nurses, although the converse is also true.

The fact that so many of the statements referred to the nurse and that such a high percentage of patients found that the nurse taking an interest, giving support, talking to patients, caring, and asking about how the patients feel was helpful suggests that the nurse being at the day centre was important. In the absence of a comparison group however, it is impossible to know whether the nurses added something different compared to a day centre run by



another profession or group. The nurses did not just 'talk' to the patients; there is evidence from the patient responses that the nurses' conversations were seen as helping patients look at their situations differently, and that most of these found this helpful; 41% agreed that the nurses 'delted into the past' and many found this helpful.

The responses from the patients suggest that the day care service was seen as a place where they could discuss psychiatric matters, as the statement 'The nurses ken about me' suggests. This could also be implied from the statement 'the nurses have special qualifications'. The answers to the statement 'People worse off at the day centre' suggest that this aspect of the day centre was seen to be unhelpful by 41% of the patients. 20% of the patients however were not helped by 'meeting others with similar troubles'; perhaps the fact that more patients were helped by meeting others with similar problems suggests that this could be a guide for future service development.

Different patients received different care at the day centre, e.g. group work, playing games, or keeping busy and these factors of the day centre were perceived differently. It is regretted that further details about these patients (e.g. type and length of illness, etc.) were not collected, to find out what patient attributes are linked with this different perception of the community psychiatric nurses' helpfulness.

It will be remembered that the scores given by the patients were divided artificially for the purpose of analysis into helpful and unhelpful; this distinction should be interpreted with care. More weight should be attached to the patients' comments about helpfulness. For the patients' comments on 'un-helpfulness' or 'lack of help' one is left wondering whether the nurses were rated as such because the patient had no particular problem in the area of enquiry (for instance: p206: 34% of patients did not rate making their own way to the day centre as helpful, perhaps because they had no difficulty in the area of 'getting about').

The day centre was seen by half the patients to have 'a nice atmosphere', to be a 'place to go', 'to be kept busy', by half not. Most of the patients found these aspects of the day centre helpful, although some did not. A high percentage of patients found the nurses' talking and caring to be helpful. It could be argued that it was this aspect of the day centre that kept patients attending.

The least experienced nurses in community work who took an interest were more likely to be perceived as helpful and were more likely to help patients make friends. It is difficult to know whether this finding really does mean that the nurses with less experience in community work are more helpful. It could well be, other attributes of the lesser experienced nurses that made them more helpful. This finding has face validity however: one of the risks of emotionally demanding work is that there is a danger of developing the 'burnout syndrome'; some of the symptoms include "reduction of time spent with patients, reduced availability for discussion and the professional becomes less caring, more controlling and less feeling" (Hume and Pullen 1986).

#### *'Home visiting PQRST'*

#### The views of 'East' and 'West' patients compared

For both 'East' and 'West' patients, the manner of the nurse, e.g. 'caring, taking an interest, asking how the patient is keeping and making the patient feel not forgotten' all are statements which suggest that the patients see these attributes of the nurses as helpful. This finding provide support for the work of Rogers (1957), who suggests that empathy, warmth and genuiness are crucial facilitating conditions in therapy.

The nurse being cheerful and cracking jokes was perceived as being helpful by a large number of 'East' and 'West' patients. This suggests that the patients perceived the nurses as 'cheering up' the patients and this was experienced as beneficial. It would be interesting to relate this finding to patient data and see if this behaviour was differently perceived by patients with varied diagnoses.

The nurses were perceived as doing different activities: 'talking, having cups of tea, looking around the house, taking blood and giving medication'. It is unclear whether these differences are to do with varied needs of patients or because the nurses organised their work differently. Based on the preliminary observations and interviews with the nurses, the latter interpretation may be relevant: the nurses based at West Hospital did not take blood; the nurses from East Hospital seemed more involved in medication giving activities, a conclusion supported by the finding that a higher proportion of 'East' patients reported receiving medication.

Half 'East' and 'West' patients 'had cups of tea' with the nurses and found this helpful. This does raise the question of whether or not this was helpful because of the talk that went along with this, or if it was the company and social interaction that was seen to be helpful. If it was the latter it could be argued that another person, other than a nurse, could carry out this activity. Patients reported the nurses as special: they were seen to have 'qualifications in helping others' and be 'caring'. Without comparative data, e.g. finding out what different professionals do during home visits, or finding out how patients perceive other professionals it is unclear what 'nursing' *per se* brings to the care of patients. Peplau (1960) argued that the nurse/patient relationship is different from a friendship relationship and said that in the latter "social chit chat is replaced by the responsible use of words which help to further the personal development of the patient" (Peplau 1960). With these comments in mind, the finding



that almost 40% of 'East' patients and almost half of 'West' patients agreed that they 'knew the nurse's personal circumstances' is noteworthy. Although it is not entirely clear what this means, the suggestion is that the nurses share personal information about themselves with the patients. Peplau (1960) has commented that :

The nurse's biographical data is a burden to the patient who has no recourse but to translate the nursing situation into a social, chum-like one.  
(Peplau (1960), p965).

Contrary to this comment, almost all the patients in the present study, who did share the nurse's personal circumstances, found this helpful. One cannot help but wonder why this was helpful, e.g. was the nurse seen as a substitute friend? The strong agreement found to the statement 'the nurse visits the home on a friendly basis' suggests this may be the case, and points to the importance of this aspect of the nurse/patient relationship (see p36). One also wonders why the nurses shared information with some patients and not others. These features of the patient/community psychiatric nurse contact must be explored further.

A high number of 'East' and 'West' patients agreed that they 'got to know the nurse', yet a lower number of 'East' patients agreed that 'a relationship had developed' between the nurse and patient. This suggests that patients see these factors as two different activities; the findings from discussions with the nurses suggest that nurses see these as similar. A very high proportion of patients said that they could trust the nurse, but it is unclear what the nurses could be trusted with; this proportion did not tally with the proportion that agreed that the nurse can be talked to in confidence. It is perhaps a surprising finding that these proportions were not similar; it is also surprising that 'East' patients did not consider 'talking to the nurses' to be confidential by 36%. Future work must be aimed at exploring what the patients understand by the words 'trust', 'confidentiality', and 'developing relationship'.

The scattergrams for each item for 'West' patients showed that there was a trend for increased helpfulness to be linked with increased visiting. This could be related to consumer feedback; i.e. the nurses more frequently visited patients from whom they received feedback that they were helpful. This would confirm the previous findings of Sladden (1979), where an association was found between the patient deteriorating and a decrease in visiting frequency by the nurses. It is unclear whether the patient's rating of helpfulness changes over time.

#### **Patients' views of day care compared with home visiting**

The 'caring' nature of the nurses was commented upon by both 'East' and 'West' patients and lends support to the importance of this in community psychiatric nursing work. There is more emphasis in the 'day care' PQRST on statements which refer to helping the patient change, e.g. 'the nurses delve into the past' and 'the nurses let me see things differently'. The 'home visiting' PQRST items emphasise the friendly relationship developed with the nurse, e.g. 'The nurse visits on a friendly basis' and 'I know the nurse's circumstances'. These differences represent differing views of 'East' patients, where the items for the PQRST were collected.

### 4:3 THE CARERS' VIEW OF THE SERVICE

One of the main interests of this study was to focus on the carers' perception of community psychiatric nursing, and their perception of help was the main outcome measure used in the study. The selection criteria for carer inclusion are detailed in section 3:4 p99-103. Carers of patients visited by the community psychiatric nurses of both East and West Hospitals used the family PQRST (for further details refer back to Chapter 3:5). These carers are referred to as 'East' and 'West' carers respectively.

This section consists of two parts. The first, begins with details about the carers who completed the PQRST. The findings for each area of data collection are then displayed, side by side where possible, to enable direct comparisons and to allow evaluation of the evidence of material differences between the two sets. The results for each section of the 'Family PQRST' are presented separately (see p138). More complex relationships within the data are then explored: helpfulness in relation to specific factors of the nurse or carers, and helpfulness in relation to frequency of visits. Discussion of the results then follows.

#### *The findings*

##### **The Respondents: 'East' Carers**

There were fifty-six carers available for inclusion in the study. Of these, eleven patients refused permission for the carer to be contacted (7:11 patients said that the community psychiatric nurse had not been in contact with their relative; despite this, relatives may nevertheless regard the community psychiatric nurse contact as helpful, but the patients still did not wish me to contact the carer). There were forty-five carers available to complete the questionnaire; of these, ten did not complete the questionnaire (3, one in his eighties, did not understand the task; 7 refused: 3 said they disliked forms although it became apparent



that they were unable to read or write; all the others said that the patient was well and had been for the past two years). From an original sample of 56 potential carers for inclusion in the main study, the final number available for analysis was smaller: thirty-five carers completed the questionnaire. As can be seen from Table 5, this figure was further reduced and only twenty-four carers completed all three sections of the questionnaire.

**Table 5: Number of 'East' carers who completed the PQRST**

35 carers attempted to complete the PQRST.

2:35 were unable to rate whether the nurse had helped or not

2:35 filled and rated PQRST 'patient problems' only.

7:35 filled and rated PQRST 'nurse aspects' only.

24 carers filled in the THREE sections of PQRST.

26 carers filled in PQRST about 'patient problems'

31 carers filled in PQRST about 'nurse aspects'

#### **The Respondents: 'West' carers**

There were twenty-eight carers available to complete the questionnaire. Four patients (all elderly), did not have any relatives or carers to whom the PQRST could be given. Three patients refused permission for me to contact their carer. Of the remaining twenty-one patients' carers, three were unable to complete the questionnaire - one carer had had a stroke, one did not speak English sufficiently well, one carer did not read or write - and one carer refused to do the PQRST. Seventeen carers remained available to complete the questionnaire. All respondents completed all three sections of the PQRST.

### Description of the carers

The relationship of the carers to the patients, is listed in Table 6. There were equal numbers of male and female 'West' carers, although slightly more 'East' carers were women. The largest single group of carers, in both areas, was 'husbands': 'East' carers comprised of three husbands in the elderly age group; all the 'West' carer/husbands were young. Most of the 'East' carer/daughters (8:11 'East' carers) and all 'West' carers were looking after aged relatives.

Table 6: Relationship of 'East' and 'West' carers to patients

'East' carers Total number	Relationship	'West' carers Total number
6	Mothers	4
1	Fathers	0
11	Daughters	2
1	Son	0
4	Wives	3
17	Husbands	11
4	Female friends	0
1	Male friend	0
TOTAL: 45	(Totals represent all the carers approached)	21

### Results

Using descriptive statistics one is able to gain some useful insights into the community psychiatric nursing contact with carers and the types of problems helped by this contact. To begin with, the findings from the first section, 'nurse aspects,' are detailed.

Table 7: Percentage of 'East' and 'West' carers who agreed (in 'yes' column) and disagreed (in 'no' column) with statements in 'NURSE ASPECTS' of Family PQRST. Absolute numbers in brackets

Summary of PQRST Items	% 'East' carers		% 'West' carers	
	NO	YES	NO	YES
CARER CAN CALL THE NURSE.	20 (7)	66(23)	18 (3)	65 (11)
CPN WILL VISIT IF SOMETHING IS WRONG	23 (8)	66(23)	6 (1)	76 (12)
MEETING ON MY TERRITORY IS BEST	71 (25)	17 (6)	47 (8)	41 (7)
THE NURSES ARE FREER	74 (26)	14 (5)	53 (9)	30 (5)
THE NURSE IS AN OUTSIDER	57 (20)	31(11)	47 (8)	41 (7)
THE CPN STAVES OFF RECURRENCE	63 (22)	26 (9)	35 (6)	47 (8)
THE CPN PREVENTS HOSPITALISATION	83 (29)	6 (2)	59(10)	24 (4)
CPN STOPS CARER SEEING A PSYCHIATRIST	83 (29)	6 (2)	65(11)	23 (4)
CPN ARRANGES DAY CARE	49 (17)	40(14)	77(13)	12 (2)
CPN ARRANGES ADMISSION	40 (14)	46(16)	59(10)	24 (4)
CPN ARRIVES UNANNOUNCED	51 (18)	37(13)	71(12)	19 (3)
HELPS THE CARER UNDERSTAND ILLNESS	34 (12)	51(18)	29 (5)	59 (10)
GIVES THE CARER BACKING	40 (14)	49(17)	35 (6)	47 (8)
CPN TELL CARER THEY ARE DOING OK	54 (16)	43(15)	47 (8)	41 (7)
MAKES THE CARER FEEL LESS ALONE	23 (8)	66(23)	35 (6)	53 (9)
CARER CAN SEE CPN ALONG WITH PATIENT	43 (15)	46(16)	24 (4)	65 (11)
CARER FEELS APPROACH CPN IF WORRIED	49 (17)	40(14)	53 (9)	28 (5)
CARER FEELS TALKS TO CPN RE ANYTHING	26 (9)	63(22)	24 (4)	65 (11)
CARER FINDS CPN EASY TO TALK TO	17 (6)	69(24)	18 (3)	71 (12)
PATIENT NEEDS TO TALK TO THE NURSE	72 (25)	11 (4)	65(11)	23 (4)
CPN COMES TO SEE THE PATIENT	31 (11)	54(19)	0 (-)	82 (14)
THE NURSE ASSESSES THE PATIENT	29 (10)	60(21)	29 (5)	59 (10)
CARER LEAVES PATIENT ALONE WITH CPN	74 (26)	11 (4)	59(10)	29 (5)
CPN CAN SAY TO PATIENT, CARER CAN'T	60 (21)	29(10)	53 (9)	35 (6)
THE PATIENT'S PRESENCE INHIBITS CARER	71 (25)	14 (4)	82(14)	6 (1)
CARER TALKING BEHIND PATIENT'S BACK	71 (25)	6 (2)	83(12)	6 (3)

Footnote: not all questions were answered by all the respondents

'East' carers: n = 35; 'West' carers: n = 17.



*'Nurse Aspects' section of Family PQRST:*

Table 7, p226, shows the percentage of carers who agreed and disagreed with the statements in the 'Nurse Aspects' section of the questionnaire, for both East and West Hospitals' community psychiatric nurses and the findings are presented in the text below.

**'East' carers**

These questions were universally scored positively (see Figure 14, p228). Most relatives found it particularly helpful, however, to be able to call the nurse and for the nurse to visit if something was wrong, suggesting that the service is seen as a specialist, crisis service. It is interesting however that not all carers felt that they were able to call the nurse, suggesting that there is selectivity as to whether the community psychiatric nurses make themselves available in this way.

Almost 70% of the carers found the community psychiatric nurse 'easy to talk to', in contrast however, 17% did not. 63% of the relatives felt they could talk to the community psychiatric nurse about anything; again in contrast with this, 25% of the sample did not feel they could talk to the community psychiatric nurse about anything. Judging by the content of most of the statements in this section, the service appears to have been perceived by relatives as a patient orientated service. Many of the statements however, did concern the carer, and 51% of carers considered that the community psychiatric nurses helped them understand the patient's illness and gave them backing; 66% of carers felt that the community psychiatric nurses made them feel that they were not alone: these could broadly be described as supportive functions of the community psychiatric nurse. The statement 'The nurse tells me I am doing OK' - 54% of the relatives disagreed with this, suggesting that this element of support by the community psychiatric nurse was not universally provided by the community psychiatric nurses, or at least not to all carers. The statement 'the nurse is an outsider' aroused disagreement in almost 60% of carers. 71% of the relatives disagreed with the statement 'Meeting on my territory is best'.

East carers

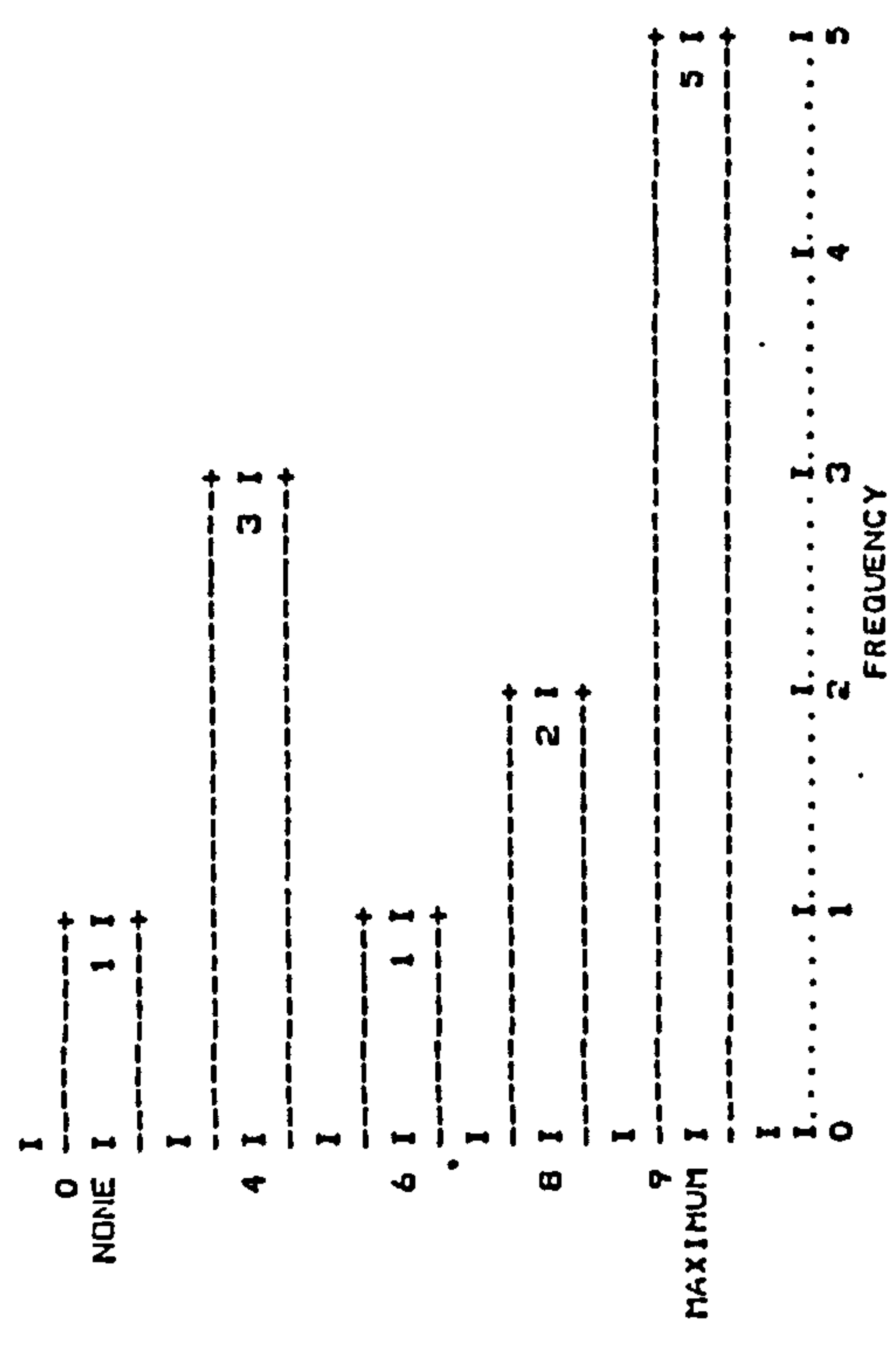
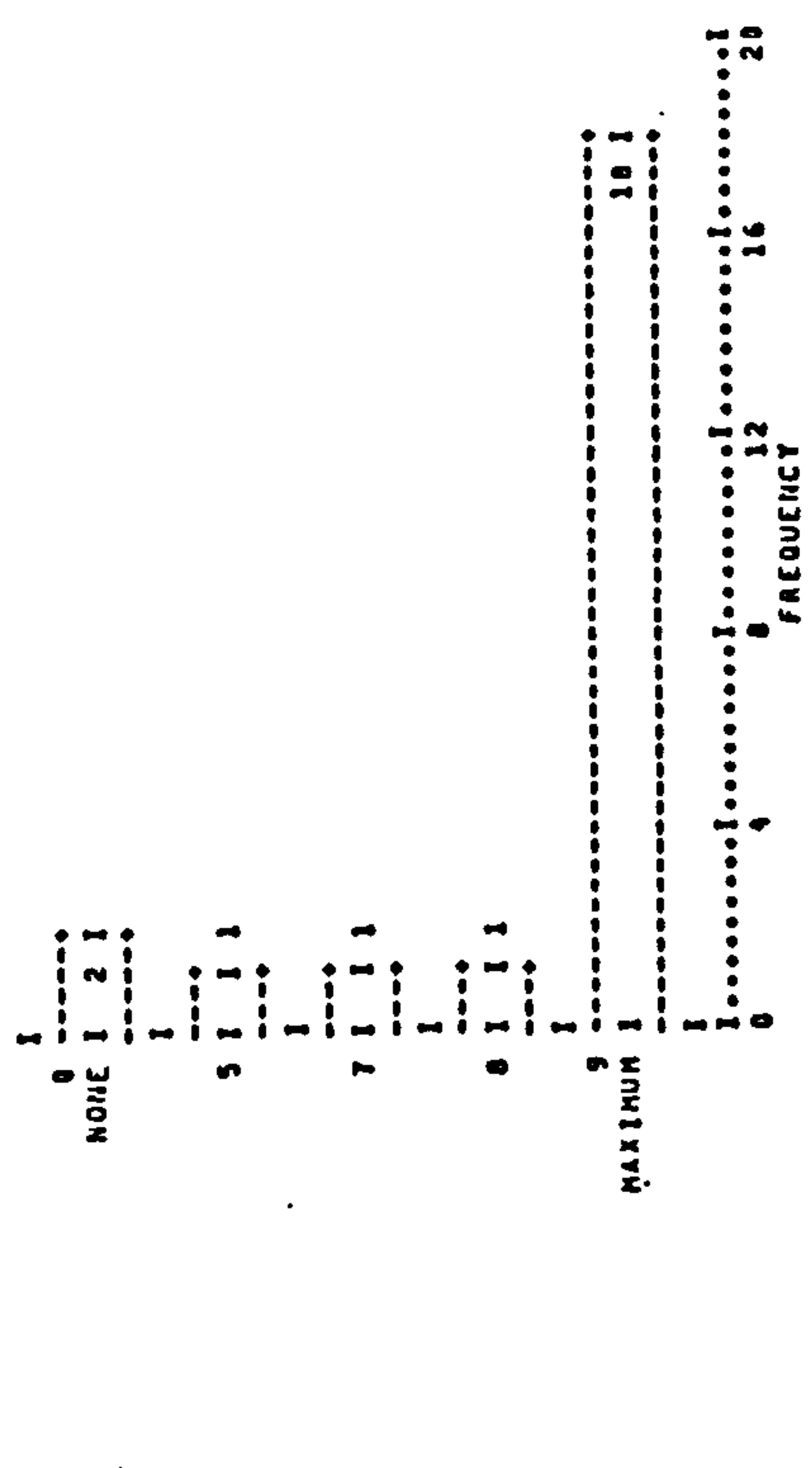
West carers

FILE:

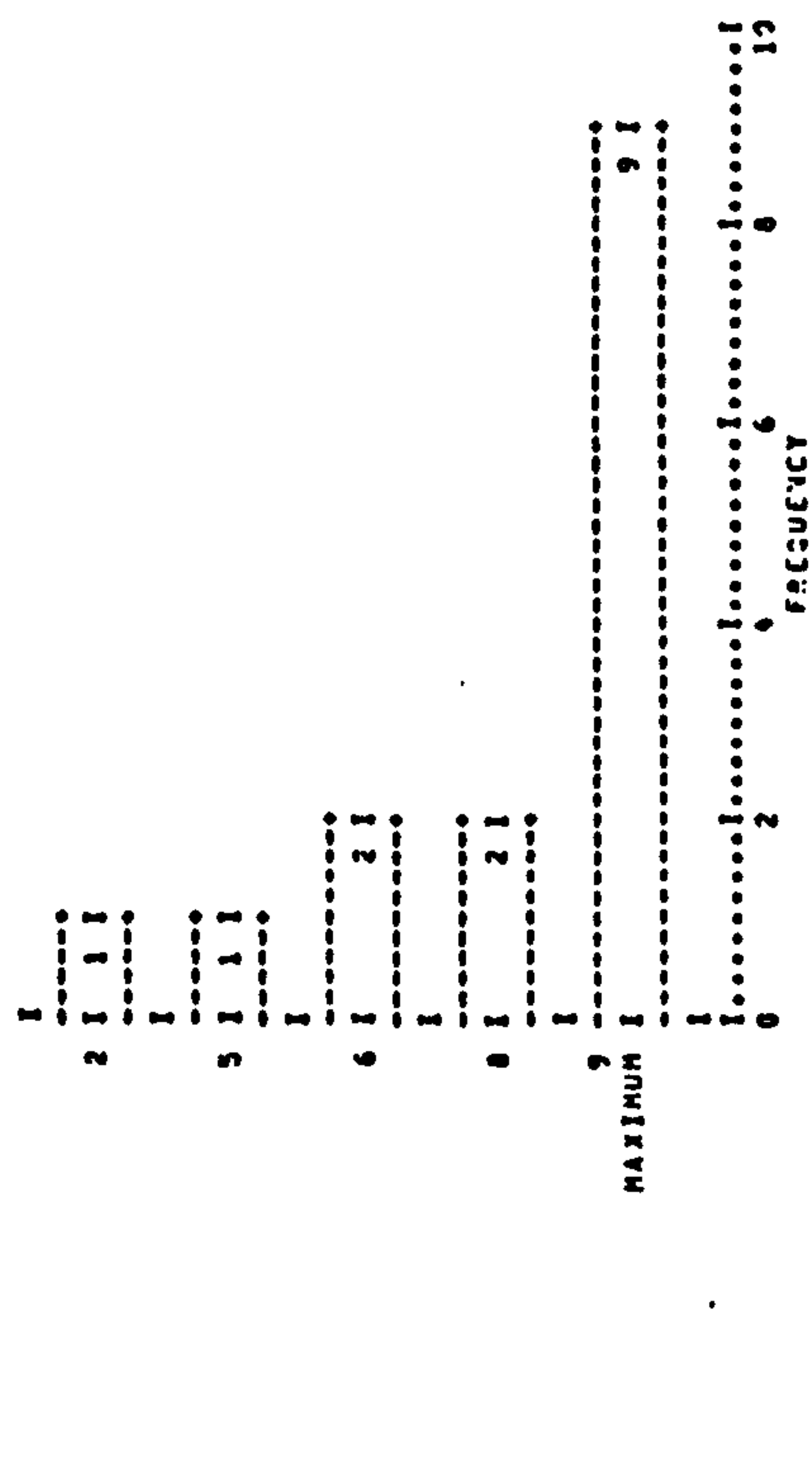
01 CAN CALL THE NURSE

Q15

NURSE IS EASY TO TALK TO



02 NURSE TELLS ME AM DOING OK



Q17 NURSE GIVES ME BACKING

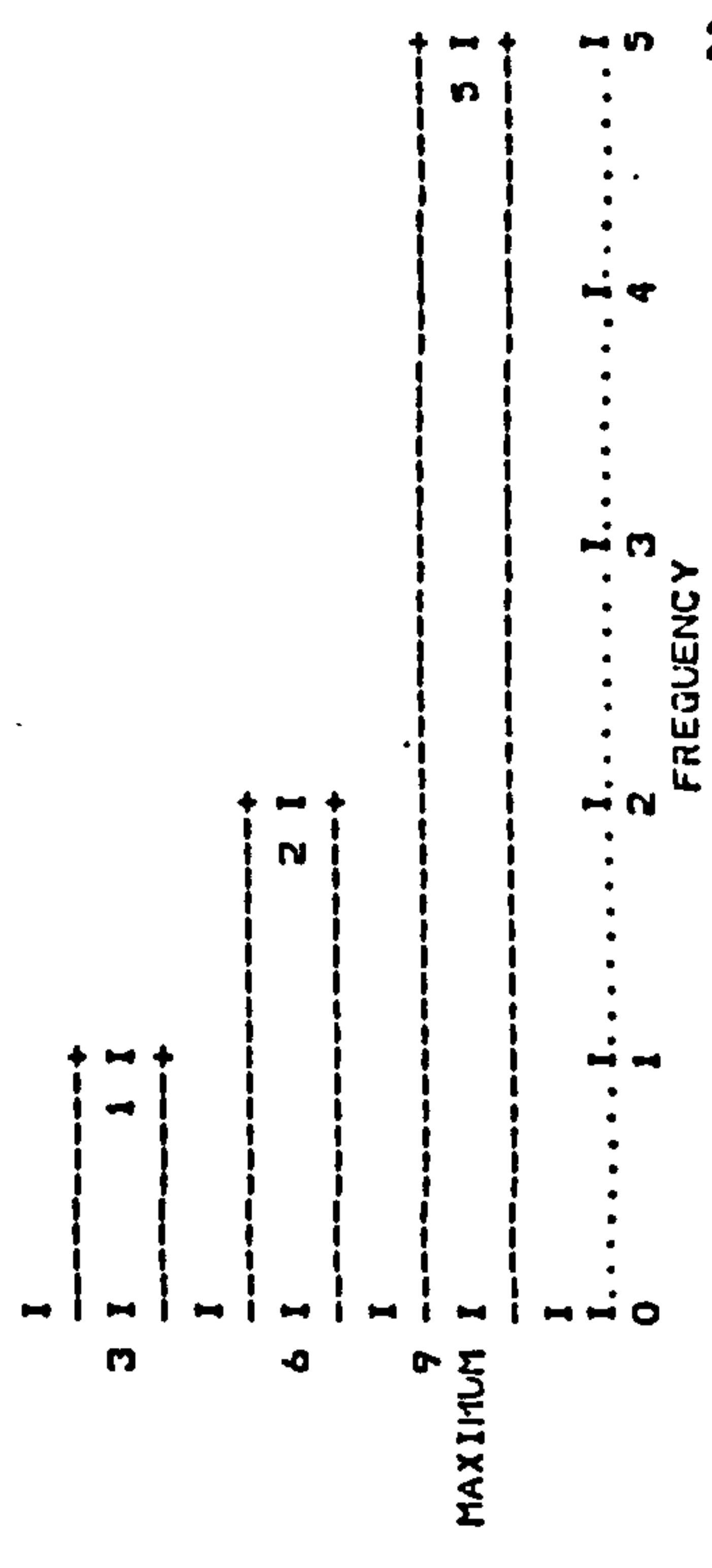


Figure 14: Showing skewed frequency distributions: Nurse Aspects PQRST

One of the rationales behind community psychiatric nursing practice is that community psychiatric nurses prevent patients from going into hospital (see p157). As far as the 'East' carers were concerned, 83% of the carers disagreed with this statement. 63% of the carers did not feel that the community psychiatric nurse contact prevented relapse or onset of illness. Almost half the carers who commented that the community psychiatric nurse arranged day care and hospital admissions considered these activities maximally helpful. Slightly more than half the carers had planned contacts with the community psychiatric nurse.

#### 'West' carers

Although less marked than in the East, there was a definite trend for the carers' answers to be rated positively (see Figure 14, p228). The findings for 'West' carers are elaborated below.

Almost 60% of carers did not think that the community psychiatric nurses prevented patient hospitalisation (compared with the previous findings, double the number of carers in this region considered the nurse *did* prevent hospital admission). Almost half the carers (47%) felt that the community psychiatric nurse contact prevented relapse. The community psychiatric nurses organised day care for only 20% of the carers and admission for 24% of the carers. A much higher percentage of carers in this region felt that 'meeting on my territory' was best and that the community psychiatric nurse was freer visiting at home.

65% of relatives felt they could call on the nurse and 76% felt the nurse would visit if anything was wrong; as for 'East' carers, both these aspects of community psychiatric nursing contact were considered particularly helpful. The percentage of relatives agreeing with the first statement was similar in both study areas; more 'West' carers agreed that the nurse would visit if anything was wrong; 'West' carers' scores were varied whereas 'East' carers rated the maximum possible.



The 'West' carers felt the community psychiatric nurses were supportive: almost 60% felt the community psychiatric nurses helped them understand the illness; almost 50% felt the community psychiatric nurses gave them backing and slightly more than this, 53%, felt that contact with the community psychiatric nurses made the carer feel less alone; 65% felt they could see the community psychiatric nurses while the patient was being visited; 65% felt they could talk to the community psychiatric nurses about anything and 71% that the nurse was easy to talk to. These results are similar to the feedback provided by 'East' carers.

Despite the patient orientation of the service (no 'West' carers disagreed that the nurse came to see the patient), only 29% of carers left the nurse alone with the patient and only 23% actually felt the patient needed to talk to the nurse. Almost 30% of relatives did not agree that the community psychiatric nurses assessed patients. 41% of carers saw the community psychiatric nurses as 'outsiders'.

#### *'Patient Problems' and 'Family Burden' PQRST findings*

##### **'East' carers**

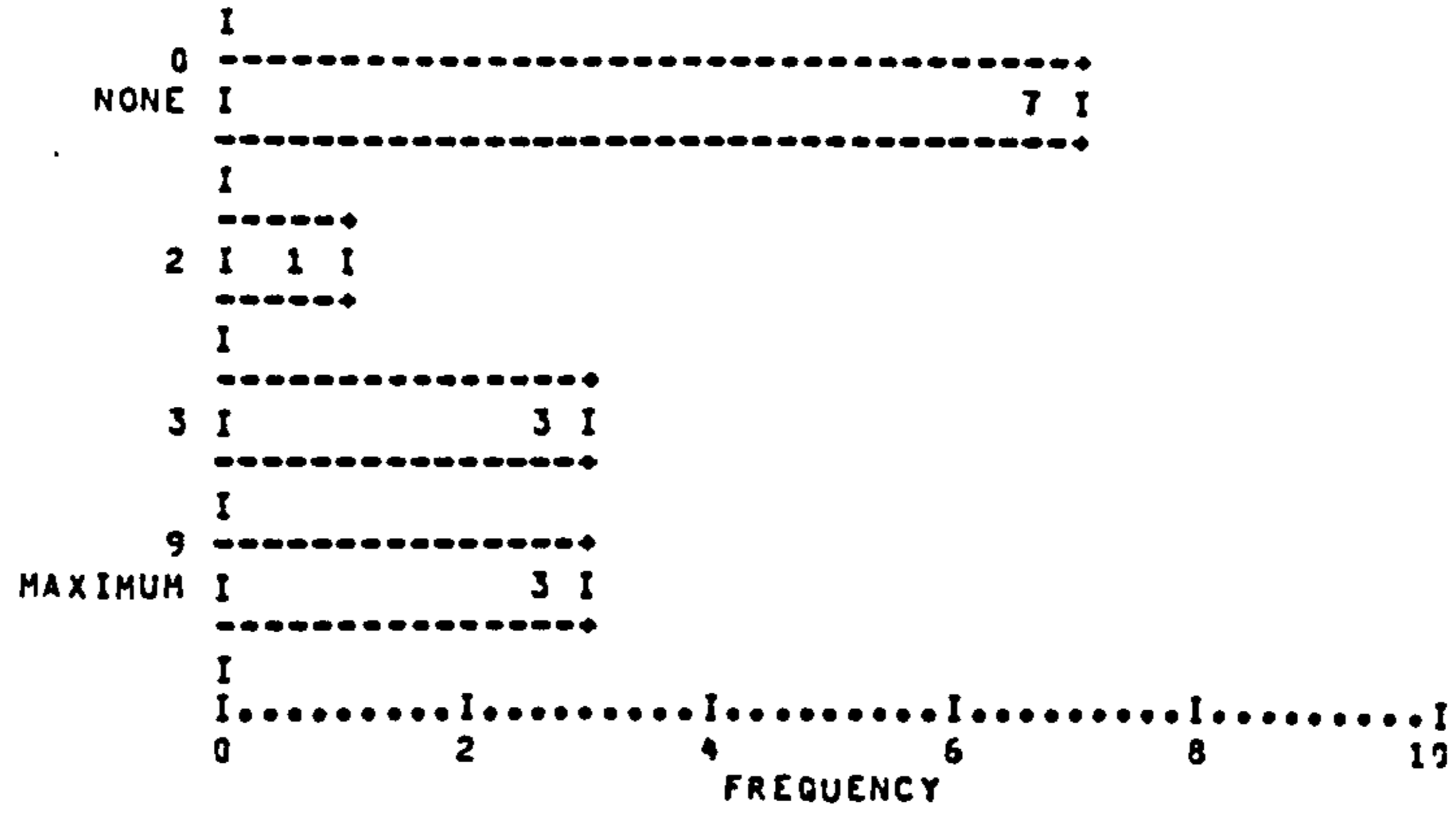
Taking individually each item of these sections of the PQRST, and using frequency counts of the scores of 0-9, the majority of the answers have a low score. The distribution of the scores shows a positive skew showing that the carers consider patient problems and family burden not to be helped, or helped little by contact with the community psychiatric nurse (See Figure 15, p231 which shows the scores in two of the items in the 'Patient problems' and 'family burden' PQRST, for 'East' carers). Closer examination of the frequency counts, reveals however, that for *certain questions* the trend was less marked - the responses were *polarised*. In other words, for *some* problems, *some* carers were helped, others not. (See Figure 16, p232). Tables 8-11 (pp233, 236, 238 and 240) list the different items of the 'patient problems' and 'family burden' PQRST and show which items had the polarised distribution (the remaining items showed a positive skew in the distribution of the scores).

046

NOT SAME PERSON I KNEW

Patient problems section

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	7	20.0	50.0	50.0
	2	1	2.9	7.1	57.1
	3	3	8.6	21.4	78.6
MAXIMUM	9	3	8.6	21.4	100.0
NOT RELEVANT	88	15	42.9	MISSING	
MISSING	99	6	17.1	MISSING	
	TOTAL	35	100.0	100.0	



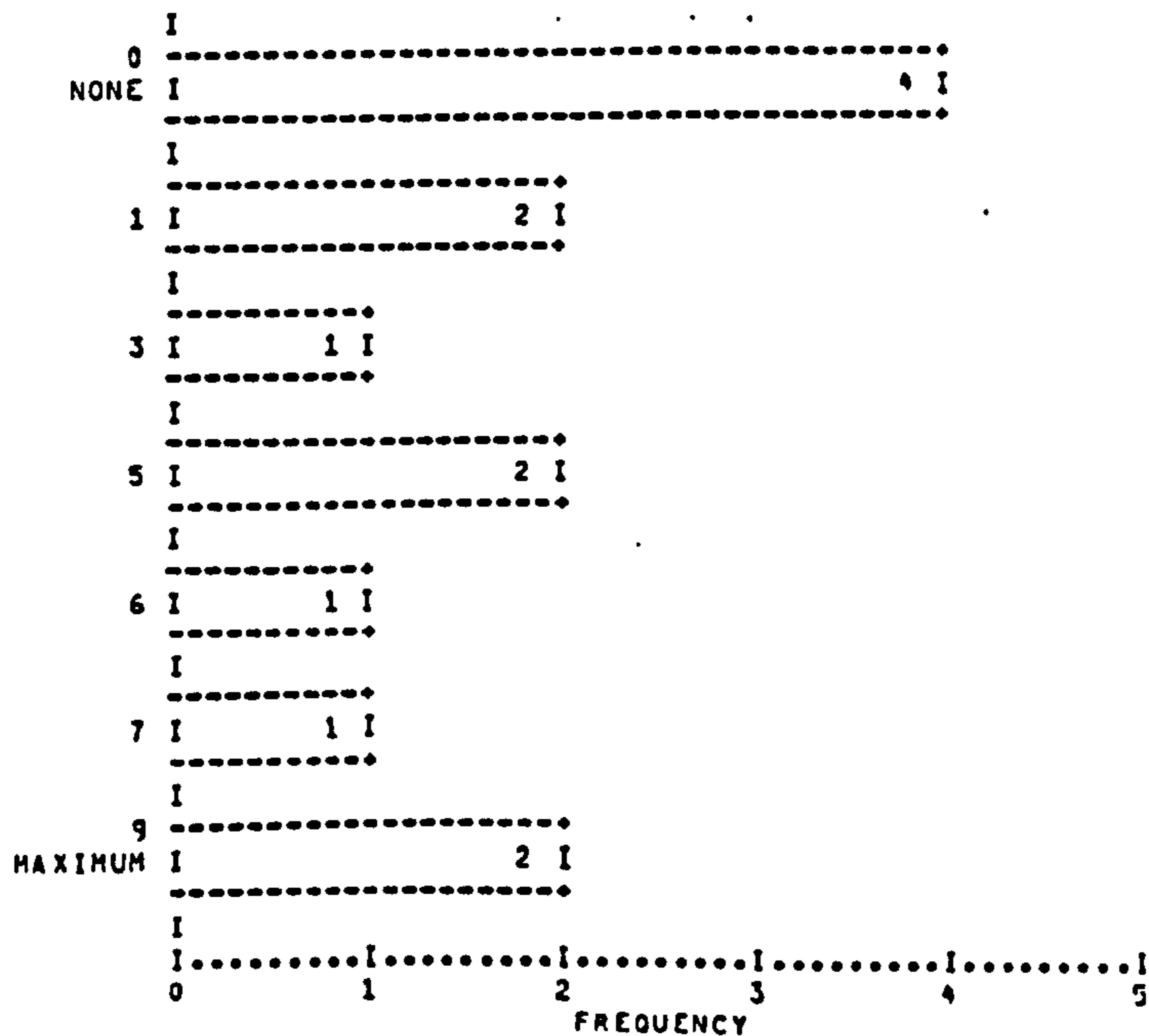
VALID CASES 14 MISSING CASES 21

059

I FEEL ON EDGE BECAUSE OF PATIENT

Family burden section

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	4	11.4	30.8	30.8
	1	2	5.7	15.4	46.2
	3	1	2.9	7.7	53.9
	5	2	5.7	15.4	69.2
	6	1	2.9	7.7	76.9
	7	1	2.9	7.7	84.6
	9	2	5.7	15.4	100.0
MAXIMUM	88	21	60.0	MISSING	
NOT RELEVANT	99	1	2.9	MISSING	
MISSING					
	TOTAL	35	100.0	100.0	



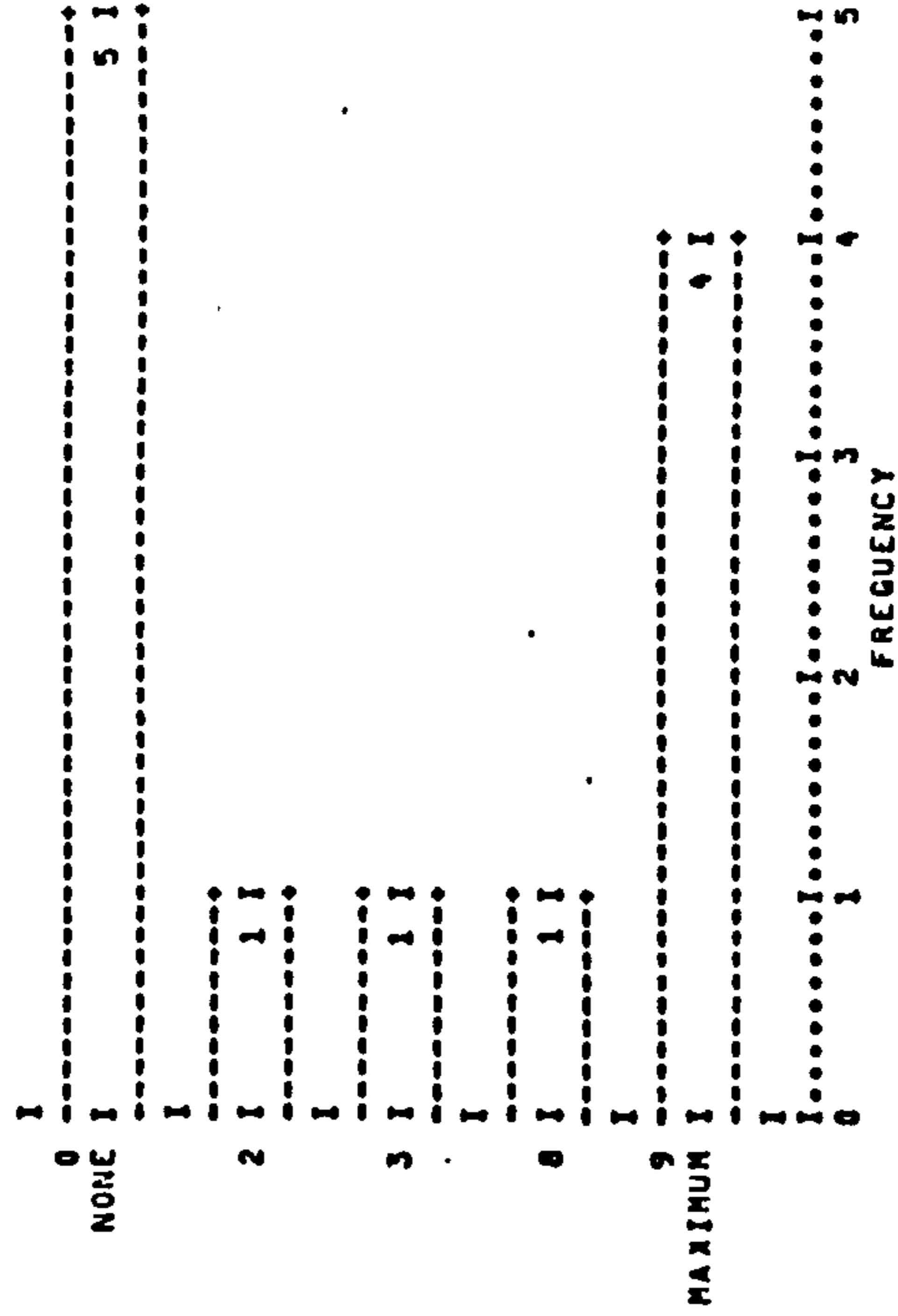
VALID CASES 13 MISSING CASES 22

Figure 15: Sample of SPSSX output showing low scores for items of PQRST, East carers

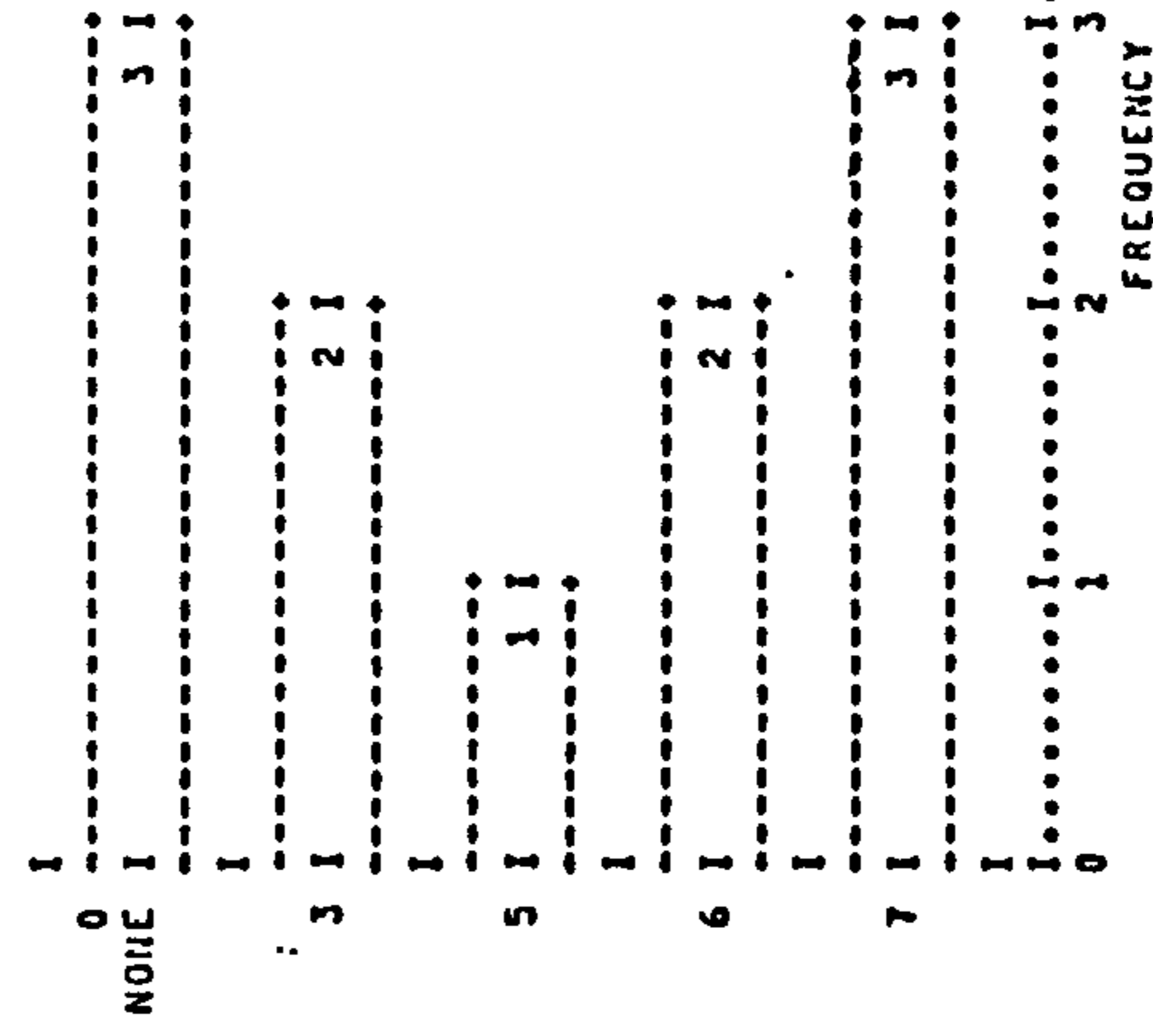
018 BEHAVES STRANGELY

036 STUBBORN

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT	VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	5	14.3	41.7	41.7	NONE	0	3	8.6	27.3	27.3
	2	1	2.9	8.3	50.0		3	2	5.7	18.2	45.5
	3	1	2.9	8.3	58.3		5	1	2.9	9.1	54.5
	8	1	2.9	8.3	66.7		6	2	5.7	18.2	72.7
	9	4	11.4	33.3	100.0		7	3	8.6	27.3	100.0
MAXIMUM	88	21	60.0	MISSING			88	17	48.6	MISSING	
NOT RELEVANT	99	2	5.7	MISSING			99	7	20.0	MISSING	
MISSING						TOTAL		35	100.0		



VALID CASES 12 MISSING CASES 23



VALID CASES 11 MISSING CASES 24

Figure 16: Sample of SPSSX output showing polarised distribution of scores: Patient problems PQRST, East carers



Table 8: Items in 'Patient problems' section of PQRST and percentage of 'East' carers who reported these problems.

Absolute numbers in brackets.

	INDECISION	63%	(22)
	PERSONALITY CHANGE	57%	(20)
*	STUBBORN	51%	(18)
*	DEMANDING CARERS COMPANY	49%	(17)
	UNPREDICTABILITY	46%	(16)
	FORGETFULNESS		} (15)
	KEEPS SELF TO SELF	43%	} (15)
*	BEHAVES STRANGELY	40%	} (14)
*	AGGRESSIVE TO CARER		} (14)
	CANNOT MANAGE MONEY	37%	(13)
	HYPOCHONDRIASIS		} (12)
	CANNOT COPE WITH DHSS	34%	} (12)
*	GETS INTO ARGUMENT AT HOME	31%	} (11)
	CANNOT BE LEFT ALONE		} (11)
	EATS TOO MUCH/TOO LITTLE	31%	} (11)
	POOR HYGIENE	29%	(10)
	DISTURBS CARER AT NIGHT		} (9)
	HIDES WHAT FEELING	26%	} (9)
*	HAS ODD IDEAS		} (8)
	OVERTALKATIVE	23%	} (8)
	NEEDS HELP WITH DRESSING		} (7)
	IS INCONTINENT	20%	} (7)
	REFUSES MEDICATION		} (6)
	LACKS INSIGHT	17%	} (6)
	WANDERING		} (6)
	SUICIDAL	14%	(5)
	SMOKES ALL THE TIME	12%	(4)
	AGGRESSIVE OUTSIDE THE HOUSE		} (2)
	DRINKS TOO MUCH	6%	} (2)
	ARGUMENTS WITH NEIGHBOURS	3%	(1)

n = 35

Footnote: Asterisk indicates one or more scores greater than 4 were recorded by the carers

*Patient problem PQRST*

**'East' carers**

Table 8, p233, shows the list of problems included in the 'patient problem' section of the PQRST, and lists the percentage of 'East' carers faced with these problems; the items with scores of a polarised distribution are marked with an asterix in this table. Detailed examination indicates that the types of 'patient problems' helped are behaviours that could be described as the most extreme behaviours listed in the questionnaire; these could be described as 'typical' psychiatric problems and could predictably have been regarded as behaviour that would have caused problems for the relatives (e.g. odd behaviour and ideas, arguments, aggression).

**'West' carers**

Examination of the frequency counts of the scores of 0-9, for each item of the 'patient problems' section, reveals that most of the answers were evenly distributed across all the scores (see Figure 17, p235, item no. 46). This is in contrast with the results cited above, where the majority of scores were low.

There was one problem where the distribution of answers was along the 'normal' curve: this was for 'keeps self to self' suggesting that the community psychiatric nurses were moderately helpful with this problem; in one item the responses suggested that community psychiatric nursing contact was no or little help: in relation to the problem of 'indecision'; the problem 'aggression directed at the carer,' which had a polarised distribution of scores for 'East' carers, was answered positively by 'West' carers (see Figure 17, p235 for printout illustrating these results). For 'West' carers, only one problem fell towards the 'helpfulness' end of the scale (see Table 9, p236, which also shows the items in which were found a polarised distribution of scores).

Comparison of Tables 8 (p233) and 9 (p236), suggests that the East nurses were selectively helpful with marginally more problems than the West nurses: for six compared with four problems, some carers were helped, others not.

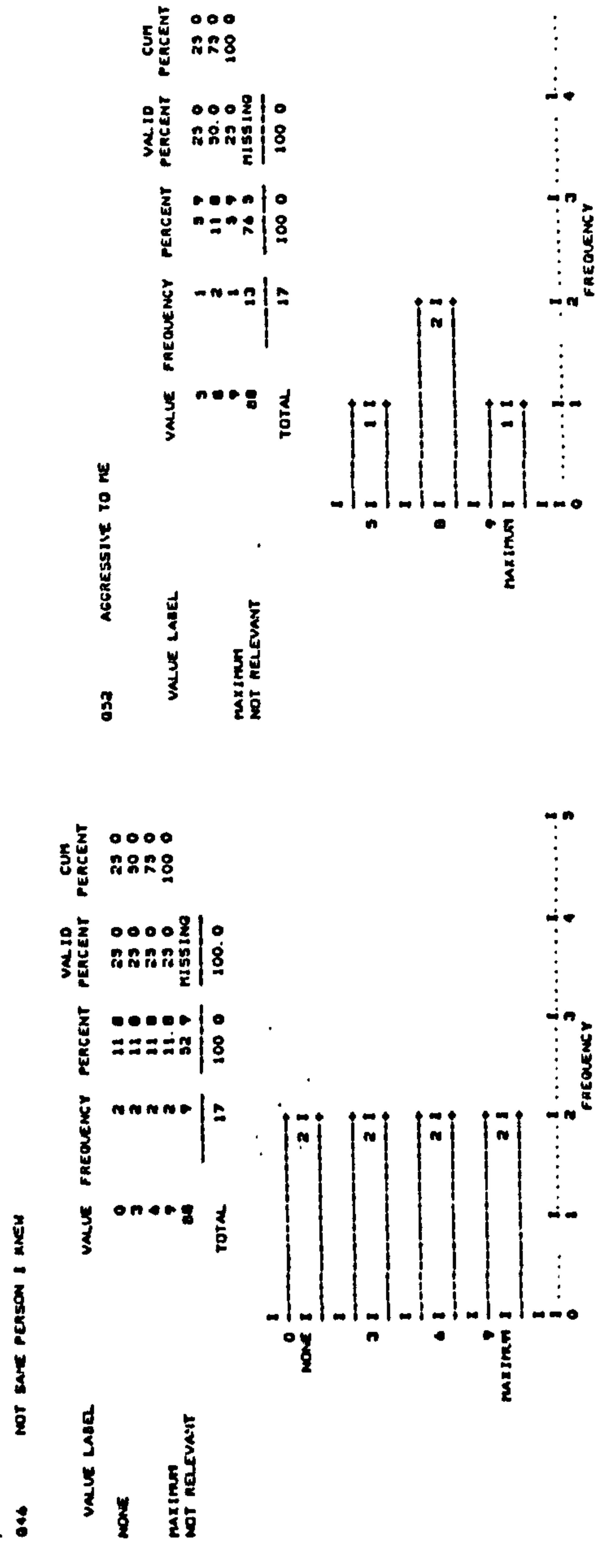
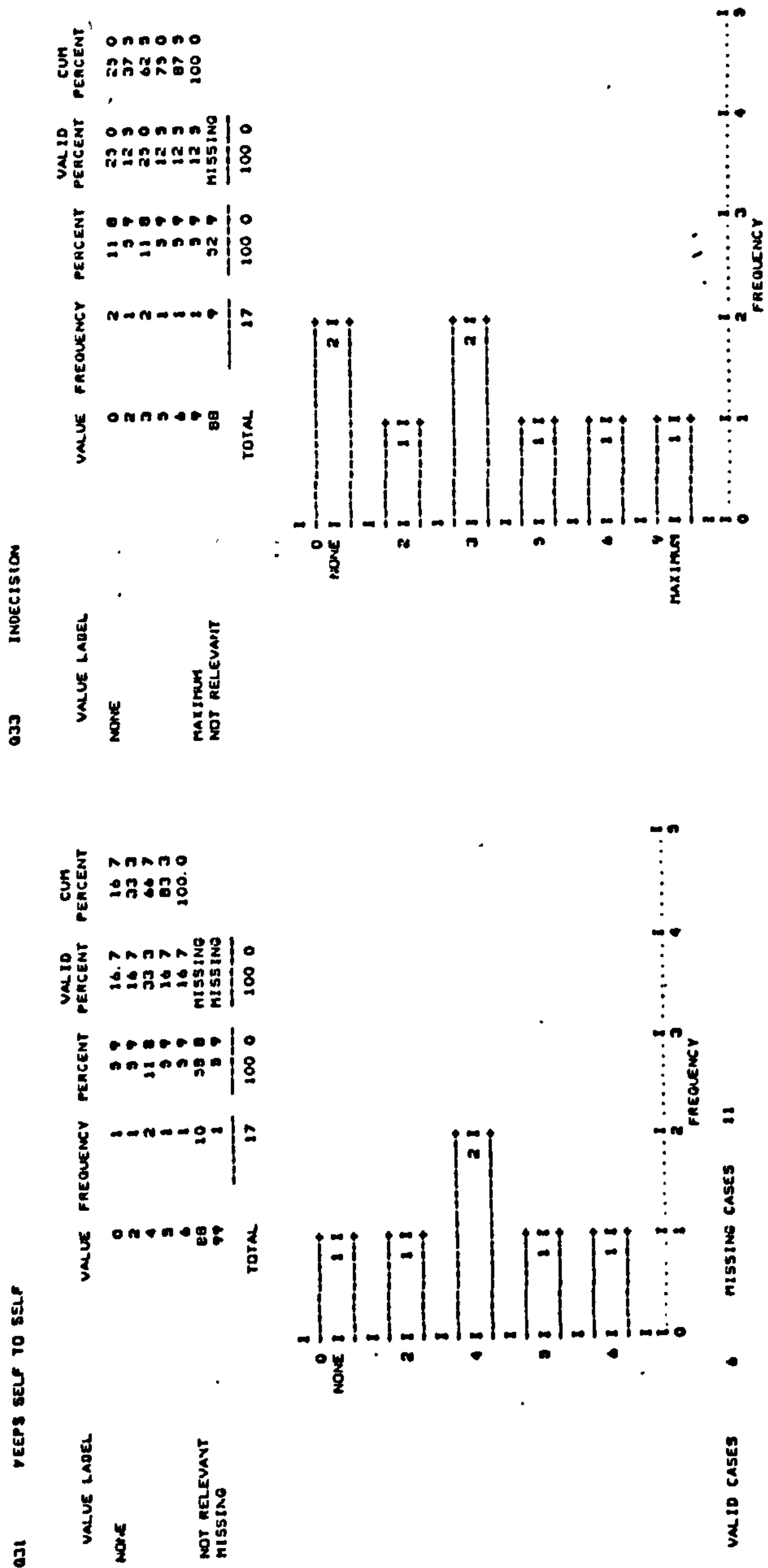


Figure 17: Sample of SPSSX output showing frequency distributions of scores : Patient problems PQRST, West carers



Table 9: Items in 'Patient problems' section of PQRST and percentage of 'West' carers who reported these problems. Absolute numbers in brackets.

*	DEMANDING CARERS COMPANY	59%	(10)
*	SUICIDAL	47%}	(8)
	INDECISION	}	(8)
	PERSONALITY CHANGE	47%}	(8)
*	UNPREDICTABILITY	41%}	(7)
*	HYPOCHONDRIASIS	}	(7)
	KEEPS SELF TO SELF	}	(7)
+	STUBBORN	}	(7)
	FORGETFULNESS	41%}	(7)
	GETS INTO ARGUMENT AT HOME	35%}	(6)
	CANNOT MANAGE MONEY	24%}	(4)
	EATS TOO MUCH/TOO LITTLE	}	(4)
	HIDES WHAT FEELING	}	(4)
	HAS ODD IDEAS	}	(4)
	AGGRESSIVE TO CARER	}	(4)
	OVERTALKATIVE	24%}	(4)
	CANNOT BE LEFT ALONE	18%}	(3)
	IS INCONTINENT	}	(3)
	SMOKES ALL THE TIME	12%}	(2)
	BEHAVES STRANGELY	}	(2)
	AGGRESSIVE OUTSIDE THE HOUSE	12%}	(2)
	LACKS INSIGHT	}	(2)
	DISTURBS CARER AT NIGHT	12%}	(2)
	POOR HYGIENE	}	(2)
	NEEDS HELP WITH DRESSING	6%}	(1)
	CANNOT COPE WITH DHSS	}	(1)
	REFUSES MEDICATION	}	(1)
	DRINKS TOO MUCH	6%}	(1)
	WANDERING	0%	(-)
	ARGUMENT WITH NEIGHBOURS	0%	(-)

n = 17

Footnote: \* marks one or more scores greater than 4 were recorded by the carers; + show problems with trend was towards helpfulness.

With the exception of 'demanding the carer's company', the types of problems which are helped (for some of the carers), are different for both regions studied; the problem 'types' generally fall into a category of 'typical' psychiatric problems: suicidal behaviour, hypochondriasis, abnormal eating and unpredictability.

If the entire list is inspected, the four topmost problems of 'East' carers also appeared high in the list of problems mentioned by 'West' carers. 'West' carers found the community psychiatric nurses were helpful for the top three problems. Suicidal behaviour and hypochondriasis, problems for a large number of the 'West' carers, were not experienced as problems for as many of the 'East' carers; nor did the 'East' carers perceive the community psychiatric nurses as helpful with these.

#### *'Family Burden' PQRST*

##### **'East' carers**

Results of the family burden section of PQRST, also suggest that only certain aspects of the experience of caring were helped by the community psychiatric nurse (see Table 10, p238, which details the impact that caring for a mentally ill relative had on carers). The general difficulties and feelings associated with caring are helped for some carers; the more extreme feelings and experiences of the carers are not relieved by contact with the community psychiatric nurse. This is in contrast to the 'problems' section, where the opposite was the case.

It is clear however that certain aspects of management of the patient are shared with the community psychiatric nurse (being on edge and sharing worries about avoiding upsetting the patient: see Figure 18, p239 for illustration of the findings); other components of 'East' carers' experience of managing patients are neglected. 'East' carers' community psychiatric nurses were not perceived to help with the daily drudgery of caring nor did they help with a large part of the 'experience' of caring for a mentally ill relative.

Table 10: Items in 'Family burden' section of PQRST and percentage of 'East' carers who reported these problems. Absolute numbers in brackets.

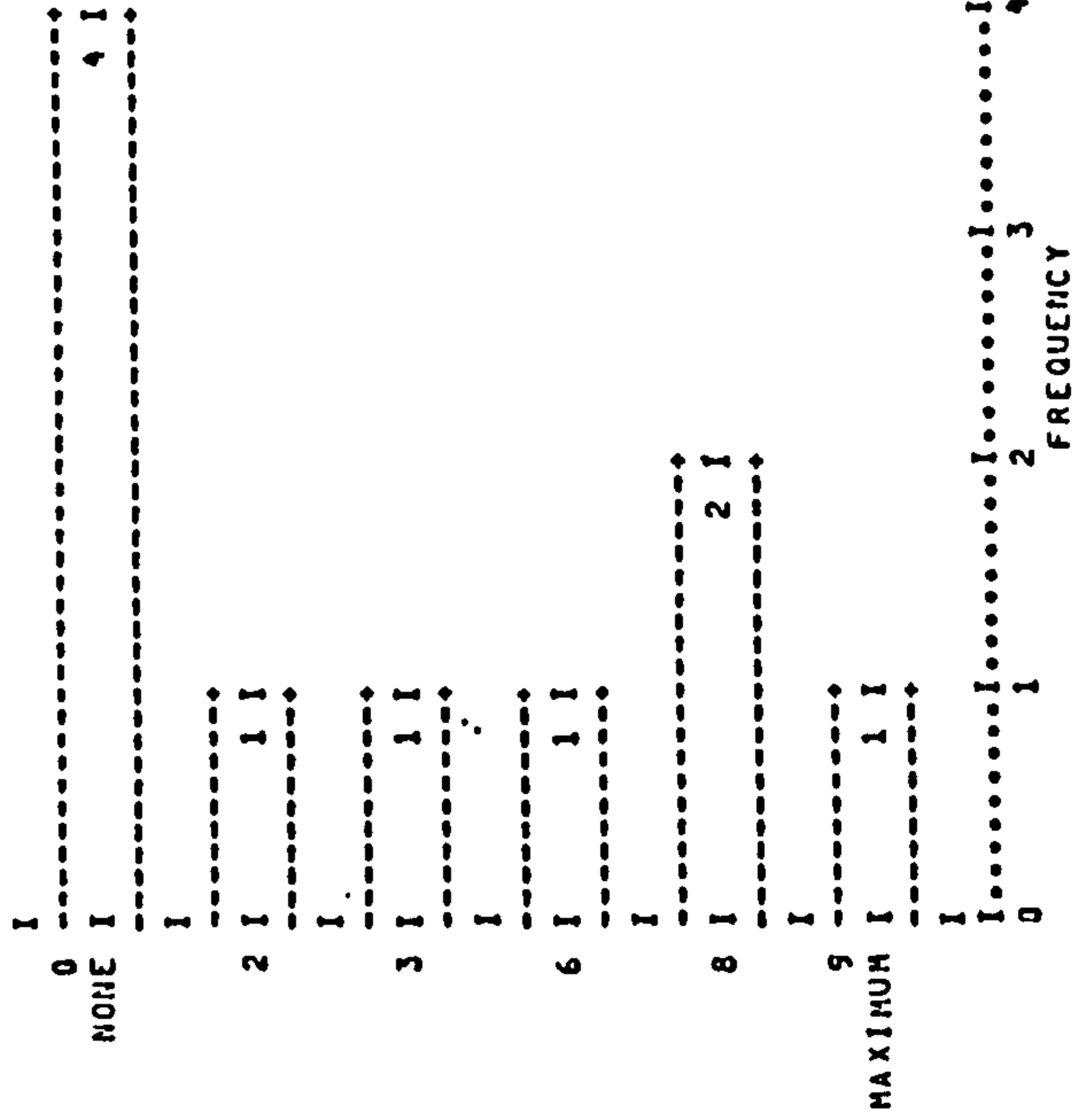
CARER WANTING TO KEEP PATIENT OUT OF HOSPITAL	57%	(20)
HAVING SUCH A LOT TO DO	49%	(17)
MAKING DECISIONS	46%	(16)
* FEELING ON EDGE	40%	(14)
CARER DIFFICULTY IN CONTROL OF TEMPER		} (14)
CARER DOING MOST OF DOMESTIC TASKS		} (12)
* CARER TAKING CARE NOT TO UPSET THE PATIENT	34%	
NOT KNOWING WHAT THE PATIENT THINKS		} (12)
WORRY ABOUT RE PATIENT IF CARER DIES		}
CARER FEELING DEPRESSED	31%	(11)
CARER NOT HAVING DONE THINGS		}
ANXIETY ABOUT KNOWING IF DOING THE RIGHT THINGS	29%	(10)
LOSS OF LOVE AND SUPPORT FROM PATIENT		}
CONFUSION ABOUT WHAT IS ILLNESS OR NOT	26%	(9)
UNABLE TO LEAVE THE HOUSE	20%	(7)
UNABLE TO INVITE FRIENDS IN	17%	(6)
SUFFERING THROUGH LACK OF MONEY		} (4)
FEAR OF BEING HARMED BY THE PATIENT	11%	(4)
BEING EMBARRASSED BY THE PATIENT		} (4)
BEING LEFT TO BRING UP THE CHILDREN	8%	(3)

Footnote: Asterisk indicates one or more scores greater than 4 were recorded by the carers; n=35.



358 I HAVE TO BE CAREFUL NOT TO UPSET PATIENT

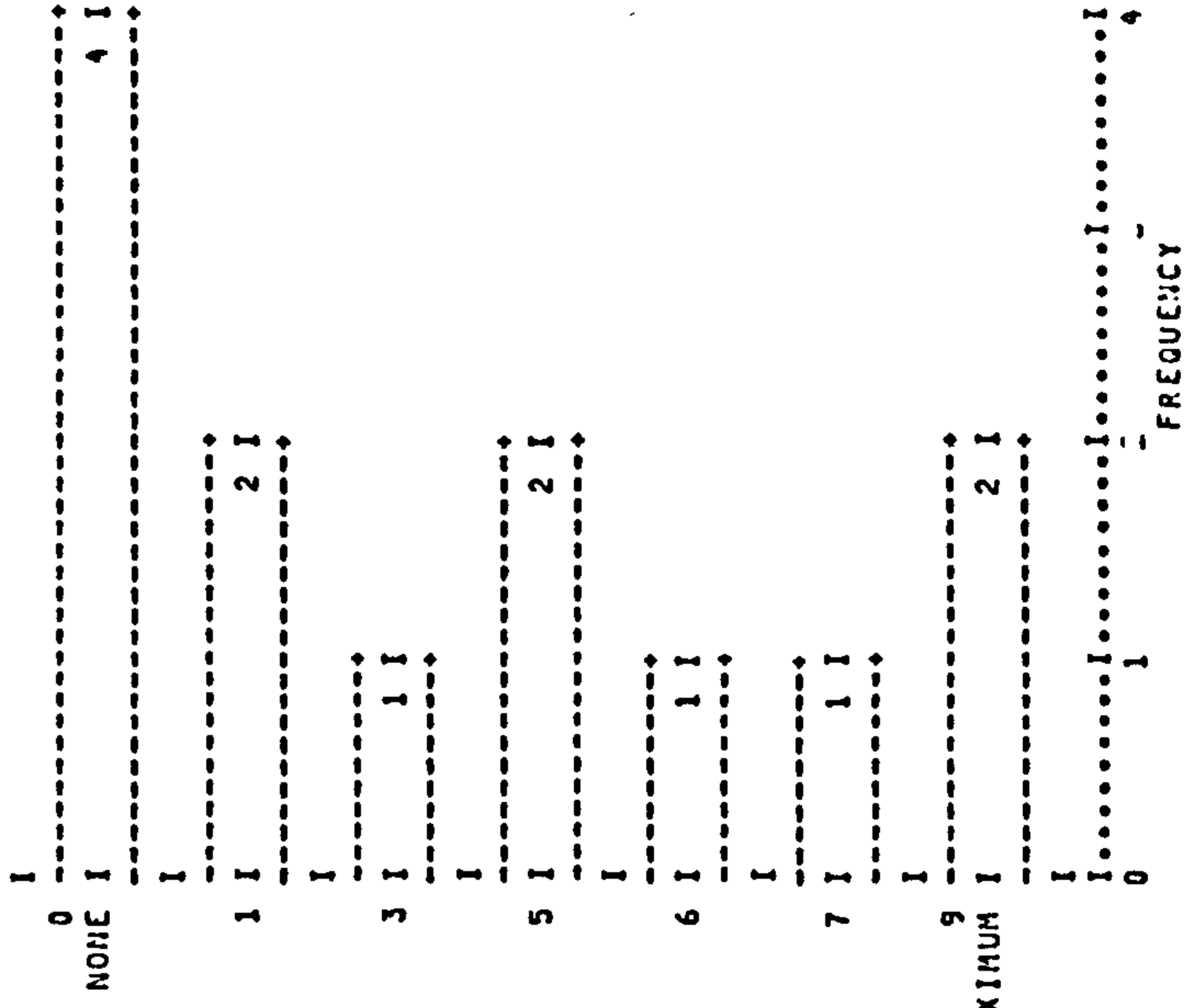
VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	4	11.4	40.0	40.0
	2	1	2.9	10.0	50.0
	3	1	2.9	10.0	60.0
	6	1	2.9	10.0	70.0
	8	2	5.7	20.0	90.0
	9	1	2.9	10.0	100.0
MAXIMUM NOT RELEVANT	88	23	65.7	MISSING	
MISSING	99	2	5.7	MISSING	
TOTAL		35	100.0	100.0	



VALID CASES 10 MISSING CASES 25

059 I FEEL ON EDGE BECAUSE OF PATIENT

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	4	11.4	30.8	30.8
	1	2	5.7	15.4	46.2
	3	1	2.9	7.7	53.4
	5	2	5.7	15.4	69.2
	6	1	2.9	7.7	76.9
	7	1	2.9	7.7	84.6
	9	2	5.7	15.4	100.0
MAXIMUM NOT RELEVANT	88	21	60.0	MISSING	
MISSING	99	1	2.9	MISSING	
TOTAL		35	100.0	100.0	



VALID CASES 13 MISSING CASES 22

Figure 18: Sample of SPSSX output showing polarised distribution of scores: Family burden PQRST, East carers

Table 11: Items in 'Family burden' section and percentage of  
'West' carers who reported these problems.  
Absolute numbers in brackets.

u	NOT KNOWING WHAT THE PATIENT THINKS	}	
*	KEEPING THE PATIENT OUT OF HOSPITAL	53%}	(9)
*	MAKING DECISIONS	}	
u	WORRY RE PATIENT IF CARER DIES	41%}	(7)
u	HAVING SUCH A LOT TO DO	35%}	(6)
u	CARER UNABLE TO CONTROL TEMPER	}	
+	CARER FEELING DEPRESSED	}	
u	LOSS OF LOVE AND SUPPORT FROM PATIENT	35%}	(6)
	CONFUSION ABOUT WHAT IS ILLNESS	29%}	(5)
u	CARER DOING MOST OF DOMESTIC TASKS	}	
u	FRUSTRATION AT NOT HAVING DONE THINGS	29%}	(5)
	ANXIETY ABOUT KNOWING IF DOING THE RIGHT THINGS	23%}	(4)
u	FEELING ON EDGE	}	
u	UNABLE TO INVITE FRIENDS IN	}	
	UNABLE TO LEAVE THE HOUSE DUE TO PATIENT	23%}	(4)
	CARER TAKING CARE NOT TO UPSET THE PATIENT	18%}	
	BEING EMBARRASSED BY THE PATIENT	}	(3)
	BEING LEFT TO BRING UP THE CHILDREN	18%}	
	SUFFERING THROUGH LACK OF MONEY	12%}	(2)
	FEAR OF BEING HARMED BY THE PATIENT	}	

n = 17

Footnote: \* marks items where carers scored 4 or more;  
+ trend towards helpfulness;  
u trend towards no help.

### 'West' carers

Table 11, p240, gives a description of the impact of caring on 'West' carers. The scores for each item in the family burden section of the PQRST were examined to see how the community psychiatric nurses helped. The word 'trend' is used here, to describe most of the findings, because the number of responses to each item was often very small: one response more or less could greatly change the shape of the curve (see Figure 19, p242). This must be borne in mind in the ensuing discussion.

The distribution of the scores showed a definite trend for the items to have low scores, suggesting that contact with the community psychiatric nurse was little or no help; there was a trend towards 'helpfulness' as regards the community psychiatric nurses' contact with carers who felt depressed; two statements had polarised scores which suggested that the community psychiatric nurses appeared helpful to some relatives in 'keeping patients out of hospital' and also helpful to some carers as regards 'making decisions' (see Figure 19, p242, for an illustration of these results).

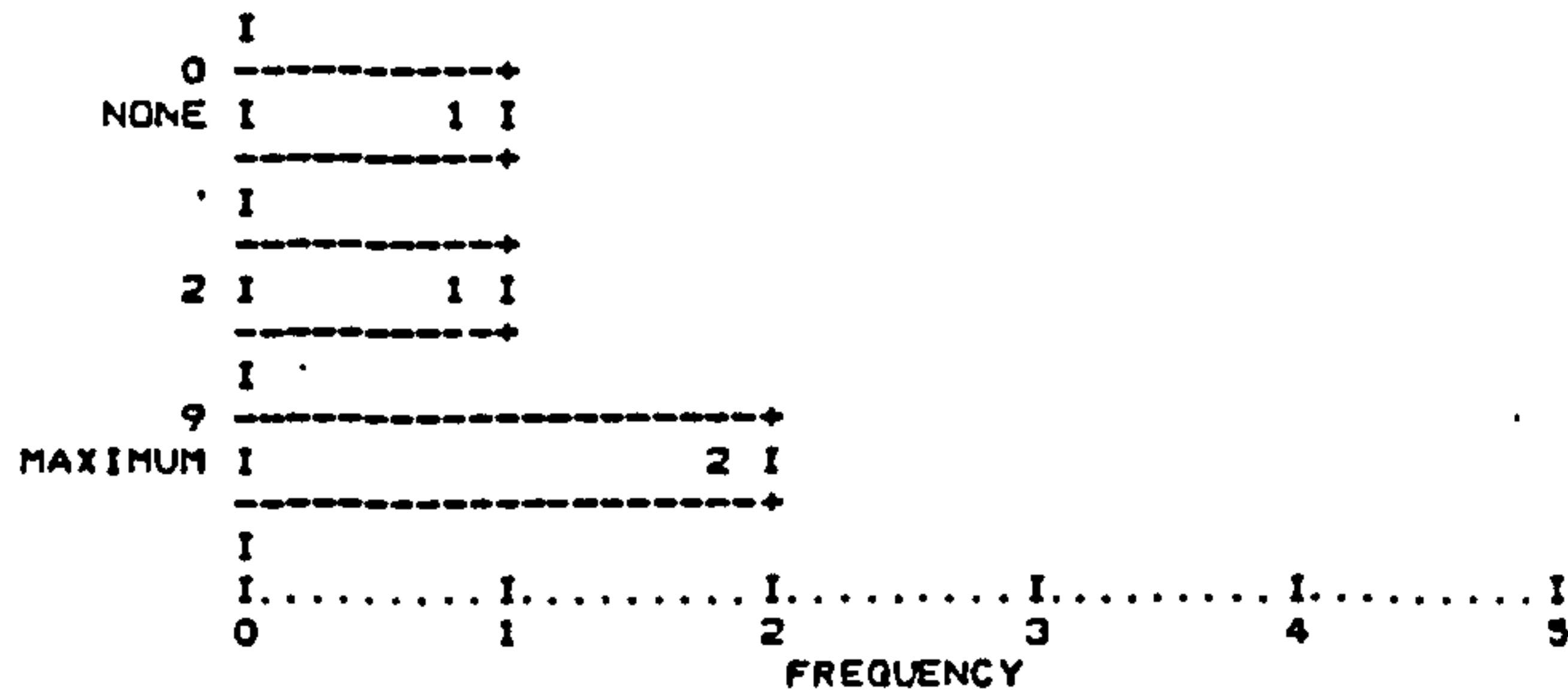
#### More complex relationships within the data:

##### Helpfulness and specific factors of the nurse or carers

In addition to looking at the answers to individual questions, scores of 0-4 were considered 'unhelpful' and scores of 5-9 as 'helpful' (note the previous comments about this treatment of the data: see p209); scores were also subdivided into three. The Chi-square technique was then used to test for statistical significance in the data of the frequency counts of scores within the above groups. In relation to these; male and female carers, old and young carers, nurses with large and small caseloads, the community psychiatric nurses who visited frequently and those who visited infrequently, and also attributes of the individual community psychiatric nurses (experience in psychiatry and training), were tested to find out if there were specific factors of the nurse or carers associated with helpfulness.



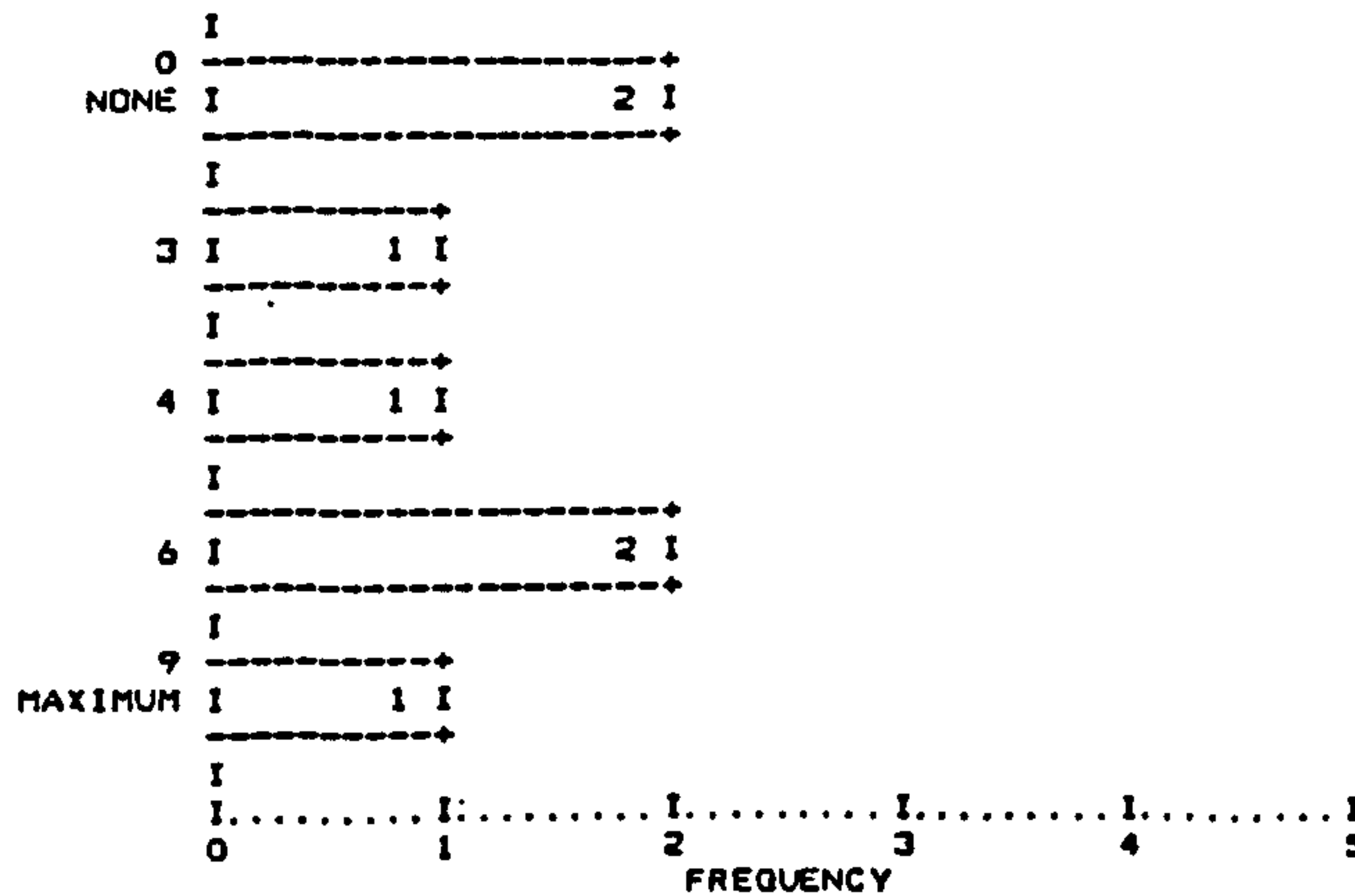
VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	1	5.9	25.0	25.0
	2	1	5.9	25.0	50.0
MAXIMUM	9	2	11.8	50.0	100.0
NOT RELEVANT	88	11	64.7	MISSING	
MISSING	99	2	11.8	MISSING	
TOTAL		17	100.0	100.0	



VALID CASES 4 MISSING CASES 13

Q69 I MAKE THE DECISIONS

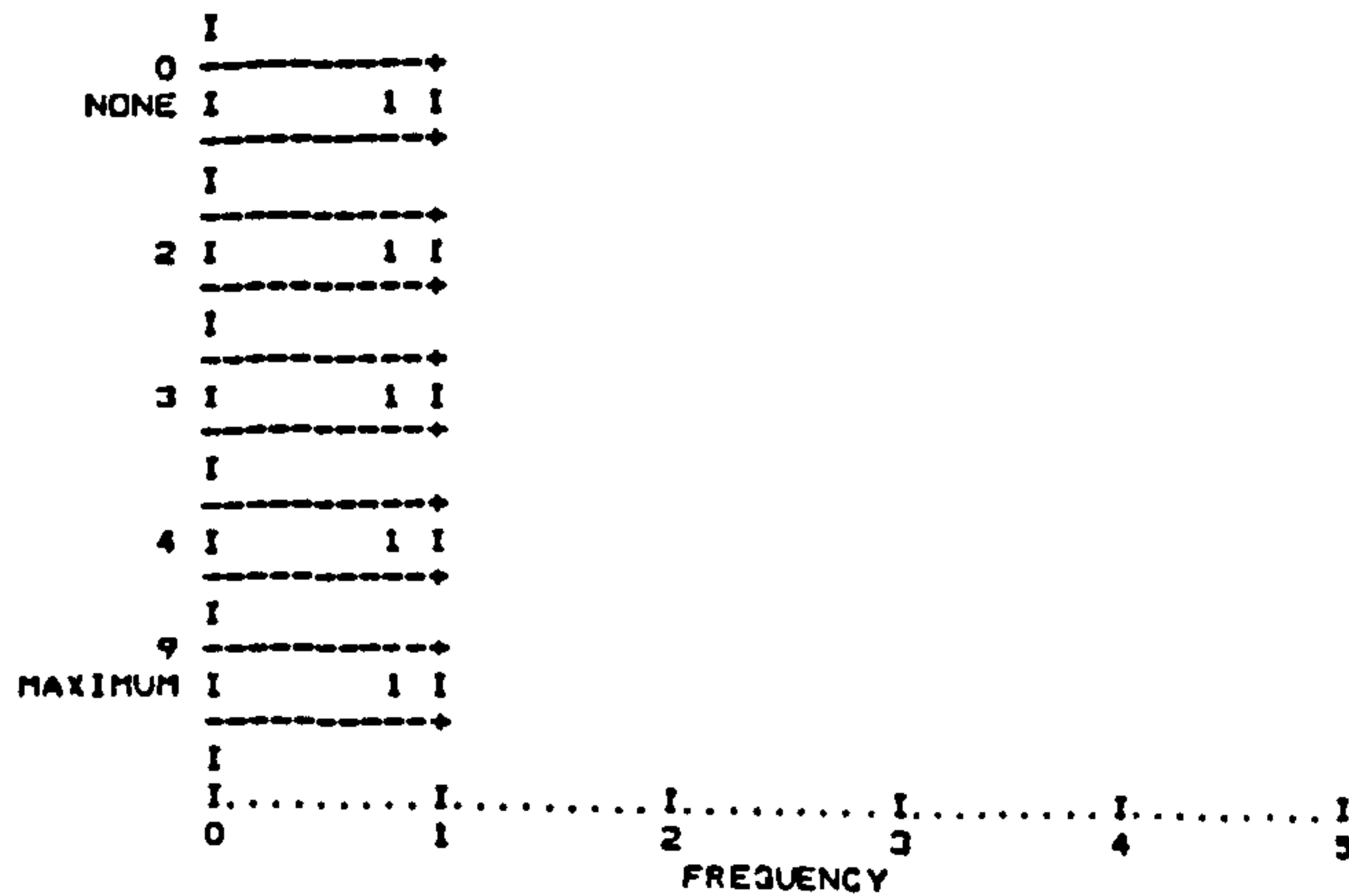
VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	2	11.8	28.6	28.6
	3	1	5.9	14.3	42.9
	4	1	5.9	14.3	57.1
	6	2	11.8	28.6	85.7
MAXIMUM	9	1	5.9	14.3	100.0
NOT RELEVANT	88	10	58.8	MISSING	
TOTAL		17	100.0	100.0	



VALID CASES 7 MISSING CASES 10

Q64 771s PAT BEHAV ILLNESS

VALUE LABEL	VALUE	FREQUENCY	PERCENT	VALID PERCENT	CUM PERCENT
NONE	0	1	5.9	20.0	20.0
	2	1	5.9	20.0	40.0
	3	1	5.9	20.0	60.0
	4	1	5.9	20.0	80.0
	9	1	5.9	20.0	100.0
MAXIMUM	9	1	5.9	20.0	100.0
NOT RELEVANT	88	12	70.6	MISSING	
TOTAL		17	100.0	100.0	



VALID CASES 5 MISSING CASES 12

Figure 19: Sample of SPSSX output showing frequency distributions: Family burden PQRST, West carers

For 'East' carers, the only associations that were significant (see comment on p209) on a Chi-square test were as follows: busy nurses, defined as those with large caseloads, i.e. over thirty patients, were significantly less likely to help carers 'take care not to upset the patient'; female carers were significantly less likely than male carers to find the community psychiatric nurse helpful in relation to the statement 'I don't know if I do the right things'; 'few visit' nurses were significantly less likely to help carers 'keep the patient out of hospital' (see Figure 20, p244). The data from 'West' carers were examined in this way, but no significant associations were found.

The numbers involved in each chi-square test were small and further groupings of questions were attempted to try to identify general trends. The scores in each of the three different sections of the PQAST were examined in relation to the scores of 'helpful' and 'unhelpful'; this illustrated the findings already discussed, that community psychiatric nurse 'aspects' were considered helpful, and patient 'problems' and family 'burden' in contrast were unhelped. The Chi-square test was used with the grouping Nurse Aspects and Patient Problems; Nurse Aspects and Family Burden; and Patient Problems and Family Burden. The association between patient problems and patient burden was highly significant, showing that relatives who felt helped with patient problems were also helped to cope with the experience of caring. Repetition of this procedure with the 'West' carer data produced the same results (see Figure 21, p 245).

Associations were sought between these groupings and male and female carers, old and young carers, individual nurses and nurses with heavy or light caseloads and nurses who visited frequently and infrequently. None was significant using the Chi-square test.

FILE: FAMILY BURDEN QAIRRE IN REL TO CPN HELP AUTUMN '84  
 0- - - - - C R O S S T A B U L A T I O N O F - - - - -  
 Q63 I WANT TO KEEP PATIENT OUT OF HOSP BY NURSE IDENTIFICATION CODE NUMBER

	COUNT	NURSE		ROW TOTAL
		Many-vis it nurse 1	Few-vis t nurses 2	
Q63				
unhelpful	1		7	7 41.2
helpful	2	5	5	10 58.8
	COLUMN TOTAL	5 29.4	12 70.6	17 100.0

0 STATISTIC ONE TAIL TWO TAIL  
 -----  
 FISHER'S EXACT TEST 0.04072 0.04412  
 NUMBER OF MISSING OBSERVATIONS = 18

FILE: FAMILY BURDEN QAIRRE IN REL TO CPN HELP AUTUMN '84  
 0- - - - - C R O S S T A B U L A T I O N O F - - - - -  
 Q66 I DONT KNOW IF I DO THE RIGHT THINGS BY REL<sup>2</sup> RELATIONSHIP OF CARER

	COUNT	REL		ROW TOTAL
		Male car er 1	Female c arer 2	
Q66				
unhelpful	1		6	6 75.0
helpful	2	2		2 25.0
	COLUMN TOTAL	2 25.0	6 75.0	8 100.0

0 STATISTIC ONE TAIL TWO TAIL  
 -----  
 FISHER'S EXACT TEST 0.03571 0.03571  
 NUMBER OF MISSING OBSERVATIONS = 27

FILE: FAMILY BURDEN QAIRRE IN REL TO CPN HELP AUTUMN '84  
 0- - - - - C R O S S T A B U L A T I O N O F - - - - -  
 Q58 I - CARE NOT TO UPSET PATIENT BY NURSE IDENTIFICATION CODE NUMBER

	COUNT	NURSE		ROW TOTAL
		Busy nur ses 1	Quiet nu rses 2	
Q58				
unhelpful	1	6		6 63.0
helpful	2	1	3	4 40.0
	COLUMN TOTAL	7 73.0	3 37.0	10 100.0

0 STATISTIC ONE TAIL TWO TAIL  
 -----  
 FISHER'S EXACT TEST 0.03333 0.03333  
 NUMBER OF MISSING OBSERVATIONS = 25

Figure 20: Sample of SPSSX output showing significant associations in East carer PQRST data



Figure 21: Sample of SPSSX output showing significant associations of  
different sections of PQRST, West carers

019 FEB 86 SPSS-X RELEASE 1.0 A ICL 2900 EMAS/VME EMAS  
University of Edinburgh - ERCC ICL 2976

FILE: FAMILY BURDEN Q'AI RRE IN REL TO CPN HELP Spring '85  
0- - - - - C R O S T A B U L A T I O N O F  
PATPROBS BY PATBURDN

PATPROBS	COUNT	PATBURDN		ROW TOTAL
		Unhelpfu	Helpful	
Unhelpful	1.00	4	3	7
Helpful	2.00	1	5	6
	3.00	5	8	13
		1.00	2.00	3.00
		38.5	23.1	61.6
		5	3	8
		38.5	23.1	61.6

0 CHI-SQUARE = 4 D.F. SIGNIFICANCE = 0.0164 MIN E.F. = 0.692 CELLS WITH E.F. < 5  
NUMBER OF MISSING OBSERVATIONS = 4 9 OF 9 (100.0%)

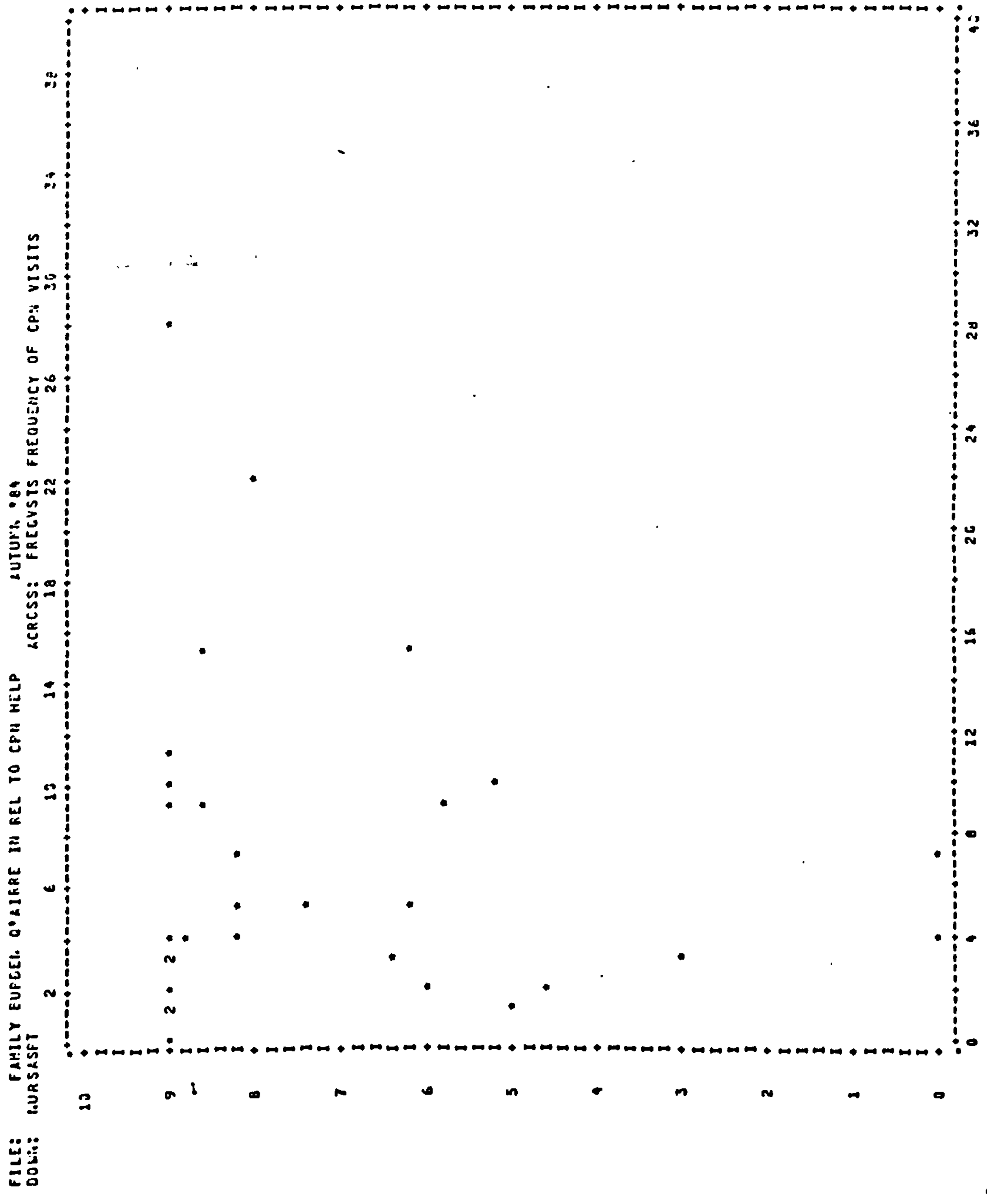
### Helpfulness and frequency of visits

For 'East' and 'West' carers, scattergrams were completed to look at helpfulness in relation to frequency of visits (see p102). These scattergrams, on p247-9, show that the data tends to be concentrated in the left hand upper triangle of the printout. This suggests that increase in frequency of visiting was related to an increase in perceived helpfulness. For 'East' carers, this trend was most clear for the 'nurse aspects' section of the questionnaire (see Figure 22, p247). This suggested trend was not statistically significant. The results from 'West' carers show that there was a suggestion in the data that for 'family burden' there was no increase in help with increase in visits. In other words the experience of caring was helped as much by infrequent visits (see Figure 23, p248).

The scattergrams suggested that some carers were helped by a few visits, others by frequent visits from the community psychiatric nurses. What is clear from the results is that frequent visiting is not viewed as unhelpful. Further scattergrams were completed showing frequency of visits in relation to items in the patient problem, family burden and nurse aspects section of the PQRST. This was to see whether visiting frequency was related to helpfulness with particular problems, family burden or nurse aspects. The scattergram for 'East' carers for the item, 'the nurse is an outsider' showed a visible tendency for increased help to be linked to increased visiting. This association was not significant and some people were helped maximally with few visits (Figure 24, p249).

### Summary of the findings

The major findings from the completion of the family PQRST by the carers are that: the carers positively evaluated attributes of the community psychiatric nurses; paradoxically, the community psychiatric nurses did not offer comprehensive help; the nurses were selectively helpful as regards patient problems and the carers' experience of burden; there appears to be some variation in helpfulness between individual community psychiatric nurses and between the two community psychiatric nursing services studied.



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 University of Edinburgh - ERCC ICL 2376 EMAS

Figure 22: Sample of SPSSX output showing scattergram results: Frequency of visits in relation to average score for each respondent: Nurse Aspects section PQRST, East carers



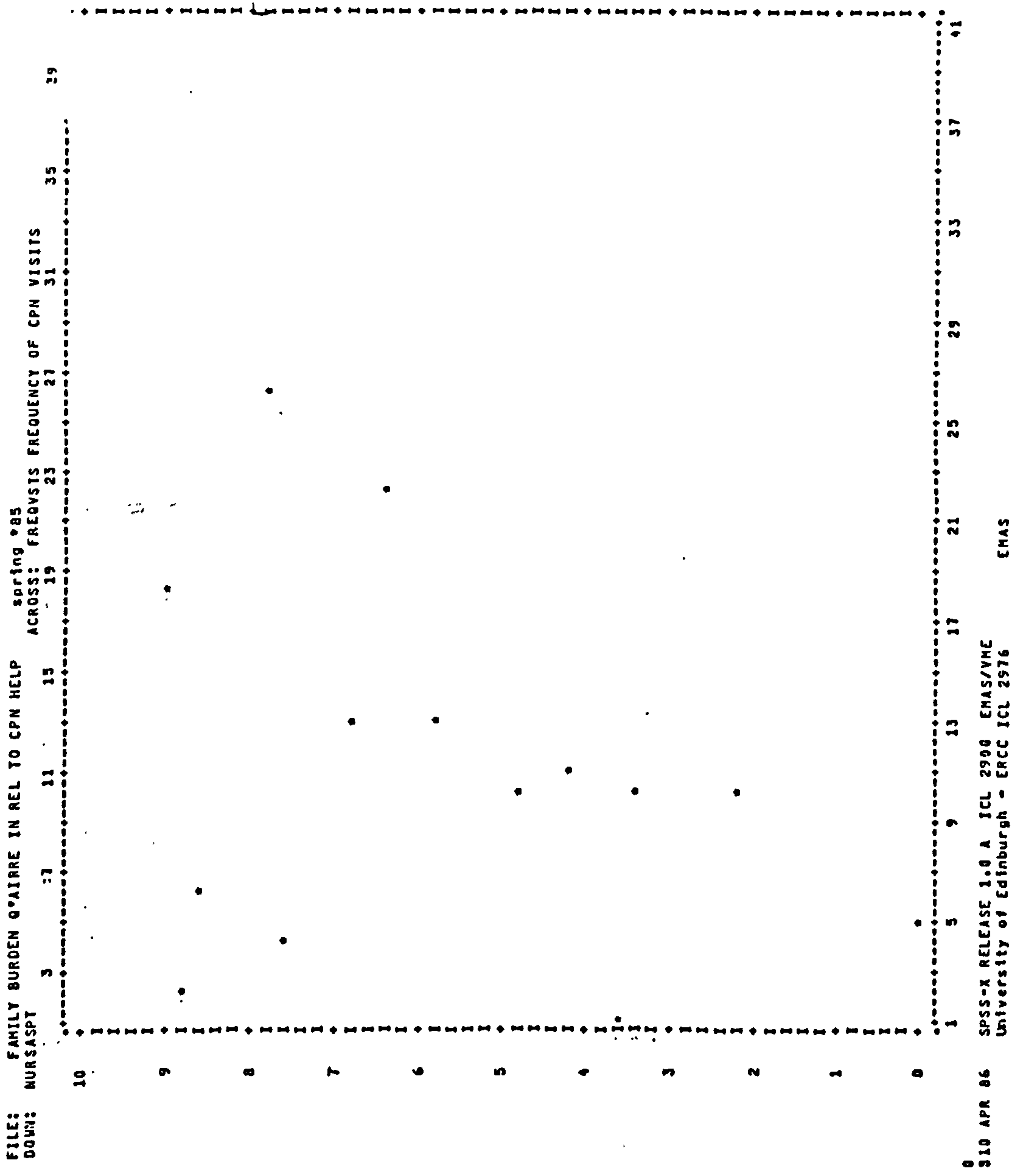


Figure 23: Sample of SPSSX output showing scattergram results: Frequency of visits in relation to average score for each respondent: Nurse Aspects section PQRST, West carers

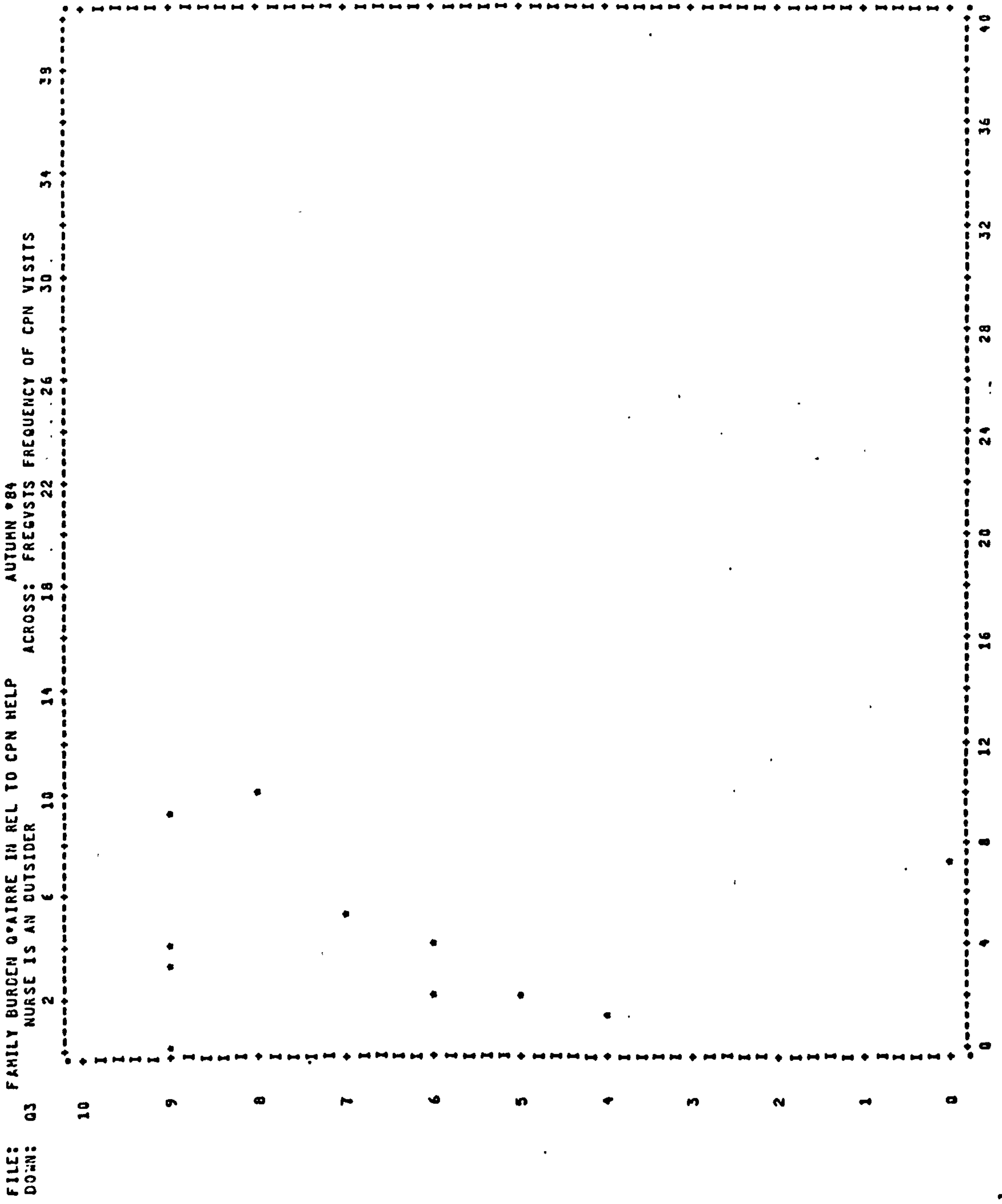


Figure 24: Sample of SPSSX output showing scattergram results: each item of PQRST, East carers

#### *4:3 Discussion of the findings*

In this section the findings presented in the previous section are discussed and possible areas for future research are identified.

Paykel et al (1983) compared care by out-patient psychiatrists with care given by the community psychiatric nurse. Paykel found there were no differences using the outcome measures; the main finding was that the patients receiving care from the community psychiatric nurses were 'more satisfied' with the care received. This study suggests that satisfaction with the relationship is an important feature of the nurse/patient contact and indicate that the carers are not only satisfied with the community psychiatric nurse, but they also find the nurse 'helpful'. The community psychiatric nurse is not perceived to be helpful to all carers as regards providing help for specific problems or the experience of caring; nevertheless the carers were unanimous in that they find contact with the community psychiatric nurse generally helpful.

#### **The carers' view of community psychiatric nurses**

Looking at the content of the 'nurse aspects' section of the questionnaire, the community psychiatric nurse is appreciated because of the service specifically given to the mentally ill patient; further, the community psychiatric nurse is perceived to offer a support to carers which is ongoing and available at times of crisis. 'East' and 'West' carers reported they could 'call on the nurse' and that the community psychiatric nurse 'would visit if anything was wrong'; these aspects of community psychiatric nursing contact were considered particularly helpful.

Psychiatric nurse training emphasises the development of relationships with patients (see p34). The replies of many of the carers, reporting that they find the community psychiatric nurse easy to talk to and a person with whom they would talk to about anything, reflect the view of the carers that a relationship of trust and care has also developed with the carers. One would think that this in turn would have led to and enabled sharing of problems.



### Community psychiatric nurses and problem relief

Carers were asked initially to agree or disagree with items listed in the problems section and thereby information was collected on how helpful the carers perceived the community psychiatric nurses to be with current problems. No systematic information was obtained about past 'problems'. Carers' comments suggested that problems had changed with time and that previous community psychiatric nursing intervention had been helpful. The majority of the carers gave the community psychiatric nurses low scores for helpfulness in relation to problems or the experience of caring (see Figures 17 and 18, pp235 and 239). Although most of the scores were low, it could be argued that to be helped at any level is better than to be given no help at all. This in fact seemed to be the predominant feeling of the carers who voiced concern that this research may result in withdrawal of the help they were getting (see p143). The nurses similarly were aware of their capacity to provide only limited help to carers (see p177) and the aim of their work is to enable willing relatives to continue caring for relatives at home.

All patient/carer pairs were being treated by the community psychiatric nurses during the data collection. The rationale of the choice of sample should have ensured that a range of patient/carer pairs were chosen, each pair being at a different stage of therapy (see p100). The low scores on helpfulness may reflect the 'process' of therapy. In other words, carers may have rated the community psychiatric nurse as a little or no help because they were going through the 'pain' of therapy and change, and therefore perceived the community psychiatric nurse negatively. An area of future enquiry would be to compare respondents who have previously received community psychiatric nursing treatment with a control group who have not.

Bearing the above mentioned comments that many carers could talk to the nurses about anything it was contrary to expectation therefore, to find that over half of 'West' carers and almost half in East, reported that they did not approach the nurses when

worried. This may provide an explanation to account for the further finding that certain carers were helped, whereas others were not.

The reasons why only some carers, when worried, approach the nurses were not systematically explored in this study and can only be surmised. The personalities of the the carers may have prevented them from approaching the nurses. Or quite simply, the carers may not have wanted help at all (generally speaking or more specifically from the nurse). Alternatively, the carers may have been receiving help from elsewhere. Other reasons why the carers may not have approached the nurses may be to do with the nurses.

The nurses, for instance, may have failed to make it clear to carers what they could provide in the way of help. Comments of carers, during the PQAST procedure, suggest that carers did not mention certain problems to the community psychiatric nurse, because they assumed that the community psychiatric nurse would not be able to help. If community psychiatric nurses intend to provide relief to carers, (and this is a point which is explored further, see p298) the onus must be on the community psychiatric nurse actively to seek information from carers, about the experience of caring, and to further inform carers about the available help. At the moment, as the qualitative analysis has shown, the nurses tend to listen to the carers with a view to picking out information which they can use, and help is offered, linked to the available resources. The qualitative analysis also shows that the nurses' work is patient focused and preoccupied with making the 'system' function rather than providing comprehensive relief to carers' difficulties.

The study also raises numerous questions about the problems helped by community psychiatric nurses. What sort of problems were helped by the nurses and why these? Were these problems helped because the community psychiatric nurses considered themselves most able to help with these problems? In what way were the problems helped? Was the help received planned by the community psychiatric nurses or was the help received coincidental? How were these problems brought to the attention of the nurses (by the nurses

themselves, carers, patients, or by other professionals)? Did others' perception of the work of community psychiatric nursing therefore influence and determine the work of the nurses? This study has only made a small step in the direction of answering these questions and many of these questions remain unanswered.

This study has given an indication of the sorts of problems which in the carers' view can be helped by contact with community psychiatric nurses. 'East' carers reported the community psychiatric nurses as helpful with marginally more 'patient' problems (see Tables 8 and 9). 'Demanding carer's company' was a problem for which the nurses in both areas scored highly; with regard to limiting the demands of patients, or helping the carer cope with these, community psychiatric nurses therefore could be regarded as especially helpful. For the problem of dealing with 'aggression directed at the carer', all West carers reported the nurses helpful. This may suggest that West Hospital's community psychiatric nurses were skilled at helping carers cope with patient aggression although specifically how this was done is unclear. The data that are lacking, as regards problem relief, are details about 'how' the nurses actually helped, an area which must be a priority for future study.

Hypochondriasis and suicidal behaviour, was a problem experienced by many 'West' carers and few 'East' carers. Some 'West' carers considered the nurses helpful for these problems; it is unclear whether this positive feedback is to do with the more effective treatment offered by West Hospital's community psychiatric nurses or whether the nature of the problems were more intractable for 'East' carers. If the latter is the case, this finding may be support for community psychiatric nurses being based in GP practices (see p38 and 200).

The other types of problems which are helped (for some of the carers), are different for both regions studied; nevertheless, the problem 'types' generally fall into a category of 'typical' psychiatric problems, as would be described by the lay public. This may lend support to the notion that the carers are instrumental in



deciding which problems the community psychiatric nurse tries to help.

For similar problems, some carers were helped, whereas others were not. What factors were associated with 'helped' carers? Was this help related to the therapeutic relationship of the nurse/patient (see p35), nurse variables (only length of experience in psychiatry and time employed in 'community psychiatric nursing' were obtained) or to patient variables (length of contact and duration of illness, for instance). These data were not sought. Exploration of these links would be a useful area for future enquiry and essential in relation to making comments on the provision of effective services.

Findings in the family burden section of PQAST, (which focused on the feeling of the carers about looking after a relative) also suggest that only certain aspects of the experience of caring were helped by the community psychiatric nurse (see Table 10 and 11). Examination of these items shows that the general difficulties and feelings associated with caring are helped for some carers. Certain aspects of management of the patient are shared with the community psychiatric nurse (being on edge and sharing worries about avoiding upsetting the patient), others are neglected. One wonders why this is the case? As reported by 'East' carers, the more extreme feelings and experiences of the carers are not relieved by contact with the community psychiatric nurse. (This is in contrast to the 'problems' section (discussed above), where extreme problems appear to have been helped). Could it be that carers are encouraged to voice feelings that are socially acceptable rather than acknowledge deep feelings of frustration, anger, fear, or misery? Or put another way, perhaps the carers are not encouraged to ventilate these emotions? The findings overall suggest that 'East' carers do not find the daily drudgery of caring or a large part of the 'experience' of caring for a mentally ill relative helped by the contact with the nurses. 'West' carers' findings suggest the community psychiatric nurses may be more specific in the help

offered, but the data from this area is minimal and little importance can be attached to the significance of the findings.

#### **Patient orientation of the service**

The 'family PQRST' results provide conflicting feedback about whether the community psychiatric nurses were viewed as providing a patient orientated service. Almost one third of 'East' carers disagreed that the nurse came to see the patient; one presumes then, that here the carers perceived the service as catering for their needs. No 'West' carers disagreed that the nurse came to see the patient, suggesting that this service was seen unanimously as a patient orientated service; paradoxically, however only 29% of 'West' carers left the nurse alone with the patient and only 23% actually felt the patient needed to talk to the nurse. Perhaps, despite the 'patient orientation' of the service commented on by the 'West' carers, the service was viewed as a help and support for them; it may be that the nurses work explicitly with both carers and patients.

Almost 30% of 'East' and 'West' carers did not agree that the community psychiatric nurses assessed patients. It is difficult to know how to interpret this finding: carers may not have understood the word 'assess'; alternatively, this may reflect the carers' lack of knowledge about this part of the community psychiatric nurse's work (Mayer and Timms 1980).

#### **Differences in the community psychiatric nursing services**

The 'nurse aspects' findings suggest that 'East' and 'West' carers have different experiences of the nurses. More 'East' carers had unplanned visits from nurses and had day care arranged for the patients. The community psychiatric nurses based at West Hospital also arranged fewer hospital admissions; a higher percentage of carers in West Hospital felt that 'meeting on my territory' was best. What accounts for these differences?

The varied settings from which the nurses worked can partly account for the differences (see p84). Additionally, the

differences may be related to varied patients' needs; the lesser use of hospitalisation for instance, by West Hospital's community psychiatric nurses may be a result of working with a patient population whose need for hospitalisation was less (the nurses worked with direct referrals from GPs and 'picked up patients at the first filter' : Goldberg and Huxley 1980 and see p88). More 'West' carers reported that the community psychiatric nurse contact prevented admission and relapse although it should be noted that high numbers of carers in both settings held the opposite view therefore disagreeing that the nurses either prevent illness or hospitalisation.

It may also be the case that individual nurses held differing theories about practice and visiting patterns, for instance, a feature brought out by the interview data. The approach of the West nurses (as judged by the researcher) was one in which the affiliation to the parent psychiatric hospital was played down; the nurses also emphasised the importance of avoiding psychiatric labelling, diagnosis and use of psychotropic drugs, and stressed the importance of helping 'clients' to develop coping skills and to solve their own problems. This approach may have been perceived by the carers who appreciated the care given at home, rather than in the 'hospital' or 'out-patient' setting. It is fascinating that the two services seemed to have differing approaches and practices and the factors responsible for these must be studied further.

#### **Significant associations in the data**

Female carers were found to be significantly less helpful to female rather than male carers, specifically as regards helping carers 'do the right things'. This supports the findings of the Equal Opportunities Commission research (1984) which found that more help was offered to male carers by the statutory organisations. Perhaps the nurses, in common with societal stereotypes, considered that female carers needed less support in the caring role.

Carers who 'felt they had to take care not to upset the patient' - were not helped by 'busy' nurses, i.e. community psychiatric nurses with large caseloads rather than small caseloads. Optimum caseload sizes are debated in the literature with little



constructive conclusions emerging (Driver 1976). The evidence from the findings in East Hospital suggests that the size of caseload only has an adverse effect on this one aspect of caring.

The finding that the association between patient problems and patient burden was very significant shows that relatives who felt helped with patient problems were also helped to cope with the experience of caring. This suggests that community psychiatric nursing intervention aimed at problem relief, should also be effective at reducing subjective burden. This clearly has implications for the training of community psychiatric nurses and for the resource use.

### Frequency of visiting

The basis for carer selection in the study was based on frequency of visiting by the community psychiatric nurses (p103). The community psychiatric nurses who visited frequently were first compared with those who visited infrequently; the only item that emerged as statistically significant on the chi-square test was: carers who 'wanted to keep the patient out of hospital' considered nurses that visited infrequently, as less helpful. It may well be that this group of carers had high expectations of the community psychiatric nurses, as regards visiting frequency.

The scattergram findings, linking frequency of visiting and 'East' and 'West' carers' perception of helpfulness found that an increase in frequency of visiting was related to an increase in perceived helpfulness of the community psychiatric nurses. It could be the case that the community psychiatric nurses are influenced by consumer reaction: the community psychiatric nurses, aware of being perceived as unhelpful, may have responded by reducing visiting frequency; and vice versa, the community psychiatric nurses, more often visited carers from whom they received feedback that they were being helpful. The 'West' carers found that the experience of caring was helped as much by infrequent visits.

Some carers feel helped by a few visits, others by frequent visits from the community psychiatric nurses. What is clear from

the results is that frequent visiting is not viewed negatively. For those carers that are visited frequently, it is unclear whether the community psychiatric nurse is rated maximally after the initial visit(s), the pattern of rating then migrating over with more frequent visiting. Alternatively, after the first visit(s), the community psychiatric nurses could be rated low, the rating increasing after each successive visit. To ascertain how the ratings changed, rating would need to have been completed after each successive visit with the carer. This would be a useful area on which to focus a future study. The comments mentioned above, linking patient data with the feedback about help in relation to frequency of visits, are also relevant here.

The nurse aspects scattergram for West Hospital had a clustering of ratings between the 9th and 13th visits (p248). This could suggest that there may be a maximum number of visits beyond which helpfulness is unrelated. Further data are required to confirm this.

Further scattergrams were completed showing frequency of visits in relation to items in the patient problem, family burden and nurse aspects section of the PQAST, to see whether visiting frequency was related to helpfulness with particular problems, family burden or nurse aspects. The scattergram for 'East' carers for the item, 'the nurse is an outsider' showed a visible tendency for increased help to be linked to increased visiting. This association was not significant and some people were helped maximally with few visits. It is unclear whether this genuinely reflects help given by the community psychiatric nurse, or whether this reflects the developing nurse/carer relationship.

Raphael (1972) in a study of hospital patients, found that patients were reluctant to rate care given negatively. It is unclear whether carers are also reluctant to criticise care received. This study suggests that they will criticise, but it is probably reasonable to presume that the dynamics involved in developing therapeutic relationships with patients are equally relevant to therapeutic nurse/carer relationships; the comments found in this study therefore, may be understated.

#### 4:4 THE GOALS OF COMMUNITY PSYCHIATRIC NURSING WORK

One of the reasons for examining the process of community psychiatric nursing, was to explore the 'goals' as expressed by the the nurses. The literature suggested that goals of community psychiatric nursing practice tend to be stated in imprecise and broad terms (see p53), and that the available quantitative measures used by community psychiatric nursing services provide little information on which to assess whether or not these goals have been attained. The laddering procedure (see Chapter 3:5, p110) was used to explore the nurses' goals and to see whether individual nurses were indeed vague in their expression of them. It was hoped that the goals could then be examined using the notion of ultimate, intermediate and immediate goals, as described by Suchman (1967). This framework was discussed in Chapter 1 (see p8), where it was also indicated that values, separable from goals, are the principles which enable priorities amongst goals to be established. For this reason the values and assumptions of the community nurses were also examined.

It was anticipated that the expressed goals provided by the nurses could be checked out against what the patients and carers said about community psychiatric nursing work in order to ascertain how far the goals of the nurses were achieved. The following paragraphs detail the goals of community psychiatric nursing work and compare these with the feedback received from carers and patients.

##### *The immediate, intermediate and ultimate goals of the nurses*

The constructs elicited by the triadic sorting procedure (see Chapter 3:5 for an explanation of these terms), could be described as 'immediate goals'. This can be justified on the grounds of the theoretical discussion (p30), which focused on the importance of the Nursing Process in community psychiatric nursing work. Based on the literature it was hypothesised that the community psychiatric nurses would use the 'Nursing Process', the first stage of which is 'assessment and information gathering'. The interview data (Chapter



4:1) confirmed that these activities featured in the nurses' work.

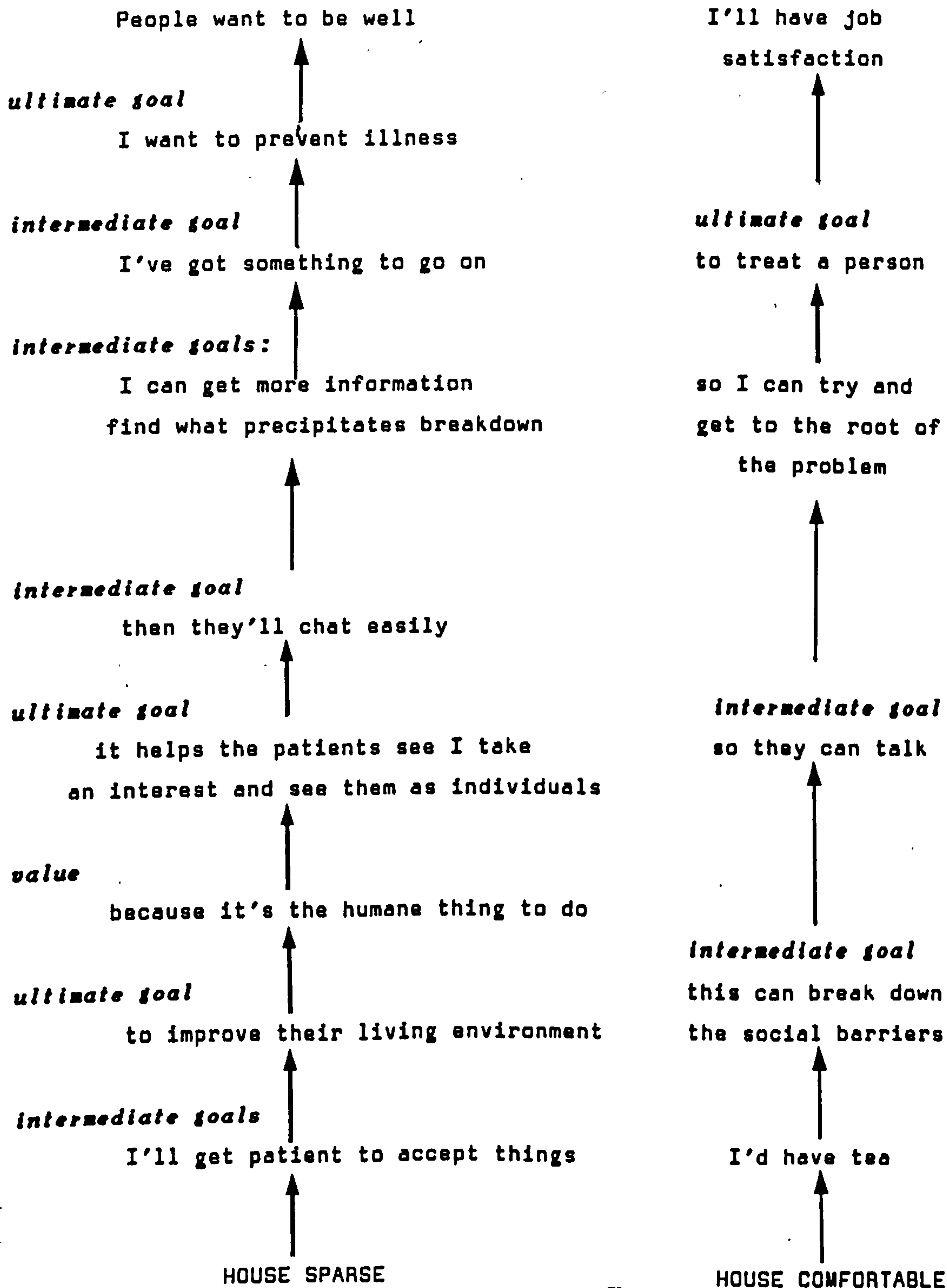
Strictly speaking, the initial goal of this part of the nurses' work is to obtain baseline information. Elicitation of 'constructs' reveals heads for the nursing assessment and details the sorts of information which the nurses used to plan care. As such the constructs can be taken to be 'immediate goals' of community psychiatric nursing work. The laddering procedure (see p110, Chapter 3:5) was then used to explore the thinking underpinning the relevance of each 'immediate goal'; from this exploration it was possible to examine the nurses' accounts of the work and identify the intermediate and ultimate goals of the nurses.

Each community psychiatric nurse was able, when led, to give a version of goals relevant to his work, and the findings suggest that there is a disparate list of values underpinning the work of each community psychiatric nurse. The elaboration of the goals into a triadic hierarchy is not as clear as the theory above suggests: this probably reflects the difficulty of being explicit about the complicated life scenarios with which the community psychiatric nurses have to deal. Often there was not just one 'intermediate' goal, but several (see example in Table 12 of a 'laddered construct', using data from the present study: p261).

Describing a goal as 'intermediate' was based on the researcher's interpretation of whether or not this appeared to be a 'step' aimed in the direction of achieving an 'ultimate goal'. Regardless of how the goals were described, this analysis showed that the nurses, contrary to the expectations of the literature, were able to discuss clearly the goals in their practice. Table 14, p269, provides a summary of the values, intermediate and ultimate goals described by the community psychiatric nurses in this study.

Table 12: Details of a ladderred construct with superimposed interpretation of goals and values written alongside.

*values:*



### Examination of the immediate goals

With the help of a content analysis (see p123, for a fuller discussion of this method of data handling) the 'immediate goals' were examined to ascertain the nurses' orientations and to see whether the constructs showed evidence of concern for the carers on the part of the nurses. The headings for the content analysis were chosen with this purpose in mind. The final headings used in the content analysis arose partly out of comparison of previous construct categorisations reported in the literature (detailed below) and were chosen because the descriptions fitted the data. An attempt to further check the validity and reliability of the content analysis (by sending it to experts in the field) failed. The choice of headings however, was sufficient to show the predominant focus of the nurses' work.

Bearing in mind the advice of Berelson (1952): see Chapter 3:5, p123), definitions of the details of the headings used for the content analysis are detailed below (Table 13, see p264). Appendix 11 shows the constructs produced by each nurse, sorted into the headings used in the Content Analysis. I tried to sort the constructs consistently under a particular heading. The headings are not mutually exclusive and it is acknowledged that some constructs could have equally been sorted under another heading. For instance, constructs which mentioned 'family' in relation to self sufficiency were put in the latter category, although they could have been inserted into the home situation grouping. For this reason the choice of headings is not entirely satisfactory.

The Content Analysis showed that the the majority of constructs were 'patient focused' and that the nurses seemed little concerned with the families' needs; additionally, many of the constructs showed that the nurses were concerned with medical problems. The findings may be partly due to the choice of patients as elements for the Repertory Grid technique (see Chapter 3:5). However, the results of the qualitative analysis, which explored the usefulness of the constructs, with the nurses, did not reveal a marked change in this focus of concern.



The Content Analysis also revealed that each nurse produced a varied number of constructs, and placed different emphasis on the production of some types of constructs rather than others (see Figure 25, p266). The concern of this analysis was not to explore details of the working practices of individual nurses. The purpose of exploring individual's descriptions was to draw conclusions about community psychiatric nursing work generally and specifically in relation to care of the carers. The findings of the Content Analysis indicate useful areas for further study, to ascertain whether the differences in constructs produced represent differences in the way the nurses used models or reflect varied theoretical orientations of the nurses; the differences may result from the varied contexts in which the nurses work, or be related to differences in the patients.

### *1. The content analysis*

Few category systems have been developed for construct analysis. Existing category systems were reviewed to see if they could be used in the present study. Systems of categorisation have emerged from previous researchers' data: Davis (1984) used Duck's (1973) classification of constructs. The latter author classified constructs into psychological, role and 'other' categories which, he claimed, allowed his constructs (on friendship) to be placed into exclusive and exhaustible categories. These categories seemed too broad to classify the constructs used by the community psychiatric nurses.

Philip and McCulloch (1968) using repertory grid, identified two clusters of constructs used by social workers to describe patients. These groups concerned the degree to which a patient functions and copes socially, and the feelings of the social worker towards the patients. These groupings were relevant for classification of the constructs produced by the community psychiatric nurses, but were limited in that they did not enable description of the range of constructs produced by the nurses.

**Table 13: Content Analysis headings and definitions used.**

**1. HOME SITUATION**

Any description where home situation is described

**2. ILLNESS**

Any description where illness label is used

**3. TREATMENT**

**(a) PATIENT RESPONSE**

Any description where patient response to treatment is mentioned

**(b) DESCRIPTION**

Where treatment offered is detailed

**(c) MEDICATION**

Any description where medication is mentioned

**(d) TIME ORIENTATION**

Any description denoting future orientation or expectancy or past orientation or expectancy of patient contact with CPN services

**4. SOCIAL INTERACTION**

**(a)** Any statement in which face-to-face, ongoing interaction is indicated or lack of face-to-face, ongoing interaction is indicated.

**(b)** Interpersonal statements which might curtail interaction with others, or encourage it.

**5. WORK - FINANCES**

Any descriptions where work or finances are mentioned

**6. SELF-SUFFICIENCY**

**(a)** Any statement denoting interdependence, initiative, confidence and ability to solve one's own problems or the opposite

**(b)** The ability to attend to aspects of daily living - hygiene, washing, dressing, nutrition or inability to attend to aspects of daily living

**7. FACTUAL DESCRIPTION**

A characteristic so described that most observers would agree that this is factual and not open to question.

**8. SELF-REFERENCES**

Any statement where the nurse refers directly to himself

**9. VALUE JUDGEMENT**

Any description which is subjective and suggests moral evaluation

**10. PROBLEMS IDENTIFIED**

Any statement where 'problems' are focused on.

Lifshitz (1974), who studied the perceptions of trained and untrained social workers, developed seven categories from his work: 1. task orientation; 2. a description of concrete situations; 3. abstract intrapsychic characteristics; 4. abstract interpersonal or interpsychic characteristics; 5. abstract social values; 6. intellectual characteristics; 7. affective - egocentric approach. The categories developed by Landfield (1971) proved to be the most helpful in guiding the construct categorisation used in this study: Landfield (1971), developed a manual which provides twenty-two categories into which constructs can be placed. Some of these descriptions were borrowed: social interaction, self-sufficiency, factual description, self-reference. Combined with these headings, I developed six other categories. The definitions used with the headings are described in Table 13. The findings of this analysis, the quantitative data base for the extraction of goals, are presented in Figure 25, p266.

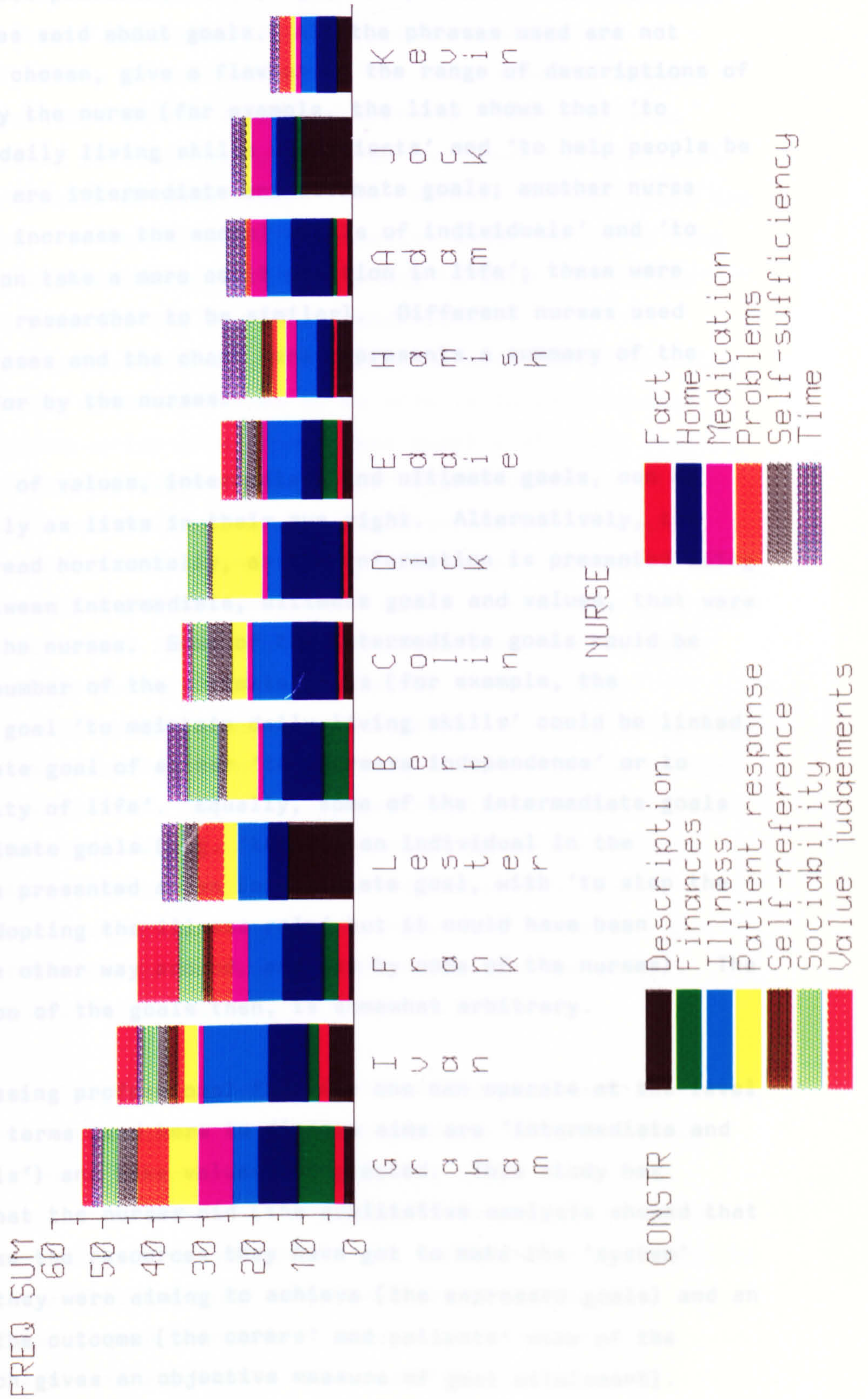
#### Examination of values, intermediate and ultimate goals

The laddering procedure revealed that different nurses also produced varied lists of values, intermediate and ultimate goals which, it can be assumed, influence practice. Elaboration of these lists for each nurse is irrelevant to the purpose of this study, but a useful future enquiry would be to examine these findings closely, and in particular try to identify how the values actually influence practice in the individual nurse/patient situations, and how each nurse establishes priorities within the goals they set.

The results detailed in the previous section (Chapters 4:2 and 4:3, pp204-250), present the findings of the Personal Questionnaire Rapid Scaling Technique (PQRST: see p129) and in effect provide feedback of whether or not attainment of the goals was achieved. In the following pages, the values, intermediate and ultimate goals referred to by the nurses are presented and discussed in relation to what the patients and carers said about the 'process' of community psychiatric nursing.



Figure 25: Constructs produced by each nurse  
 Constructs are sorted by Content Analysis





The phrases presented in the Table 14 present information about what the nurses said about goals. All the phrases used are not listed; those chosen, give a flavour of the range of descriptions of goals given by the nurse (for example, the list shows that 'to maintain the daily living skills of patients' and 'to help people be independent', are intermediate and ultimate goals; another nurse mentioned 'to increase the social skills of individuals' and 'to help the person take a more adult position in life'; these were judged by the researcher to be similar). Different nurses used different phrases and the chart here represents a summary of the goals aimed for by the nurses.

The list of values, intermediate and ultimate goals, can be read vertically as lists in their own right. Alternatively, the list can be read horizontally, as the information is presented using the links between intermediate, ultimate goals and values, that were provided by the nurses. Some of the intermediate goals could be linked to a number of the ultimate goals (for example, the intermediate goal 'to maintain daily living skills' could be linked to the ultimate goal of either 'to increase independence' or to improve quality of life'. Equally, some of the intermediate goals could be ultimate goals (e.g. 'keeping an individual in the community' is presented as an intermediate goal, with 'to stop the individual adopting the illness role' but it could have been presented the other way around, and was by some of the nurses). The classification of the goals then, is somewhat arbitrary.

In assessing professional function one can operate at the level of aims (the terms used here to discuss aims are 'intermediate and ultimate goals') and take values for granted. This study has focused on what the nurses did (the qualitative analysis showed that the nurses use the resources they have got to make the 'system' work), what they were aiming to achieve (the expressed goals) and an analysis of the outcome (the carers' and patients' view of the service, which gives an objective measure of goal attainment).

It is only when one starts to ask 'was it worth doing anyway?' that one gets into a political level of discourse where an examination of values is indispensable. At this level of debate, there are no possible purely objective criteria. In this sense detailing 'values' is less appropriate for the level of functional analysis, the concern of this study. The 'values' of the nurses are detailed however, as they provide information about the value base of the nurses' work which influences the way in which the nurses' prioritise the goal setting aspect of their work.

The community psychiatric nurses could be described as working from a basis which embraces values to do with: autonomy and self sufficiency; preservation of a dignity and quality of life; respect for the individual and beliefs about care 'in the community' (for instance it is better to avoid hospitalisation and institutional neurosis and promote care in the family situation). As Downie and Telfer have commented (Downie and Telfer 1980), values are essentially comparative in nature and this was borne out by the manner in which the nurses referred to values. (The nurses commented for example, that "autonomy is better" implying a negative comparison). The description of 'values' is related to the content of the 'ultimate goals'. These values are displayed alongside the goals with which they were most often linked. As with the goals mentioned, this presentation is somewhat contrived and is not intended to be expounded as a rigid prototype, but rather a rough guide to the framework of values referred to by the community psychiatric nurses in this study.

Broadly speaking the nurses' goals could be described as either patient centred, job centred or family centred in nature. These were linked, though. If asked to clarify the goals to do with 'family', the nurses talked about helping the family cope in order to improve the patient's quality of life. When asked to explore the importance of 'patient autonomy' the nurses referred to the importance of running an economic service or getting job satisfaction from seeing patients manage on their own.



**Table 14: a summary of the values, intermediate and ultimate goals described by the community psychiatric nurses.**

<b>Patient-centred goals</b>			
<b>INTERMEDIATE GOALS</b>	<b>ULTIMATE GOALS</b>	<b>VALUES</b>	
improve patient coping capacities	help patient cope	<b>Autonomy</b>	
help individual change	help patient manage		
develop relationships	increase confidence		
help individual achieve	" "		
get person to talk	able to offer self		
give opportunity to improve	promote independence		
encourage patient to do things	better to help self		
discourage the sick role	promote self sufficiency		
.....			
focus on precipitants	avoid hospitalisation		<b>Community care is good</b>
help person solve problems	avoid relapse		
set realistic targets	" "		
aim to work through feelings	avoid escape to hosp		
help person deal with stress	" " " "		
" " cope " "	prevent illness		
look for early warning signs	" "		
get person to ventilate	" "		
provide company and stimulation	" "		
avoid uprooting person/family	to reduce stress		
keep people in families	maintains roles		
keep person in community	won't learn sick role		
.....			
want to get to know a person	provide indiv progs	<b>Respect for Individual</b>	
get information to work on	provide indiv care		
show that I care	interested in person		
be a friend to patient	indiv feels valued		

Table 14 continued.

## Patient-centred goals (continued)

INTERMEDIATE GOALS	ULTIMATE GOALS	VALUES
get person to accept gifts	improve environment	Quality
reduce myths re mental illness	educate the public	of
put support services in	avoid risks	Life
make self available	to prevent crises	
help give person a role	increase self esteem	
help individual mix socially	feedback from others	
help person to go out	see life is worthwhile	
maintain daily living skills	enable person to survive	
help person self medicate	opportunity to socialise	

## Family-centred goals

INTERMEDIATE GOALS	ULTIMATE GOALS	VALUES
to develop respite services	to relieve the family	Family
make carer's life easier	to reduce the burden	care
give carer practical help	improve coping capacity	is
help family understand	improve communication	good
improve home relationships	patient stays at home	
keep relatives informed	family continue caring	
give carer support	" " "	
allow care to ventilater	" " "	
prevent crisis	CPN & carer cooperate	

## Nurse-centred goals

INTERMEDIATE GOALS	ULTIMATE GOALS	VALUES
I would lower my expectations	avoid getting frustrated	Job
collect maximum possible info	provide efficient service	is
get to know patient well	use time well	satisfying
avoid hospital admission	prevent blocked beds	
reduce myths re illness	make job easier	
educate the public	others' expectations fit	
I want to use my skills	to use my training	

### *Patient and carer feedback about goals*

Feedback about the 'process' of community psychiatric nursing was obtained and provided the substance of the statements in the PQRST (see Chapter 3:5 and Appendices 6, 7 and 8). The comments made by the patients and carers have been explored in the Chapters 4:2 and 4:3. It is also possible to look at the statements and make comment about how the 'goals', as expressed by the nurses, were perceived and experienced by the consumers.

For the purpose of presentation, the statements included in the patient and carer PQRSTs are re-classified into the goals and value groupings used in Table 14. 'Values' are included in this presentation for illustrative reasons only. (The intention of this section of the analysis is not to fit the consumers' views into the same set of values as the nurses. This would be unreasonable: job satisfaction - a value of the nurses could not be expected to figure highly in the patients' and carers' scale of values). The point at issue in this analysis is not to compare the nurses' and consumers' value systems, but rather, the level of comparison is that of goals.

The major finding of this analysis is that some criteria for assessing the nurses' success in meeting their own aims have been fulfilled and that there is a good deal of congruence between what the nurses sought to achieve and what the clients experienced.

#### **The patients' view of goals**

Analysis of the comments of patients at the day centres suggest that many perceive the 'intermediate goals' of the nurses (see Table 15, p272 which reclassifies the contents of the 'day care PQRST' in relation to the 'goals' and 'value' groupings discussed above). The 'ultimate goals' were less accurately perceived by the patients; the most obvious omission is that the patients did not explicitly focus on the work of the nurses as being aimed at 'avoiding hospital admission'; 'preventing illness' or 'keeping individuals with families'. Neither did the patients see the nurses as educating them about mental illness, although this could be implied by reference to seeing 'other people at the day centre being different'. A further point of note is that the patients also



commented on the work of the nurses in terms of their activities: these descriptions could be likened to the task centred definitions, of community psychiatric nursing, referred to earlier (see p29).

**Table 15: Statements in 'day care PQRST' grouped in relation to the goals and values expressed by the community psychiatric nurses**

**AUTONOMY:** I made friends at the day centre  
 The Day Centre is like a family  
 People there are worse off than me  
 I meet others with similar troubles  
 The nurses talk to me  
 The nurses have time for discussion  
 I talk to nurses re things I couldn't discuss elsewhere  
 The nurses let me see things differently  
 The day centre builds up my confidence  
 The nurses tell me not to get dependent  
 I make my own way to the day centre  
 The nurses delve into my past

**QUALITY OF LIFE:** The Day Centre is a place to go  
 The centre has a nice atmosphere  
 I can phone the nurses any time  
 The nurses give me support  
 I feel I am helping others  
 I am kept busy at the Day Centre  
 I get a meal at the day centre

**RESPECT FOR THE INDIVIDUAL:** The nurses take an interest in me  
 The nurses make me feel important  
 The nurses ken about me  
 The nurses care  
 The nurses say things that comfort me  
 The nurses don't treat me badly  
 The nurses listen to me  
 The nurses ask how you are feeling

**COMMUNITY CARE IS GOOD:**  
 I can get things off my chest  
 I have company at the day centre  
 Others at the day centre are different

**Task orientated definitions of the work:**  
 I attend a group  
 We play games  
 The nurses give me my medication  
 The nurses arrange for me to see a psychiatrist

**Unsorted statements:**  
 The nurses are cheerie  
 The nurses have special qualifications

A similar interpretation can be used to comment on the perception of the patients who were visited at home (see Table 16, p273 for a reclassification of the contents of the 'home visiting PQAST' into the 'goals' and 'value' groupings detailed earlier). The patients visited at home discerned the 'intermediate goals' described by the nurses, and the patients also focused on the task centred nature of the work. Analysis further showed that the goals emphasising 'individualised care' are experienced most keenly. The goals grouped under 'autonomy' and 'community care is good' were comparatively little used. The 'home visited' patients referred especially to the 'manner' or way in which the nurses worked; these comments could be converted into the intermediate goal expressed by the nurses of 'showing they care' or 'befriending'.

**Table 16: Statements in 'home visiting PQAST' grouped in relation to the goals and values expressed by the nurses**

**AUTONOMY:** A relationship has developed

**QUALITY OF LIFE:** You get to know the nurse  
I know the nurse's circumstances  
I can talk to the nurse confidentially  
The nurse brings things I need  
The nurse talks to me

**RESPECT FOR THE INDIVIDUAL:** Home visit better idea of me  
The nurse takes an interest  
I know I am not forgotten  
The nurse cares  
The nurse asks how I am keeping  
I can trust the nurse  
The nurse visits informally

**COMMUNITY CARE IS GOOD:** Same nurses visits all the time  
There is no waiting at the house  
It is convenient at the house

**Task orientated definitions:** The nurse has a cup of tea  
The nurse has a look around  
The nurse takes blood  
The nurse gives medication  
The nurse visits regularly

**Unsorted statements:** The nurse has other qualifications  
The nurse cracks jokes  
The nurse is patient  
The nurse is attentive  
The nurse is cheerful

### The carers view of goals

Feedback from the carers about community nursing work was restricted to comment about the nurses rather than to problem relief or stress (see pilot study, p142). For this reason Table 17 presents a breakdown of the PQAST: 'Nurse Aspects' section only, (see Chapter 3:5).

One fifth of the statements in the 'Nurse Aspects section PQAST' refer to the patients (and are classified under the patient-centred goals); the carers therefore considered some of the nurses' patient-centred goals to have been realised. Especially, the carers commented on the 'talking' behaviour of the nurses. The carers were much less specific and less varied in their range of descriptions of intermediate and ultimate goals than those provided by the nurses. The nurses were considered to work with patients 'to prevent hospital admission' and 'to prevent relapse of illness' (goals not perceived by the patients). The format of the visiting situation was commented on suggesting that the carers endorsed some of the nurses' comments about 'community care'; again what the nurse actually does, the activities of the nurses were mentioned by the carers.

The remaining statements of PQAST: Nurse Aspects, suggest that almost all of the 'intermediate goals' expressed by nurses and included in the 'family centred goals' list (see Table 17) were endorsed by the carers. The exception to this was the goal of 'improving of relationships within the family'. Few of the 'ultimate goals' were elaborated on by the carers.

The 'outcome' information suggests that objectively the nurses did not help very much with a high proportion of the carers' problems. Nevertheless some goals were attained, because some carers experienced relief of problems and help with the feelings associated with looking after a mentally ill relative at home (see Chapter 4:3, p232). Many of the patient-centred goals identified by the carers, were also attained - as evidenced by the high evaluations of scores given to the items in the 'Nurse Aspects' section of the questionnaire (see Chapter 4:3).



**Table 17: Statements in 'family PQRST' grouped in relation to the goals and values expressed by the nurses**

**FAMILY-CENTRED GOALS:**

Carer can see nurse when patient visited  
 Carer feels can approach nurse if worried  
 Carer feels can talk to the nurse about anything  
 Carer finds nurse easy to talk to

Carer can call the nurse  
 Nurse will visit if something is wrong

Helps the carer understand illness  
 Gives the carer backing  
 Nurse tells the carer they are doing OK  
 Makes the carer feel less alone

**PATIENT-CENTRED GOALS:**

**RESPECT FOR THE INDIVIDUAL:**

Patient needs to talk to the nurse  
 Nurse comes to see the patient  
 The nurse assesses the patient  
 Carer leaves patient alone with the nurse  
 Nurse can talk to patient and say things carer can't  
 The patient's presence inhibits the carer  
 Carer dislikes talk behind patient's back

**COMMUNITY CARE IS GOOD:**

The nurse staves off recurrence  
 The nurse prevent hospitalisation

**QUALITY OF LIFE and AUTONOMY**

nil

**Task orientated definitions of the work**

Nurse stops carer seeing a psychiatrist  
 Nurse arranges day care  
 Nurse arranges admission

**Unsorted statements:**

Meeting on my territory is best  
 The nurses are freer  
 The nurse is an outsider  
 Nurse arrives unannounced

Before concluding this section it is worth commenting that there is limited information about the nurses' goals which were not commented on by carers or patients. It could be concluded that lack of reference to a 'goal' means that the nurses were not working towards an expressed goal. This conclusion is not entirely accurate. Some aspects of the nurses' goal-seeking behaviour may by virtue of the nurse / patient relationship be misinterpreted by the recipients of care (see p36). Further, the goal, as defined by the nurses, (for example work aimed at 'promoting independence' - encouraging someone to go to the day centre) may be experienced as something totally different by patients and carers, (for example the nurse showing care and interest). It would be unreasonable for all the expressed goals of the nurses to be interpreted in the experiences of the carers or patients.

Suchman's statement (1967) that 'goals' (aimed for by practitioners in a service) should be reproducible has been referred to earlier (see p9). This analysis has shown that the community psychiatric nurses in the two services studied were able to do this: the community psychiatric nurses clearly detailed 'goals' which they aimed for. This is contrary to the information previously documented in the literature.

This analysis has also shown that there is a good deal of congruence between what the nurses sought to achieve and what the clients experienced.

# CHAPTER

# 5

# Conclusions



### 5:1 SUMMARY OF THE STUDY

In the first section of this final chapter (Chapter 5:1), the work is reviewed: the reader is reminded of the original aims and objectives and the findings of the study are summarised. This offers the opportunity to bring together material from the various parts of the study. Comment is then made about the limitations of the study and how, in retrospect, the study could have been improved. In the second section (Chapter 5:2), the opportunity is taken to look at the study in an integrated way and examine its overall implications.

#### *The work of community psychiatric nursing*

The qualitative analysis focused on the 'process' of community psychiatric nursing, an area in need of systematic study (see p52). Drawing as it does on relevant literature, this analysis has highlighted issues relevant to community psychiatric nursing practice and revealed aspects of the way community psychiatric nurses work, which were previously unknown.

It was hoped that examination of the 'process' of community psychiatric nursing would focus on the goals, assumptions and values underlying service provision and show how community psychiatric nurses do the work of community psychiatric nursing. It was also envisaged that the interview data would reveal to what extent 'caring for the carers' affected the work of community psychiatric nursing (see p69), and allow for the exploration of work with the carers, to see whether the nurses talked about 'reducing burden' or the negative effects of caring (see p52), helped relatives and patients deal with 'expressed emotion' (see p66) or if the nurses provided continuity of care (see p67). The major findings of this analysis are summarised below.

#### **The findings**

Despite the difficulties of defining community psychiatric nursing and the problems of defining the context in which community psychiatric nurses work (Chapter 2:2, p29), the qualitative analysis showed that there are common patterns to be found in the nature of the work of community psychiatric nurses. It was difficult to sort the categories from one to the next, but for the sake of explanation, three major themes emerged which pervade this account of community psychiatric nursing work.

These were: 'the ideology of individualised care'; 'juggling resources', and 'justifying the care'. The nurses 'make' community psychiatry work by juggling with resources; they are placed in a situation where they have to compromise their expressed ideology of 'individualised care' and they manage to do this by resorting to various activities which 'justify the care' given.

The literature review shows that official reports on 'community care' are ambiguous and have confused aims (Chapter 2:1). Some of this ambiguity and confusion is evident in the work of the community nurses, as seen by the confusion, at local level, about what should constitute legitimate work. Despite these ambiguities, the individual community psychiatric nurses were able to express clearly the 'goals' which they aimed for in the work (Chapter 4:4).

#### **Community psychiatric nurses' work with carers**

The nurses were more interested in care of the designated patient than in the respective carer(s). This discovery was contrary to expectation, as the literature review suggested that the work of community psychiatric nursing would involve 'relief of burden' and offer specific interventions to families of schizophrenic patients (p62-67). The findings show that the nurses were in contact with carers, but the data suggest that the 'patient focus' of the work of the community psychiatric nurses should be emphasised. These results do not demonstrate that the nurses are providing care to the carers; any care offered to carers is secondary to and contingent upon care offered to patients. The focus on 'patients' at the expense of 'care of the carers', is influenced by two factors: lack of resources and how the nurses' viewed the carers, both of which are linked (see below).

#### **1. Lack of resources**

In view of the lack of 'community resources' (detailed previously, p15-18), the finding that the work of community psychiatric nursing was affected by 'resources' was not totally unexpected. What was surprising however, was how strongly and crucially, this influenced the nurses' work. Resource availability or lack, determined who the nurses worked with (patient or carer). Further, the community psychiatric nurses appeared to offer 'individualised' care (as described by the patients: see p272-3): this may testify to the nurses' success in using their

skills of 'developing relationships' (the nurses did this by 'showing they care' and 'playing the role of the nurse': see p155).

Individual patients (and families) who do not 'fit' the available resources were variously classified (see p182) and 'fitted' into a framework which allowed the nurses to legitimately, i.e. in a caring way, reject certain patients and justify particular care provision to others (see model use, below). The community psychiatric nurses in effect, 'labelled' patients, an activity which prescribed management of patients; the data show that the sources of the demands (e.g. new, at risk, or manipulative patients) were the main determinant of who got what care).

## *2. The nurses' view of the carers*

The data show that the nurses view carers as a resource to help the nurses. This suggests that the nurses endorsed the view of care 'by' the community, which was seen to be preferable to institutional care (p22-25). The nurses' use of the 'independency rationale', implicit in the anti-institutional movement, can also be interpreted as evidence of the nurses' commitment to care by the community. Holding this view would imply that the nurses equate the primary carer with 'the community' where mutual respect and support was the norm (see Chapter 2:1, p22). This study shows that, for the relative, caring can be a stressful, lonely and isolating experience (see Chapter 4:3, pp238 and 240).

The nurses' view of the carers, (which arose, in part at least, from lack of resources), and of patients (who were seen as individuals), also involved prejudice: the findings demonstrate that the nurses' preconceptions affected their work, although they tried to maintain good practices by developing a consensus and making joint decisions. Somewhat paradoxically, although the nurses strove to maintain good practices, other evidence, such as lack of the use of systematic assessment tools and lack of supervision, suggests that standards of clinical practice could be improved.

The interview data suggest that individual community psychiatric nurses had mixed feelings about the extent to which they should help the carers. The nurses were aware of the negative effects and 'burden' experienced by relatives: to a certain extent, the nurses' management of patients was geared to reduce this. Again paradoxically, however, much of the work of community psychiatric nursing was aimed at maximising the help that could be gained from the carer. When the nurses talked of



providing day care and social interaction opportunities: this was seen as being advantageous to patients, by improving their capacity to relate with others: (see 'social model of care', p32). This treatment was not offered as a means of reducing the level of expressed emotion to which patients were exposed, nor did the nurses talk of providing this care for the benefit of the family (see p66-67: intervention packages based on 'expressed emotion' studies). The nurses did talk of creating 'therapeutic dependency'. This shows the value which the nurses placed on providing ongoing support to patients. This term is similar to the notion of 'continuity of care' referred to in the literature (p67-69), although it should be noted that this phrase was predominantly used to describe work with patients, rather than carers.

One of the major findings about the work of community psychiatric nursing is the emphasis the nurses placed on 'developing relationships' (see p153). This behaviour was vital to the community nurses, allowing them to make the system work (managing crisis, preventing admissions to hospital and providing early treatment). This emphasis, and the nurses' accounts of the work, suggested that they use a 'social' model of care. The nurses however, take an eclectic approach to model use (see Chapter 2:2, p31-34) and use all the other models, namely the psychological, medical and behavioural. The nurses talked less often of using a behavioural model or approach. This emphasis of the work, on 'developing relationships' contradicts the findings of other researchers who found the work of hospital based psychiatric nurses was more on the medical model (p39 - 41).

#### *An evaluation of the 'outcome' of community psychiatric nursing*

This study attempted to produce an 'outcome' measure of community psychiatric nursing: helpfulness of community psychiatric nursing input, as perceived by the 'carers' of mentally ill patients looked after at home. The work of community psychiatric nursing was also explored, by examination of the comments of patients and carers, about the process of community psychiatric nursing.

'Helping the carers' was emphasised in the literature as being a goal of community psychiatric nursing work (p56). It was hoped that, by using the PQRST (see Chapter 3:5, p129), this method would find out whether carers were helped by contact with community psychiatric nurses and whether or not the nurses specifically helped with relief of

'subjective' and 'objective' burden (p62). This focus of the study was considered timely, in view of the emphasis of current policies on the development of community care, which increasingly encourage families, particularly women members, to care for mentally ill relatives, at home (see p26).

Systematic exploration of community psychiatric nursing work in relation to relief of burden has not been undertaken before. The present study has also examined a range of community psychiatric nurses' patients and explored 'frequency of visiting' in relation to outcomes.

### **The consumers' view of community psychiatric nursing**

Chronologically, this study began with the patients' view of community psychiatric nursing. Both the patients and carers in the present study were able to give an account of community psychiatric nursing. The patients demonstrated that there were three strands which they found helpful about contact with the community psychiatric nurses at the day centre: these were to do with the setting of the contact, the other patients who attended and finally, the nurses themselves. More statements were made about the nurses, suggesting that the patients consider the nurses to be particularly influential. Patients visited by the community psychiatric nurses in the home setting also made reference to the manner and attributes of the nurses, and the benefits of the context in which they were visited (Chapter 4:2, p212).

A major finding was that patients and carers found the interest and concern shown by the community psychiatric nurses was 'very considerably' helpful (Chapter 4:3). The nurses talked about 'showing they cared'; this aspect of the work was clearly picked up and appreciated by the consumers.

Another notable finding of the PQRST focus of the study was that the consumers' view of 'community psychiatric nursing' was 'shaped' by their experience of the service provided. The researcher found that the carers had little to say about 'problems' experienced (p142). An explanation to account for this difficulty may be that the carers were unaware, first of the problems for which they could or did get help; alternatively, the carers may not have perceived their caring activities as 'problems' at all, but merely as aspects of the caring situation to be tackled on a daily basis. This interpretation would support the finding that the nurses 'shape' needs. This conclusion can be linked back to the



interview data, where we saw that the nurses controlled and manipulated the conversations with carers. These data also showed that the nurses were not predisposed to concern themselves with the carers' welfare and that help offered to carers was related to the available resources. The nurses could be described as 'ignoring' the burden of the relatives.

Comments from carers, during the PQAST procedure, suggested that the carers were instrumental in bringing up problems for discussion (see p252). The onus is therefore on the carers to complain or raise problems - hence allowing the 'ignored' burden to become 'revealed'. Hoenig and Hamilton (1974) found that relatives do not ask for help; this is supported by the findings of this study, where half the carers did not tell the nurses if they were worried (Chapter 4:3).

The interview data also showed that the community psychiatric nurses used carers as a resource. The PQAST statements did not suggest that the carers felt 'used': in fact, many carers considered themselves supported by the nurses (see p226).

Feedback from the carers showed that they viewed the nurses as a crisis intervention service (in the carers' words, "the nurses would visit if anything was wrong"). Additionally, the community psychiatric nurses are seen as a 'specialist' service where advice and expertise was offered on psychiatric matters. The nurses tended to offer selective help to the carers about 'typical' psychiatric problems and about the 'experience' of caring for the mentally ill and it is unclear what factors are related to this selectivity.

#### **Day care and contact with the carers**

Cormack (1976) found that psychiatric nurses working in the hospital setting did not foster contact with relatives. Sladden (1979) found that the community psychiatric nurses in her study tended to have contact with the relatives in the home setting rather than in the clinical setting. It would be reasonable therefore to assume that community psychiatric nurses based in the day centres had limited contact with the carers.

In the present study, approximately 12% of the patients attending a day centre, (7:56), stated that the community psychiatric nurses had not been in contact with their relatives. This is further evidence of the nurses 'ignoring' family burden (by not visiting the carers of the mentally ill at all), a strategy which benefits the 'system'.



### *Limitations of the study*

From the outset, this study set out to examine the effects of community psychiatric nursing work. The title of this thesis, although accurately reflecting the content of the following text, is not entirely consistent with the wish, also expressed by the author, to 'evaluate' and measure effectiveness. This inconsistency arose out of the difficulties inherent in evaluating a service as complicated and diverse as that of community psychiatric nursing; these difficulties, of course, are not peculiar to this study but are typical of any research work aimed at attempting to link outcomes with inputs.

The nature of community psychiatric nursing itself constitutes a whole spectrum of activities ranging from the one-off provision of information and physical help to a complex amalgam of practical and/or emotional support, counselling, collaboration with various agencies and professionals. The task of attempting to link change in patient behaviour with community psychiatric intervention may always be an almost impossible endeavour. In these circumstances, the 'natural' course of the condition being treated is unknown, and the question of whether any care is better than none will always remain unanswered. This study did not have any of the conditions sufficient to establish whether the outcome measures can in fact be linked to the community psychiatric nursing intervention: for example, random assignment of the population to an 'experimental' and a 'control or comparison' group; different interventions offered to each of these groups; clear specification of the types of intervention being used (with separation of the effect of the method used from the influence of the person giving the help). Bearing these factors in mind the findings presented above must be viewed with caution.

Any attempt at evaluation is a matter of assessing the value or worth of an activity; if this is accepted, it follows that evaluations are essentially subjective judgements, varying with the viewpoints and the roles of the evaluators. The criteria used in this study to explore value were viewed from the vantage point of the families of patients visited by community psychiatric nurses. The carers' view is only one, though important, element in the constellation of factors that need to be taken into account in judging effectiveness. A fuller picture of 'effectiveness' may have emerged if other kinds of data had also been acquired which could have supported these measures. Further, it should

be noted that follow-up data are of little use unless comparison can be made with the state of affairs at the start of the intervention. For this a prospective study would be required.

A highly structured measure - PQRST - was used to examine outcome. The aim was to produce as 'objective' a measure of satisfaction (of carers with community psychiatric nursing provision) as was possible. However, what could be said about 'satisfaction' remained very partial, and the data were difficult to interpret. The use of the PQRST to measure 'help' failed to shed light on what the carers actually meant by 'helpfulness', and to provide information about the reasons for the answers. Thus the tool employed did not allow me to explore the thinking and reasoning behind the carers' views. A different research approach could provide these data.

Other reservations about the design of this part of the study include the fact that the number of carer respondents was small; this limits the generalisability of the findings. Nevertheless, the findings give clues as to the help that carers are receiving from community psychiatric nurses, and provide pointers to areas of future study. An initial intention of the study was to focus on a range of patients and their respective carers. It is regretted that more biographical details of both patients and carers were not collected in order to link helpfulness (or otherwise) with other variables. As a result, the available data are somewhat frustrating because they provide little information with which to explore the helpfulness of community psychiatric nursing work (see, for example, p254, where the carers are selective about what they share with the nurses; it is unknown whether this is related to a failing on the part of the nurses or a reluctance by the carer).

All respondents were given a choice about completion of the PQRST. Those that agreed to comply with the procedure (see p224) may represent a self-selected group which had strongly positive or negative comments to make about the community psychiatric nursing service. It is unknown how typical of other available carers this group is. Another source of bias in the data, lies in the fact that all the patient/carer pairs were currently receiving community psychiatric nursing care: this may have inhibited the carers from criticising the nurses. Further, the carers were aware that the researcher was a community psychiatric nurse: this too, may have had an inhibiting effect on the carers' willingness to be



critical of the nurses. The findings therefore must be interpreted with care.

As with any piece of research, the endeavour raises more questions than it answers. The consumers' view of the community psychiatric nursing service was limited by the explicit focus of the study. Another research method, with a less structured format, would have allowed for exploration of the carers views, expectations and past experiences of care provision. It might, in hindsight, have been more illuminating.

Any study committed to 'evaluation' of service provision should begin with clear statements of the aims being pursued by the clinicians. It emerged early in the study's conception that the aims of community psychiatric nursing provision were ill-defined; part of the study was therefore devoted to examination of the aims or 'goals' of community psychiatric nursing work. Thus an evaluative purpose was in mind when the aims of community psychiatric nursing were first explored. This exercise became a main focus of the study, as it became apparent that the information had value in its own right, and contributed valid data and knowledge about the work of community psychiatric nurses. At this point the researcher's interest deviated from being totally concerned with evaluation to a two-fold concern, with evaluation on the one hand, and with an exploration of the nurses' implicit goals and orientations to practice on the other. However, in keeping with the study's intention of 'evaluation', the goals expressed by the community psychiatric nurses in the study were subjected to close scrutiny (see Chapter 4:4). The statements of goals in fact were examined separately from the measure used to look at attainment. This raises two points which should be acknowledged in this section. Firstly, was it logically acceptable to abstract the goals of community psychiatric nursing from the practitioners themselves, and secondly was it appropriate to compare these with independent statements made by patients and carers? Bearing in mind the earlier comments about evaluation of worth from varied vantage points it must be said that this tactic only tells part of a more complicated and varied story.

Another issue which should be mentioned here, is that of using the same data about nurses' goals both to define them (see Chapter 4:1), and also to assess how far these had been addressed (see Chapter 4:4). Indeed there is nothing intrinsically wrong with examining a body of data in two different ways, but there is also a circularity introduced into



the argument. In reality it is unknown whether the nurses, in the practice situation, did actually attempt to attain the expressed goals which they talked about in the interviews, and details about how these goals were achieved are also lacking.

The interviews were based on constructs gained from the Repertory Grid technique and the interview format employed was that of the 'laddering' procedure (see Chapter 3:5). These methods were employed because, as a novice researcher, I was not sure that I would be able to handle the data resulting from a more unstructured approach. This raises the question of whether the use of the structured interviews of Repertory Grid, producing 'constructs', hindered or aided the collection of data on the process of community psychiatric nursing.

Initial response to this query would be to recommend the method: tackling the interviews in this way forced the nurses to explore the information they used. These data were previously lacking and other researchers, using more traditional methods (e.g. Altschul 1972, discussed on p47), had found it difficult to encourage psychiatric nurses to discuss their work. In fact, many of the nurses commented on the fascinating nature of the interviews because they found themselves trying to verbalise aspects of the work to which they had not previously given thought.

Only a small number of community psychiatric nurses were involved in this study, and it is unclear whether the findings are generalisable to community psychiatric nursing as a whole. The findings do have a certain amount of face validity in that they appear reasonable to the researcher as a clinician; further, the fact that the findings in the second site confirm the analysis in the first area also give a certain amount of validity to the conclusions. The merits of using Repertory Grid Technique were that this method made respondents think, and produced findings which have face validity. The method is heralded as one which enables exploration of the perceptions of 'individuals'. This was indeed the case; the strength of the method, as used in this study, was that the data were also successfully compared across the group as a whole. I would recommend that future researchers should use this method in situations where respondents find it difficult to express their perceptions, and where the questioner's influence on the answers is required to be minimal. I have serious reservations about use of the method combined with the rating and quantitative measures (see p122), and

would not support wide application of this aspect of Repertory Grid Methodology.

There are of course more straightforward means of obtaining qualitative data, and it is possible (though not evident from any lack of cooperation on the part of the interviewees) that the structured nature of the techniques may have limited the ability and inclination of the respondents to enlarge upon their work. The use of the Repertory Grid Method and Laddering allowed only for scrutiny of the constructs elicited.

Pushing the nurses to explore the constructs forced them to think of generalisations which governed the work, although the nurses in fact often responded with comments on individual situations. Another method may have accrued different information, with less emphasis on general approaches and more focus on specific case management.

Taking a totally different approach with the nurses, for instance that of Participant Observation (see Pearsall 1965 and Spradley 1980), would also have supplied qualitative information about community psychiatric nursing. With the benefit of hindsight, the use of participant observation might have produced useful data which are currently lacking. Thus, other factors which affect the work of community psychiatric nursing could be studied in depth; the influence of the multidisciplinary team on community psychiatric nursing work might therefore be examined further (see p192), or alternatively, an in-depth analysis of the nurses' expectations of informal carers would be possible (see p179).

In this study, the qualitative data obtained from the structured interviews proved to be the most informative and valid. In contrast, the highly quantitative data provided little information which clarified what it was that was helpful about community psychiatric nursing intervention, and data about the reasons behind the evaluations are conspicuously lacking. I would recommend that future studies on community psychiatric nursing work explore the merits of taking an observational approach, and suggest that use of such methods may gain more valid data than that obtained in this study, using a highly structured and quantitative focus.



## CONCLUSION

The findings of the qualitative analysis described community psychiatric nursing as analogous to the staging of a theatrical production (see p151). This was because the emphasis of the nurses' work was on 'making the system work'. The community psychiatric nurses themselves 'make the system work'; this is with little guidance and direction, either from service organisers or from planners. Somewhat paradoxically, despite appearing to operate using varied *modus operandi*, the nurses provided a remarkably uniform service. These contradictory findings are not incompatible: they are testimony to the nature of the work, which is continually making compromises between the ideology, the resources and the care provided. The service appears to be uniform, because of the constraints of finite resources (which limit the number of ways in which the nurses can work) and because the nurses are socialised into the work of community psychiatric nursing by peers and colleagues.

The data show that the reality of community psychiatric nursing is that the nurses are not providing individualised care, but instead continually having to juggle resources and to justify *post hoc* the care that they give. This reality has never been documented and as such must now be recognised by educationalists, managers and planners alike.

This study has shown that the emphasis of the nurses' work is on 'developing relationships'. This emphasis is testimony to the nurses' use of the social model in the work situation, and reflects the ideology of 'individualised care' used by the nurses. Use of this ideology is beneficial: it succeeds, to a certain extent, in making carers and patients feel cared for and supported, regardless of whether actual problems were helped. Service managers' future efforts should be on helping the nurses cope with the compromises that they are obliged to undertake in order to make the ideology 'fit' the resources.

The conflict that the nurses are in has implications for morale of the service staff: if the service is to be sustained and standards of care maintained, these conflicts facing the nurses need to be acknowledged and focused on. This is not happening at present. Further, what happens if and when the demands on the service increase - do the nurses merely continue, *ad infinitum*, to 'juggle resources' and 'justify the care'? The nurses should be obliged to take stock of what they are doing and evaluate where they are going. This study has shown that the



individual nurses clearly express the goals which they aim for in their work; however, the community psychiatric nursing service itself seems to be unclear about its aims and goals. The future must bring better defined services, which are clear about their aims and goals. To do the latter, the nurses will have to be encouraged to evaluate and monitor their work: this will require a fundamental change in their educational preparation, where there is an emphasis on integrating a research component with the work. Service managers need to address this issue.

It would also appear that, as community psychiatric nursing presently exists, the consumers of the Health Service are not getting the 'best deal' out of the service: help that carers and patients receive is dependent on the available resources which are rationed out by the nurses. The nurses used the carers as resources in order to 'make the system work'. Carers did not feel 'used', but the findings show that any help the nurses gave to carers was secondary to that given to patients. Patients and (carers) who do not fit the service, as it is presently organised, are labelled, and often discharged. Any changes in the work practices of the nurses or developments (for example, liaising with GPs and working with early onset of mental illness) must be at the expense of care given to other patients (for example, at later stages of illness). Should these practices continue? If we are serious about 'caring for the carers' the work of community psychiatric nursing must be looked at, to see who should be providing this care. Focusing on resources also raises the question of who should be campaigning for the development of resources. The community psychiatric nursing service as it exists tends to, consciously or otherwise, obscure the reality of scarce resources (because it succeeds in making the system work). This situation should be challenged and must be noted by politicians and planners.

## 5:2 IMPLICATIONS FOR THE FUTURE BASED ON THIS STUDY

### *The work of Community Psychiatric Nursing*

McKendrick (1980) posed the question - on what basis do community psychiatric nurses make decisions (see p78)? The study detailed here shows that community psychiatric nursing decisions are strongly influenced by the lack of resources and at the moment individual community psychiatric nurses make the decisions about whom (or not) they offer treatment to. Meetings tend to be used to 'rubber-stamp' these

decisions, but did not appear to provide an opportunity for the nurses to debate and argue about priorities of service provision.

### Lack of resources

The influence of lack of resources on community psychiatric nursing work has implications for the future organisation of community psychiatric nursing. These implications are relevant to the organisation of community psychiatric nursing work at two levels: firstly, the level of community psychiatric nursing service provision generally and secondly, at the clinical level of individual community psychiatric nursing practice. Each of these implications is explored below.

### The organisation of community psychiatric nursing services

In the face of lack of community resources, urgent attention should be given to the issue of who should be receiving skilled community psychiatric nursing help. The literature detailing the theoretical arguments for who is eligible for treatment by community psychiatric nurses has already been presented (see p200). In summary, these arguments rest on whether or not the work of community psychiatric nursing is considered to be that of primary, secondary or tertiary prevention (see also Chapter 2:2, p37); also implied by the discussion were assumptions of what constituted 'paid' work, the inference being that tasks which could be undertaken by untrained workers should not be done by the community psychiatric nurses. These arguments reveal that community psychiatric nurses, theoretically at least, have a legitimate role to play with a wide range of people; the question at issue is about whether the decision about who receives treatment, should be an individual, a local or a nationally dictated one.

Nurses within the same community psychiatric nursing service treated similar situations differently, and thus held contradictory views about who was eligible for community psychiatric nursing treatment. It could be argued that different views within any one work setting are to be expected, and are related to different expectations of the nurses about nursing work. For example, over thirty years ago, Habenstein and Christ 1955, described three 'types' of nurses: professionalizers, traditionalizers and utilizers who are in nursing for professional reasons, vocational reasons, or simply to make a living, respectively. Nevertheless, in a situation of scarce resources it would seem to be

logical to ensure that the limited resources are being used in the most efficient manner possible. The interview data suggest that these differing views (of community psychiatric nursing work) caused some disharmony and disagreement within the community psychiatric nursing services, and it could be inferred that this was wasteful of the time and energy of the nurses. Having varied views of the work, therefore, on one level could be argued as inefficient. Further, the wisdom of 'using the existing resources to help as many people as possible' can be challenged: Some would argue that it is more efficient to target resources to fewer problems but which have clearly measurable outcomes. The managers of future community psychiatric nursing services should be tackling the business of who should receive community psychiatric nursing help, and come to a compromise about who should be the focus of community psychiatric nursing work, instead of leaving the decisions, as at present, to individual practitioners.

The first question that arises from this comment is then, should nurses in any one service jointly decide who should be the focus of their attention? The advantage of this approach would be that as a group of like-minded peers - the nurses - could argue for their respective involvement, using a common language and knowledge about nursing input. They could tailor their input to cater for local needs and problems (similar to the sentiment of DHSS 1975). If this expectation is to be realised, the nurses would have to have an awareness of the contribution of other professionals and agencies involved in the care of the mentally ill (demands in any one service necessarily are greatly influenced by the scope and nature of other available services, especially at the boundaries - as for instance the care of elderly people, where the respective remits of health and social services are blurred). This has implications for in-service training of the staff of community nursing services, they need to be provided with the opportunity to examine their work, to compare their working practices with other services, and to update their skills in relation to clinical developments.

The community psychiatric nurses themselves may not be the best people to comment impartially on their contribution in relation to individual patients (see comments by Mangen and Griffith 1982, p75). Bearing this in mind, it could be proposed that decisions about who are treated, by the community psychiatric nurses, may be more appropriately taken at a multidisciplinary level, where the combined views of different



professions can be brought to bear on the work of community psychiatric nursing. The contribution of other professions may be preferable to the 'nurse only' decisions, because others may be sufficiently distanced from the work of community psychiatric nurses, to ascertain the contribution of community psychiatric nursing input. This study has shown that this does happen, to a certain extent. This approach however, may also have disadvantages. I have shown (Pollock 1986), for instance, that varied organisational, gender, intraprofessional, and training factors influence all members of the multi-disciplinary team, and can raise barriers to the effective functioning of the team. The leader of the multi-disciplinary team, often a doctor, may be the decision maker; this has been shown to affect community psychiatric nursing development, and resulted in referrals being controlled by a consultant psychiatrist; it results in the work of community psychiatric nursing, being dominated by the medical model (Reed and Lomas 1984).

This comment raises questions about the work of community psychiatric nurses (principally, who should the nurses be helping and why; is the nurse the only person who could help this person; who has the expertise to provide the optimum level of care?) - questions which, it should be noted, are equally pertinent to other professionals involved in care of the mentally ill. Additionally, any decision about community psychiatric nursing involvement will have implications for the work of others. As such, it could be argued that the issue of who should be cared for by community psychiatric nurses should be debated much more widely, by professionals, policy makers and voluntary organisations alike. This is a solution proposed by Drucker, who comments that the 'All Wales Strategy' provides evidence of "the progress which can be made when the efforts of families, professionals, civil servants and politicians can be harnessed together" (Drucker 1987).

Examination of 'work' usually means examination of the individual professionals and staff 'at work'. Policy documents - for example, SHHD 1985, (and this research study) - do not start with an examination of tasks, but with the staff involved. In future we should be looking at what tasks need to be done for patients and carers - from the diagnosis of rare conditions to the support of those re-learning skills, lost through illness, e.g. cooking, shopping, self-care, from research into different treatment approaches, to the daily physical care of those with dementia - and only then think through what skills and staff that are

needed to carry the tasks out. Future work needs to be done in this area, so that for patients and carers the most appropriate worker can carry out the necessary action. Information for carers of patients suffering from schizophrenia or dementia may for example be better given by peripatetic information givers; company and social activity may be equally well provided, for patients who need this, by lay workers who are taught about and given an understanding of mental illness.

Each profession engaged in the mental health field has its own amalgam of knowledge based on medical and social sciences, and each has a tendency to claim individual coherence and authority. Yet there appear to be difficulties of seeing, in practice, where the contribution of one professional ends and that of another begins. This takes us into the realm of 'role blurring', where there is overlap of skills amongst the professions. The concept of the 'key worker' seems to have emerged because of this: here an individual worker co-ordinates and organises the care of a patient (or group of patients); the profession of the worker is largely irrelevant; what is important is that the 'key worker' has the skills, abilities and motivation to help the patient. The 'key worker' approach to patient care, appears to make individual workers feel especially valued, partly because they have a clearly defined task which they are responsible for carrying out; there is also less emphasis on roles prescribed by training and power positions. Perhaps we should be looking at this area more carefully and if possible enable people with lesser training to do certain tasks instead of overburdening the elite, like community psychiatric nurses, of whom there are too few.

Some work comparing the contributions of different professionals has already been done: Controlled studies have been conducted which suggest that social worker attachment to general practice resulted in chronic neurotics showing improved psychological and social adjustment receiving fewer prescriptions (Cooper et al 1975); Marks (1985) found that psychiatric nurse therapists in primary care have been effective. These are psychiatric nurses trained to assess patients systematically, carry out behaviour and cognitive therapy programmes and social skills groups - traditionally work exclusively carried out by clinical psychologists. Paykel and Griffith (1983) found that community psychiatric nurses were equally effective in the treatment of neurotic patients compared with out-patient psychiatrists. These studies need to be replicated on a wider scale. It is only when this has been achieved that manpower

targets (for community psychiatric nursing services, for example, can be established with any certainty: see p74).

The future (for community psychiatric nursing in particular) and for care of the mentally ill generally, must be one in which 'evaluation' of practice is a strong component. Drucker stated:

evaluation is a skilled task in its own right and not something which can be tacked on to the job of an already harassed project worker...More [money] should be spent on evaluating services and, if good proposals are not coming forward from outside researchers, the Scottish Office should consider commissioning research directly or employing their own researcher to carry it out. Furthermore, some of this activity should take the form of action research - in which projects would be set up with the conscious objective of providing a model for testing. (Drucker (1987), p126).

This comment should be heeded both by the Scottish Office, who have a crucial role in encouraging the evaluation of projects focusing on care of the mentally ill, and also by service managers who may be in a position to employ researchers to evaluate service provision. I have argued above for the need for evaluation of community psychiatric nursing services, particularly in the face of services functioning in a situation of 'lack of resources'. Even if the resources available for care of the mentally ill are increased, this argument still stands.

#### **Organisation at clinical level of community psychiatric nursing work.**

The lack of resources, which of course includes community psychiatric nursing personnel, means that the work of the community psychiatric nurses should be examined to ensure that the 'best' use of the scarce resources is being achieved. This entails 'evaluation' of the work, at service level. Additionally, the manner in which the nurses manage their caseloads and the influences of the individual nurses' practices should be explored to ensure high standards of nursing practice and efficient use of resources.

#### **1. Clinical Supervision**

The aims of 'clinical supervision' have been detailed as:

to facilitate the nurse in developing a different perspective on her work with clients, by encouraging



greater self-awareness and building strengths and therapeutic and coping skills. As a process effective supervision is educative without being didactic, since it promotes learning, and increases confidence and problem-solving skills in a supportive setting... (Simmons and Brooker (1986), p134-5).

This component of clinical work is advocated as a means by which individual nursing practices can be examined and offer opportunity for the nurses to monitor, explore and if necessary change their practice.

There is plenty of evidence from the data that the practice of community psychiatric nursing would benefit from 'clinical supervision'. The organisational control exerted by the community psychiatric nurse managers was minimal although it imposed some safeguards on the current system of 'patient' and 'carer' triage operated by the nurses. The nurses, however, had plenty of scope to do what they wanted.

Previous research focusing on the skills of psychiatric nursing (see p39: McIlwaine 1980 and Cormack 1983), suggested that often psychiatric nurses in the hospital setting take a 'medical model' role, support the work of doctors and use interpersonal skills minimally. The findings from the present study suggest that the nurses use various models (especially the social model with an emphasis on 'developing relationships') in community work. It could be argued that the community context allows the nurses to 'develop relationships' whereas, in the hospital setting, the time limited situation and urgency of the patient's condition restricts the opportunities of the nurse to focus on this aspect of the work. The fact that the community psychiatric nurses work is so different from that of hospital based nurses may indicate that this area of the work would benefit from the support offered by supervision.

The interview data highlight two other features of community psychiatric nursing practice which could be improved by the introduction of clinical supervision. Firstly, the data suggest that the community psychiatric nurses may have some difficulties sustaining relationships: patients who are 'difficult', 'too demanding' or who become 'over-involved' tend to be rejected (see p184). Some of the nurses then appear unable to handle these patients. Perhaps the opportunity for clinical supervision of

psychiatric nurses' work would provide the support that the nurses need to be better able to cope with these 'difficult and demanding' patients. Secondly, the finding that the nurses have preconceptions of patients and carers is a factor of the work which could be explored and revealed during supervision sessions. (This will be one, constructive way of tackling the issue of 'problematic' patients; in the light of the previous discussion, the matching of patient needs with professional expertise and indeed the whole issue of ascertaining the 'success' (or otherwise) of interventions, is an endeavour which is in its infancy. Merely introducing supervision is not the whole answer, but it is a step in the right direction).

Clinical supervision can be undertaken on a group basis, e.g. peer review or on a one to one, individual basis (CPNA 1985d). The former sharing of problems took place in an informal way in the services studied. If individual 'clinical supervision' is introduced into the day to day work of the community psychiatric nurses, one cannot help but ask who is in the best position to undertake this supervision. The easiest answer to give would be to propose the manager of the community psychiatric nursing service. Equally however, it could be argued that another professional could do this work: taking the notion of the 'key worker' concept (mentioned above), the professional with the appropriate skills should do the supervision (e.g. a clinical psychologist or behaviour therapy nurse if the nurse is using a behavioural model, a psychoanalyst if the nurse is using a psychological model, a social worker if the nurse is using a social model and so on). If nurses are eclectic in their approach to their work why should they not be eclectic in their choice of supervisors?

The attraction of 'clinical supervision' is summed up thus:

It would be misleading to imply that systems of supervision and workload monitoring only benefit individual CPNs [community psychiatric nurses]. They can also be extremely important for the service in providing a forum for examining the degree of fit between the direction in which a CPNs work is going and the overall strategy for the development of the service as a whole.  
(Simmons and Brooker (1986), p135).

This comment may indeed be persuasive in enticing the local manager to supervise community psychiatric nursing staff. This comment links



individual work practices with overall development of community psychiatric nursing services and takes us full circle back to the importance of developing a strategy (see discussion p53), and of who should be targetted to receive community psychiatric nursing care.

Regardless of the debate about who should receive treatment from community psychiatric nurses, one would have thought that there should be standardisation in relation to certain aspects of care, at least agreed direction to service provision, particularly when resources are limited. The data suggest that there are some agreed ways of managing patients (e.g. not to follow-up psychogeriatric patients, see p196). Other approaches could be agreed upon. Fisch et al 1982, propose "tactics of change" or options for "doing therapy briefly" which could be a legitimate way of working in an environment of limited resources: in an under-resourced field, these options should be explored, by both clinicians and their managers. This brings us into another topic relevant to the future of community psychiatric nursing services, that of training.

#### *The work of community psychiatric nursing: training implications*

Changes or improvements in clinical practice cannot be mentioned without comment about the importance of training aimed at updating and improving therapeutic activity. This has been implied by the above comments about supervision and in the discussion about the knowledge base, from which community psychiatric nurses would argue to care for specific individuals in the community.

The majority of community psychiatric nurses nationally (CPNA 1985b) and most of those in the present study, are not specifically trained for community work. This study, shows that few differences emerged between the trained and untrained nurses in the study (nurses with the community psychiatric nursing qualification had negative views about 'social visiting': see p161: this view may have resulted from the post-registration training which, it could be speculated, may encourage the nurses to be critical of their work). The evidence from this study showed, that regardless of training received, the way in which the community psychiatric nurses structure their work, and make the system function, is by using a schema not directly imposed by training.

The data suggest that the way the community psychiatric nurses



function is the product of a coping strategy, and demonstrate how the nurses make the system work. 'Clinical supervision' could be included in the future work of community psychiatric nurses, in order to help them cope and function better. Alternative strategies could be taught to the nurses, like using a behavioural approach to care or integrating 'systematic assessment tools' into the practice of community psychiatric nursing, each of which are detailed below.

The nurses in the present study said little about interventions which could be subsumed under the description of offering a 'behavioural model' or approach to care: some of the nurses referred to 'goal' or 'target setting' (see p162), and behaviour was focused on with a view to changing it (see p167), but more often than not alternative models were used as the treatment of choice. The behavioural model offers opportunity for nurses to be systematic and focused in their approach (see above and particularly the work of Barker and Fraser 1985). This approach would be particularly advantageous to community psychiatric nurses, if we consider the previous comments about evaluation and efficiency. The interview data suggest that the nurses 'labelled' patients, and that this activity may have had the effect of making 'dependent' patients even more dependent (see discussion on p182-6). A more productive stance for the nurses to take would be for the nurses to use positive descriptions, which may serve to motivate and promote patient independence, and which would also help the nurses to focus on the patients' merits, rather than deficits and demands. This approach has its roots in the behavioural model; nurses using this more positive focus have been described as taking a 'constructional' approach to patient care (Barrowclough and Fleming 1986 and Barker 1986). The behavioural model, then, should be taught to community psychiatric nurses as a valuable approach to care.

An additional way in which teaching could potentiate the individual nurses' practices would be to inform the nurses of the benefits of 'systematic tools' (see Barker 1986) which can aid focusing on the patient and target nursing activities; these not only provide a clear picture of the work to be done, but also form a record of interventions which can be useful in the objective assessment of improvement or change. Systematic assessment tools should be used to limit the wasteful use of nursing input and

optimise resource use. Use of these tools would also be a practical help to the nurses, when they have to make choices about whom to target for treatment.

Literature based evidence suggests that some community psychiatric nurses work with patients with early symptoms of mental illness: Stanfield (1984) has described the use of the General Health Questionnaire by community psychiatric nurses. This screening tool, devised by Goldberg (1978), provides a method of identifying emotionally distressed individuals. If used by community psychiatric nurses attached to a health centre or GP practice, this tool can "weed out the potential victims and provide prompt and effective service" (Stanfield 1984).

The data do not suggest that the nurses are aware of the literature on expressed emotion (see p66), and on the importance of reducing patient contact with carers (to reduce risk of relapse), although the nurses did speak of reducing 'burden'. These topics should be known by the nurses, regardless of the involvement that they have with the carers (see below), and highlight another area of teaching which should be made known to community psychiatric nurses.

The previous paragraphs have identified specific research findings and practical techniques which should be taught to community psychiatric nurses. The issue of 'mandatory' training for community psychiatric nurses is a contentious issue, and the courses that do exist have been criticised because they do not provide skills based programmes (see comments: p73). The above discussion suggests that community psychiatric nurses need more skills, and that current community psychiatric nursing courses should have a component on 'skill acquisition'. It could also be argued, based on this analysis of the work of community psychiatric nurses, that present post-registration training be more focused on issues relating to coping with conflicting demands and resource management, and should include a component on 'moral philosophy', for example, which may help make these decisions better understood.

In relation to the 'mandatory training' debate, however, it could be argued - and I would here - that the required skills could and should be taught on an 'in-service' basis. This would support the philosophy of continuing education for nurses in Scotland, proposed by Auld (SHHD 1981), and would be even more applicable in



the future, if the proposals of the nurses' governing body, the United Kingdom Central Council's (UKCC's), for revisions of basic nursing education are accepted (UKCC 1985).

The UKCC have published discussion documents on the future of the nursing profession, in which they advocate a more balanced mix of services with a shift away from hospital centred health care to an emphasis on health promotion and prevention. The papers also argue that basic nurse training must be revised to accommodate the changes in orientation of practice: they recommend and emphasise a 'common core' training for all nurses, with a focus on the social sciences and study of behaviour, life styles, human development, concepts of health, self-care, and coping mechanism (where illness is considered a deviation from health). This is similar to the proposals of the Psychiatric Nurses Association in Scotland (PNAS 1986), and a departure from the current training which is bedded in the biological sciences. The proposed 'common core' resembles the content of present-day community psychiatric nursing courses, so with the passage of time, post-registration training for community psychiatric nurses, as we know it today will become redundant. Future community psychiatric nurse training may evolve to become skills-based training, provided at 'in-service' level; if this was the case, training for community psychiatric nursing would not be specialised, but be provided to all psychiatric nurses [who may in the future be doing more work in the community anyway, if the recommendations of the Shape Report (SHHD 1980b), come to fruition].

#### *Community psychiatric nursing and care of the carers*

One of the concerns of this study is community psychiatric nursing work and the carers; a final comment therefore must be made about the role of community psychiatric nurses with carers. Hunter (1978), commented that "more active and open co-operation should be sought from the caregivers (Chapter 2:3, p49). The present study suggests that the nurses do co-operate with the caregivers, and in particular, the latter help the nurses in their work with patients. The interviews suggest that the focus of concern of the nurses is the patients and that this is partly due to limited resources. This is as good a reason as any to argue against increased community psychiatric involvement with carers. It could also be argued that



community psychiatric nurses, as presently trained and organised, are not equipped to care for the needs of families and carers, and that the emphasis of their training is on patients' needs.

Teaching the nurses about the theory of burden and strategies to reduce the adverse effects (as proposed above), may go some way towards influencing community psychiatric nursing practice in the direction of encouraging the nurses to enquire into the experiences of the carers as regards 'objective' and 'subjective' burden. The nurses may then, if not able to treat carers, at least be in a position to argue for service development based on 'caring for the carers'. This will put a stop to the current situation of the carers having to ask for help.

The importance, therapeutically, of the personality and attitude of the nurse has already been discussed (Chapter 2:2, p35). The findings from the PQRST part of the study suggest that this component of the nurse/patient or nurse/carer relationship were found maximally helpful. The emphasis on the importance of these attributes for nurses given in the training of psychiatric nurses, should be continued. The help provided by the nurses should not be underestimated, and many carers in the study commented that they would not know where to turn if they did not get the help that they do from the community psychiatric nurses. The carers considered the nurses to be the key professionals in the community setting, whom they would seek out to get help with psychiatric matters. Unlike other professionals for example, the community psychiatric nurses appeared to be available and willing to visit in times of emergency.

In the absence of improved, skills-based training for community psychiatric nurses, increased support to carers should logically be undertaken by another profession (for example social work). Social workers are specifically trained to do family work, and as such they may be able to take a more focused approach to their needs. The disadvantage of social work involvement, in caring for the carers, is that until recently, under the guise of Mental Health Officer training, they were not specifically trained in care of the mentally ill (Prentice and Leckie in Drucker 1987). Having a social worker targetted to 'care for the carer' could result in two sets of workers going into a home, one to help the patient the other, the carers. This may not necessarily be a bad idea, but it would be wasteful of

resources, and would compound the split of 'social care' from 'health care' (see p21), an approach to care which seems to be divisive rather than cohesive.

A more constructive and practical solution to the issue of caring for the carers would be for more research to be commissioned, aimed at comparing the contribution of different workers with varied expertise and training. Additionally, extensive surveys need to be undertaken focusing on the tasks that carers require to be done, to help them in the business of caring for a mentally ill person at home. Only then will we be in a position to plan how future services can be organised to the benefit of the 'informal carers'. This will be preferable to the current situation, as evidenced by the PQRST data, which suggests that the community psychiatric nurses 'shape' the needs of the carers and (often inadvertently) render their burden 'ignored' rather than 'revealed'.

In focusing on the future of community psychiatric nursing and the care of the carers of the mentally ill at home, the comments of Brenton (1985), are pertinent. She stated:

the informal deliverers of 'community care' have saved the state a great deal of money, but the costs to *them* of this primary care are never included in the economic equations. 'Supporting the supporters' has never been an instinctive goal of the statutory social services. More often than not, they have tended to ration their resources...their intervention delayed until the inevitable but initially preventable crisis has made more organised and expensive forms of care mandatory.  
(Brenton (1985), p151).

This quotation accurately describes the situation as it exists in relation to the carers and the community psychiatric nursing services studied here. I would argue that no one professional can possibly have the solution to supporting the supporters and caring for the mentally ill. Future research and service provision must be aimed at looking at the contributions of all workers with the mentally ill, including the 'informal' carers.

# APPENDICES



APPENDIX 1

Consent form for medical staff of West Hospital

I am willing to give permission to LINDA POLLOCK to gain access to the case-notes and CPN records of:

- 1.....
- 2.....
- 3.....
- 4.....
- 5.....
- 6.....
- 7.....
- 8.....
- 9.....
- 10.....

I understand these individuals will be visited, interviewed and asked to complete a questionnaire within the next three months. I agree to this approach being made and will inform the researcher if I wish approval to be withdrawn. I also see no reason why an approach should not be made to the carer of these individuals.

.....Consultant's Signature

.....Date

APPENDIX 2

Consent form for patients involved in study in West Hospital

PATIENT'S CONSENT FORM

I.....  
.....  
(Insert name and address) hereby declare that:

(a) I know what I am being asked to do (for fuller details, see attached sheet).

(b) An explanation has been given to me of any possible risks that might occur.

(c) Having taken into consideration these factors, I agreed to participate in this research project.

(Signed).....(Date).....

I have a telephone, and also agree to being contacted by telephone if necessary.

.....Sign your initials if you agree.

Telephone Number:.....Suitable time to 'phone.....

## **An introduction to the use of repertory grid technique as a research method and clinical tool for psychiatric nurses\***

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### **An introduction to the use of repertory grid technique as a research method and clinical tool for psychiatric nurses**

This paper outlines a technique, the repertory grid technique, which offers the opportunity for psychiatric nurses to document information gained in an interview setting. The method, which consists of structured and systematic questioning, allows exploration of individual's systems of meanings. Data collection is separated from inference, hence the criticism that the nursing data is impressionistic and opinionated is avoided. The controlled conversational format of the technique provides an enhanced awareness of receiving information and interpreting it, and the primary data is clearly presented and available for discussion about conclusions. These data can be subjected to qualitative and quantitative analysis and the method is to be recommended as a research technique which could be of value to psychiatric nurses at the clinical level.

### **INTRODUCTION**

This paper derives from research which the author has been engaged in while undertaking a Scottish Home and Health Department Research Fellowship. The research has three main objectives: (1) to describe and compare the work of a sample of community psychiatric nurses in two different areas; (2) to elicit family and patient's view of the community psychiatric nursing (CPN) service; and (3) to compare the above data in order to identify the CPN activity which patient and family find beneficial.

Data are at present being analysed and findings will be presented at a later date. It is anticipated that this research will substantially contribute to the 'process' of the CPN care and an evaluation of the CPN service, in terms of the family and patient's perception of their problems being changed by CPN contact.

\*This paper was first presented at the CPNA (Community Psychiatric Nurses Association) Training Conference in Loughborough, April 1985.

This article focuses on one of the methods of data collection used in the CPN consumer study — repertory grid technique (repgrid). This is presented as a method potentially of value to psychiatric nurses, at the therapeutic level (where the bread and butter work is assessment and treatment by interview). It is also of value to psychiatric nurses as a means of making their work research based and open to scientific manipulation.

### **REPGRID**

Repgrid is a type of structured interview which was developed by a clinical psychologist, George Kelly, in the 1930's (although he did not publish his work until 1955). Kelly developed the technique in an effort to present a method of data collection which, firstly, focused on the individual, rather than large groups which was typical of the large correlational studies in vogue at the time. Then, although psychologists could demonstrate a link between cigarette smoking



and extraversion, birth order and verbal intelligence, or body type and mental illness, these associations didn't help Kelly as a clinician when faced with a chubby man, who lights up a cigarette, says he is an only child and would like to talk about his problems! Kelly, then, rejected these studies as having little relevance in helping him in the clinical situation with clients. He further deplored the idea of individuals (via symptoms) being fitted into boxes (diagnoses) that have general application. Kelly also disliked the distant authoritative approach which some of his colleagues assumed, where problems and stresses were 'interpreted' by 'experts' and patients were passive recipients of 'answers' and 'cures'. This may sound like contemporary rhetoric, but Kelly developed repgrid in response to the demands of the clinical situation 30 years ago, in the hope that it would aid him in his approach to psychiatric patients. The technique clearly has relevance to today's psychiatric nurses and particularly as psychiatric nursing is striving to become more research based.

#### **Repgrid as a clinical tool**

By using repgrid, both the patient and therapist are involved in presenting a picture of how the patient perceives the world. She/he is responsible for presenting a picture of who and what she/he is. The whole technique has a conversational format and clinician and patient can discuss the survival value of the particular map that is drawn.

Everyone has a blinkered view of people, by virtue of upbringing, schooling and life experiences. As therapists, our training further blinkers us (see Burgess 1981, whose classic examples illustrate how individuals with the same history and problems are interpreted quite differently depending on which 'conceptual model' of care is used). This 'blinkering' can be a serious problem to understanding someone else's point of view and cannot be overcome by self-discipline or tightening of resolve. Repgrid, by its structured format, offers a method where the therapist's input is minimal (and tightly controlled) and where the emphasis is on the input from the interviewee (patient) rather than interviewer (therapist).

Most interview situations have periods when therapist and patient talk together or talk over

each other; sentences may be finished off by the therapist and (mis)interpreted, or suggestions made; often the therapist is not so much 'listening' to what the other is saying as preparing the next remark, and hence opportunity is lost for discussion of patient-relevant material. The conversation can meander and transgress from the problem at hand to irrelevant issues. The structuring of the interview, as outlined by repgrid, controls the conversation, rather like the conch shell in 'Lord of the Flies' (Golding 1960) and hence facilitates listening and the collection of pertinent material.

#### **Repgrid as a research tool**

This technique has since been used in various settings other than the clinical one (see Stewart & Stewart 1981 and Thomas & Harri-Augstein 1985). One of the uses to which repgrid has been applied is in the research arena. The merits of the technique, as outlined above for the clinical setting, are also assets as far as research is concerned. These can be summarized as follows.

- 1 The individual focus of the technique provides an effective means of exploring an individual's perception (of people, events, activities).
- 2 Observer bias is reduced almost to zero and objectivity is maximized.
- 3 The discipline involved in the application of the technique ensures that each interview is structured and is truly constructive. The interviewer is forced to keep quiet and the rigour of the compare and contrasting techniques ensures that the interviewee elaborates at length his/her understanding of his/her problems.
- 4 The method is said to minimize the input from the observer/interviewer (Stewart & Stewart 1981).
- 5 The conversational format of the technique also offers itself as a tool which is simple and enjoyable for the interviewee (Smith & Kendall 1963). Further, it is not anxiety provoking for the interviewee according to Watson (1970a); the respondent is reassured that his/her own opinions are being sought, so there is no right or wrong answer.
- 6 The method makes it difficult for the interviewee to interpret its aims and to intro-



duce and maintain a systematic bias in the responses (Rowe 1971)

- 7 Repgrid obtains qualitative data and information in a systematic fashion which can then be open to a hermeneutic approach. Alternatively, this qualitative information can provide information which enables examination of the vocabulary of individual members of a group. This may be used in the pilot stages of a research project to help develop questionnaires which are meaningful to the respondents (Stewart & Stewart 1981)
- 8 The results can also provide quantitative data which can be complementary to the findings of a qualitative nature. This quantitative data can be analysed by principal component analysis, the results of which can be presented visually and diagrammatically, as well as mathematically (Slater 1976, 1977).

### Repgrid as part of theory

Kelly developed a complete theory of personality which he published in 1955 and called 'personal construct theory' (PCT). The technique can be used separately from the theory (Thomas & Harri-Augstein 1985) or combined with the theoretical approach (Button 1985). The tenets of the theory are outlined, in as much as they are necessary to understand the jargon involved in the technique. An elaboration of the theory can be found in Kelly (1955, 1963) and Bannister & Fransella (1980).

### Personal construct theory (PCT)

Kelly believes that man is a scientist. (His rather sexist view on life is confirmed when one realises Kelly is also talking about women!) Basically, he believes that humans develop hypotheses which they test and modify or discard in order to be able to survive. This is an active process then, which influences and conditions how individuals see the world. Kelly believes individuals build up a network of hypotheses based on unique experience which is called a 'construct system'. The repgrid offers the opportunity for an individual's 'construct system' to be tapped.

### The technique itself—the format of the procedure

This is best demonstrated with a simple exercise (taken from Stewart & Stewart 1981).

- (1) Put the following three words on three separate pieces of card: CAR, TRAIN, DONKEY.
  - (2) Now, can you think of one way in which two of the objects represented by these cards are *alike* each other but *different* from the third? In other words, can you think of something that two have in common but the third is different?
  - (3) Write down the answer in the form of two phrases or descriptions separated by a hyphen.
- You may find it helpful to move the cards around as different positions may trigger off new thoughts.

This completed exercise illustrates the fundamental process underlying repgrid work, namely, construct elicitation by triadic comparison.

Some of the examples of phrases or descriptions that you may have produced could be as follows.

Have wheels — Have legs  
 Hard — Furry  
 Carry few passengers — Carry many  
 Go on rails — Go where please  
 Useful end product — Polluting end product  
 Use organic fuel — Use inorganic fuel  
 Born — Made  
 Fast — Slow  
 Owed personally — Owned by organizations  
 Covered — Open to elements  
 Appeals to kids — Doesn't

Clearly these descriptions above were viewing CAR-TRAIN-DONKEY as modes of transport. One could see them as entirely different; if you were a nursery nurse you may think of them as toys and provide some of the following descriptions.

Washable — Not  
 For boys — For both sexes  
 Cuddly — Harsh  
 Dull — Bright colours

Each list of phrases gives individual reflections of a personal world.

### Assumptions

The assumptions of the method are listed in Pervin (1975) and Kelly (1963).



The pairs of descriptions are called 'constructs'. The 'similarity' description is designated the 'emergent pole'. The 'difference' description is the 'implicit' or 'contrast pole'. One of the fundamental assumptions about a construct is that it is a bipolar dimension of judgement, a description which always has an opposite. Light is nonsense without a sense of its opposite, which could be heavy or dark; similarly, blunt is nonsense without an appreciation of its opposite, sharp. This opposite may not always be the dictionary opposite but the semantic opposite which conveys individual meaning and understanding.

Critical — Uncritical (dictionary opposite)  
 Critical — Accepting  
 Critical — Loving  
 Critical — Boring (semantic opposites)  
 Critical — Not an emergency

The 'elements' are the words written on the cards. Normally more than the three used in the illustration are used. All should be discrete (one can imagine how difficult it would be to compare and contrast HORSE—DONKEY—MULE!).

The elements define the content of the interview, and select the subject matter. Choice of elements should be linked to the purpose of the interview. In its original form the technique was called the Role Construct Repertory Test; this consisted of different role titles (like teacher, moral person, person you admire, parents, spouse, brothers) and was assumed to provide some insight into the way an individual constructed his or her interpersonal environment.

The use of repgrid has expanded to include many purposes. It has been developed for use in market research: to improve project design and quality control; to investigate motivation at work; and to evaluate training needs and the success of training events (Stewart & Stewart 1981, Thomas & Harri-Augstein 1985). It has also been used in the clinical situation to study group psychotherapy (Watson 1970b).

## DATA COLLECTION

Different parts of the repgrid technique are useful for different purposes.

### Elicitation of elements

This can be meaningful in itself and provide new insights of a descriptive nature (just having to think of and provide a list of events from which something was learned; colleagues at work who you like, dislike, learn from, fear, etc).

### Elicitation of constructs

This can be useful in providing an accurate description of how that individual views the world and a wealth of qualitative information can be gleaned.

### Grid construction

If constructs and elements are to be integrated into a 'grid format', elements are listed along the top and constructs along the side of a matrix (see Figure 1). The interviewee is then asked to allocate constructs to elements. Traditionally dichotomous choices were offered for the constructs (Kelly 1955), where the subject simply places a tick in the cell, if the particular person in a column can be described by the emergent pole of the construct. Rating and ranking methods have since been employed. These are discussed fully in the textbooks.

Insertion of the information into a 'grid' format with each element rated in terms of the construct (see Figure 1), allows the primary data to be clearly presented and available for discussion. It also provides a record which can be reviewed over time to assess change and therapeutic movement.

The insertion of data into grid format, as illustrated by Figure 1, can aid focusing on problem areas. Constructs can be examined separately, as discussed below, or in combination; or alternatively, elements and element scores could be looked at and compared.

The examples given below illustrate the possible discussion that may emerge as a result of the scores presented on the grid in Figure 1.

#### *Example one*

Construct: down to earth — clever.

This example shows that the individual completing the grid believes she is clever, unlike the rest of her



	Elements										
	Mum	Dad	Brother	f-Self	Best pal	Ex pal	Teacher	Minister	Sister	Ideal self	
Boring											With it
Chatty											Miserable
Down-to-earth	√	√	√	×	√	√	×	×	√	?	Clever
Knows me											Does not understand me
Can be trusted											Disliked
Thin											Fat
Cares											Does not
Hits out											Never hits out
Always the same	1	6	1	6	2	5	1	1	1	3	Enjoys life
<i>Constructs</i>											<i>Constructs</i>
Emergent pole											Contrast pole

FIGURE 1. Showing a grid matrix. √ = example 1; × = example 2. Cells are filled with either ticks and crosses or numbers; the combination shown is for illustration purposes only.

family and friends. The two professionals are perceived as clever and the subject is unsure about her 'ideal self'. Perhaps this is focusing on an area of conflict that is of clinical significance. Completion of a grid could highlight this.

*Example two*

Construct: always the same — enjoys life.

In this example mum and dad are seen almost as opposites, dad being more like the respondent and the ex-friend. Brother and sister are more like mum. Again the rating shows that the subject is not sure about the 'ideal self'. This could be discussed. The contrasting ratings could be looked at (do mum and dad's different personalities cause problems; is the subject compared to the brother and sister; does the respondent get into trouble because she enjoys life?).

**ANALYSIS**

There are numerous techniques open to facilitate analysis of the data presented in grids. These vary from content analysis of the qualitative information to sophisticated analysis of the quantitative data grid matrixes, by computer packages (see Pope & Keen 1985, and Thomas & Harri-Augstein 1985 for an overview of the methods).

**Laddering**

This is a procedure described by Hinkle (1965), for eliciting increasingly superordinate con-

structs, that is, constructs of a higher order of abstraction than those initially elicited. It is a technique developed from repgrid, which is also conversational and aimed at systematically obtaining information from one given construct and exploring the meaning of this.

This laddering procedure is explained clearly and at length by Judkins (1976), Fransella & Bannister (1977), Stewart & Stewart (1981), and Wright (1970).

Wright (1970) elaborates the use of this technique (with diagrams) in the exploration of the meaning of the symptoms for a phobic woman. By implication, he also discusses and explores the meaning of symptom change. Tschudi (1977), also provides an 'ABC' model, based on laddering, which examines the importance of symptoms in the patient's terms.

This kind of enquiry is similar to what Scheff (1968) has called 'negotiating reality', and is of particular interest to the clinician engaged in effecting behaviour change. Like repgrid, the 'laddering' provides a tool for documenting this conversation (Landfield 1971).

Hinkle's (1965) procedure has been called laddering 'up', from a construct. This is illustrated in the following exercise.

*Exercise 2*

- (1) Take two people you work with and yourself. Put these names on cards.

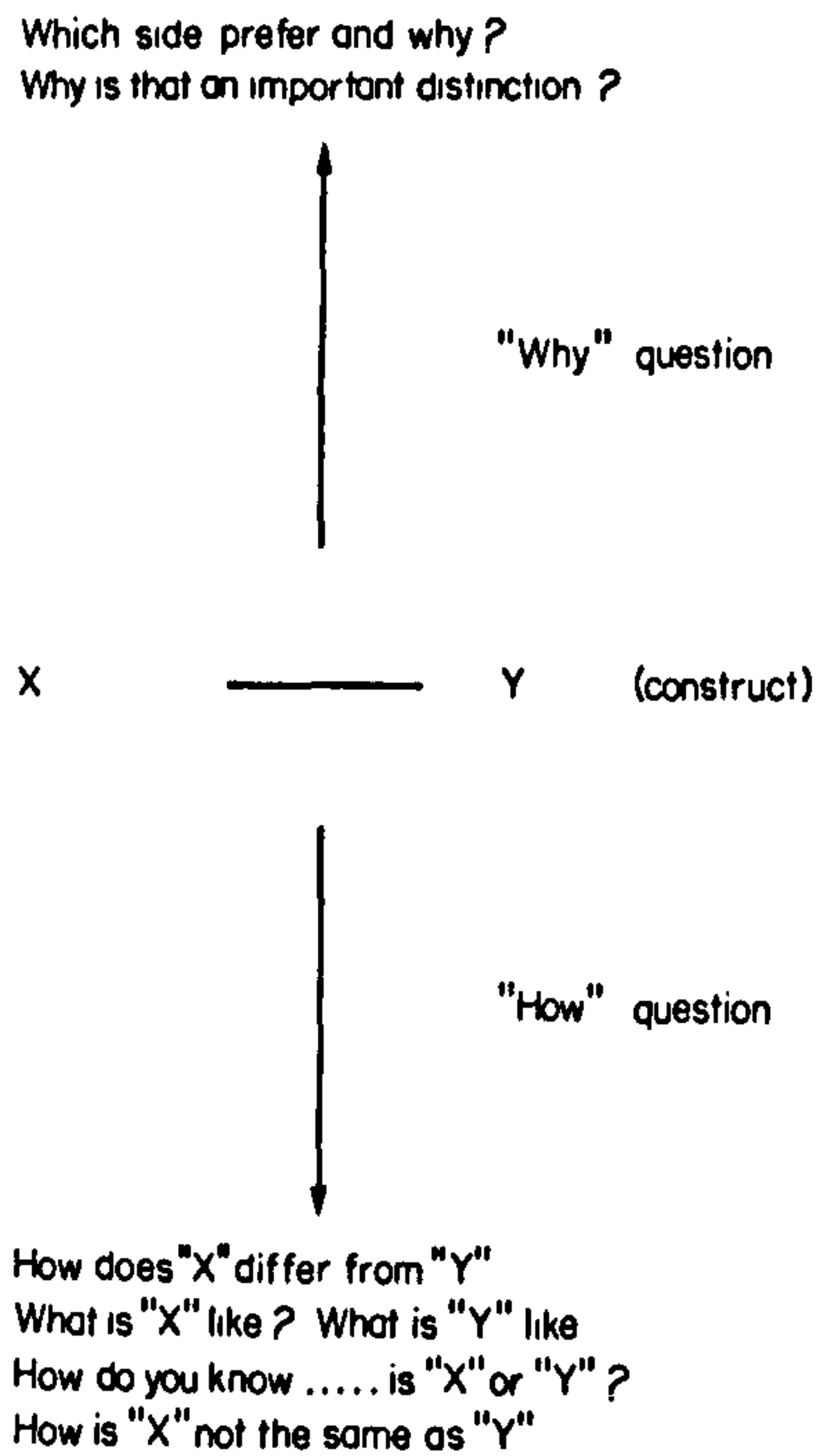


FIGURE 2 Illustrating the process of laddering.

- (2) Produce a construct by asking how are two similar in the way they work but different from a third?
- (3) Ask yourself, do you prefer to work with people at one end of the construct or the other?
- (4) Make a note of the answer.
- (5) Then ask why you have that preference, compared with the alternative.
- (6) Make a note of the answer.
- (7) Ask then why that is so.
- (8) Repeat until you cannot go any further, and no more explanations are possible.

Equally the laddered conversation can be directed downwards to more subordinate constructs. This aspect of laddering was explored by Landfield (1971), in his pyramid technique. Landfield's elaboration, is called laddering 'down' from a construct, and basically involves systematically asking 'how' one side of the construct is different from the other, or asking 'what' questions systematically—what is... like compared with... (the other side of the construct). See Figure 2 for a summary of this 'laddering' process.

## CONCLUSION

A grid can never reveal 'the truth' about a person, since a person doing it has to simplify and compromise to meet the demands of the technique. In the words of Rowe (1978), 'the analysis is expressed in the form of a graph, itself no more an accurate picture of the person than a map of England is an accurate picture of the country!'

This method does not hold the magic answer to the problems of evaluation in the field of psychiatry. This paper is an attempt at introducing a research tool which is as yet little used in psychiatry and could be of value to psychiatric nurses at the clinical level.

## Summary

The repertory grid technique, and the 'laddering' procedure have been outlined as methods which can be of practical value to psychiatric nurses in the clinical situation. They can further be used to evaluate progress and symptom change and provide a means by which psychiatric nurses can introduce a research component into their practice.

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## APPENDIX 4

## CHECKLIST OF ACTIVITIES FOR TAPE RECORDING

Pilot work with the tape recorder allowed me to develop a checklist of activities which ensured that the taping of interviews in the main study was uneventful.

(i) Power source:

(a) Using batteries:

The machine I used had a red light which indicated if the battery had been charged; half way through the first interview the battery failed and the tape stopped; to avoid this pitfall I decided to re-charge the batteries routinely before each interview (for several hours). If there was a choice however, I used the mains lead.

(b) Using the mains:

I must have an adaptor for round and square plugs: this was especially relevant as I was recording in different locations.

(ii) The interview room:

Before meeting the subject to be interviewed time should be spent assessing the environment in which the interview was taking place; this included finding out where the mains switches were and ensuring that there was a table nearby for the tape recorder; preferably this should be at a good height to catch voices of both questioner and respondent; another important point too, was to organise the seating to facilitate relaxed conversation. This pre-interview room organisation of furniture, allowed the interview time to be used maximally for the research purpose and also avoided unnecessary upheaval.

(iii) Recording was affected by the positioning of the tape recorder, whether or not the respondent smokes and/or speaks clearly. Accurate positioning should be checked by testing recording during the first five minutes: this time was spent chatting re the days work and served the additional purpose of relaxing the interviewee.

(iv) It was preferable to use known brands of tapes. In cheaper tapes the notches at the back often failed to make contact and did not record (this was remedied by putting a piece of sellotape over the back notch to facilitate contact). It was always better to be confident that the taping was proceeding and I preferred to buy the more expensive tapes. A spare tape should always be taken to each interview: in case of fault in one tape or an interview being lengthy.

## APPENDIX 5

## Order of systematic presentation of element triads

3	10	13
6	7	8
9	12	2
4	1	15
11	14	5
8	6	12
3	11	4
10	2	5
7	1	13
15	14	9
14	4	6
8	15	12
1	10	3
7	13	2
5	9	11

The presentation was calculated using random number tables and each element was used three times.

Appendix 6: Family PQRST

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	SCORE					
											1	2	3	4	5
I know I can call the nurse anytime	The nurse tells me I am doing all right	The nurse is an "outsider"	The nurse comes to the house to see .....	The nurse will arrange for .... to go into hospital	The nurse will visit if anything is wrong	I have to approach the nurse if I am worried	The nurse arrives unannounced	The nurse arranged for ... to go to the Day Centre	The nurse assesses how ... is						
The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is	The help I get from this is						

Nurse Aspects section Q1 to Q26

Name \_\_\_\_\_

Date \_\_\_\_\_

Assessment occasion \_\_\_\_\_



	PG14										PG10					SCORE
Q11	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurse can say things to .....that I couldn't															
	The help I get from this is															
Q12	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I can see the nurse when ..... is being visited															
	The help I get from this is															
Q13	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurse coming to the house staves off the chance of ..... becoming ill again.															
	The help I get from this is															
Q14	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Meeting the nurse on my territory is best. I feel restrained at the hospital															
	The help I get from this is															
Q15	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurse is easy to talk to															
	The help I get from this is															
Q16	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I know I've not been left on my own															
	The help I get from this is															
Q17	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurse gives me backing															
	The help I get from this is															
Q18	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurse explains and helps me understand what is going on with .....															
	The help I get from this is															
Q19	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I can talk to the nurse about anything															
	The help I get from this is															
Q20	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses are freer when they come to the house. They've only me to concentrate on & I get more information															
	The help I get from this is															

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Name \_\_\_\_\_

Date \_\_\_\_\_

Assessment occasion









SCORE

PQ14 PQ10

Q37	..... doesn't wash properly and keep clean	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q38	..... Gets into arguments with neighbours	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q39	..... hides what they are feeling from me	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q40	..... doesn't look after his/her clothes	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q41	..... gets into arguments in the house	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q42	..... can be violent and aggressive (outside the house)	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q43	..... can't cope with DHSS	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q44	..... smokes all the time	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q45	..... can be suicidal	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>
Q46	..... is not the same person I used to know	<input type="radio"/>
	The help I get from the nurse with this is .....	<input type="radio"/>

16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

Assessment occasion

Date

Name

Q47	PQ14										PQ10						SCORE
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	
..... eats too much/little	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help that the nurse gives me with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... behaves strangely	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help that the nurse gives me with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... cannot be left alone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... has odd ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... is incontinent	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... can be aggressive to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... cannot manage money	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... disturbs me at night	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help that the nurse gives me with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... refuses medication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
..... does not believe he/she has been ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
The help I get from the nurse with this is .....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

Assessment occasion

Date

Name



	P014										P010						SCORE				
	1	2	3	4	5	6	7	8	9	10	1	2	3	4	5	6	7	8	9	10	
<b>Q57</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I worry about what will happen to ..... when I'm dead The help that the nurse gives me with this is .....
<b>Q58</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I have to be careful not to upset ..... The help that the nurse gives me with this is .....
<b>Q59</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I feel on edge because of ..... The help that the nurse gives me with this is .....
<b>Q60</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I am afraid of being harmed by ..... The help that the nurse gives me with this is .....
<b>Q61</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I am not able to leave the house because of ..... The help that the nurse gives me with this is .....
<b>Q62</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I have to do such a lot to help ..... The help that the nurse gives me with this is .....
<b>Q63</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I want to keep ..... out of hospital The help that the nurse gives me with this is .....
<b>Q64</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I find it difficult to know if ..... 's behaviour is illness or not The help that the nurse gives me with this is .....
<b>Q65</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I can't invite friends in because of ..... The help I get from the nurse to cope with this is .....
<b>Q66</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I just don't know whether I am doing the right thing The help I get from the nurse to cope with this is .....

Family Burden section Q57 to Q76

Name \_\_\_\_\_  
Date \_\_\_\_\_  
Assessment occasion \_\_\_\_\_



	P014										P010					SCORE					
Q67	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I have had to take on more of the domestic tasks The help I get from the nurse to cope with this has been .....																				
Q68	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The money coming into the house has suffered The help I get from the nurse to cope with this is .....																				
Q69	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I have had to make most of the decisions The help I get from the nurse to cope with this is .....																				
Q70	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The love and support I get from ..... has suffered The help I get from the nurse to cope with this is .....																				
Q71	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	Looking after ..... has meant I have not done things I wanted The help I get from the nurse to cope with this has been .....																				
Q72	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I find it difficult to control my temper when faced with .....																				
Q73	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The help I get from the nurse to cope with this has been .....																				
Q74	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I have been left to bring up the children The help I get from the nurse to cope with this is .....																				
Q75	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I get depressed and miserable dealing with .....																				
Q76	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The help I get from the nurse to cope with this is .....																				
	It is so difficult knowing what is going on in ..... 's head The help I get from the nurse to cope with this is .....																				

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Name \_\_\_\_\_

Date \_\_\_\_\_

Assessment occasion \_\_\_\_\_



	PQ14										PQ10					SCORE					
<b>Q11</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I meet others with similar troubles																				
	The help I get from this is																				
<b>Q12</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The centre has a nice atmosphere																				
	The help I get from this is																				
<b>Q13</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I feel I am helping others																				
	The help I get from this is																				
<b>Q14</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I can get things off my chest																				
	The help I get from this is																				
<b>Q15</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses give me my medication																				
	The help I get from this is																				
<b>Q16</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	I am kept busy at the Day Centre																				
	The help I get from this is																				
<b>Q17</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses talk to me																				
	The help I get from this is																				
<b>Q18</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses ken about me																				
	The help I get from this is																				
<b>Q19</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses are cheery																				
	The help I get from this is																				
<b>Q20</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
	The nurses care																				
	The help I get from this is																				

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Name \_\_\_\_\_  
Date \_\_\_\_\_  
Assessment occasion \_\_\_\_\_



	← PQ14 →																← PQ10 →					SCORE	
Q21	I have company at the Day Centre	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q22	The nurses have time for discussion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q23	The nurses say things that comfort me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q24	The nurses don't treat me badly even though they know my problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q25	The nurses can arrange for me to see a psychiatrist	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q26	I can talk to the nurses about things I couldn't discuss with anyone else	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q27	The nurses listen to what I say	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q28	The others at the Day Centre are very different from me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q29	The nurses ask how you are feeling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Q30	The nurses have special qualifications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
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Assessment occasion

Date

Name



Appendix 8: Home Visiting PQRST

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	SCORE					
											1	2	3	4	5
By visiting me at home the nurses have a better idea of what I am like The help I get from this is	The same nurse visits all the time The help I get from this is	You get to know the nurse The help I get from this is	The nurse takes an interest in what you do The help I get from this is	The nurse cracks jokes The help I get from this is	The nurse is patient The help I get from this is	I know I am not forgotten about The help I get from this is	The nurse is attentive The help I get from this is	The nurse is cheerful The help I get from this is	I feel the nurse cares The help I get from this is						
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	PO14														PO10	SCORE
Q11	The nurse asks how I am keeping															0
	The help I get from this is															
Q12	A relationship has developed between me and the nurse															0
	The help I get from this is															
Q13	I know the nurse's personal circumstances															0
	The help I get from this is															
Q14	I can talk to the nurse in confidence															0
	The help I get from this is															
Q15	The nurse has qualifications to help others															0
	The help I get from this is															
Q16	The nurse brings me things I need															0
	The help I get from this is															
Q17	The nurse talks to me															0
	The help I get from this is															
Q18	I can trust the nurse															0
	The help I get from this is															
Q19	The nurse has a cup of tea with me															0
	The help I get from this is															
Q20	The nurse looks around and makes sure the house is clean															0
	The help I get from this is															

16 15 14 13 12 11 10 9 8 7 6 5 4 3 2 1

Name \_\_\_\_\_  
 Date \_\_\_\_\_  
 Assessment occasion \_\_\_\_\_

	PO14														PO10	SCOPE	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	
Q21	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The nurse comes to take blood The help I get from this is
Q22	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The nurse comes to deliver my tablets/get my injections The help I get from this is
Q23	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The nurse visits regularly (every month) The help I get from this is
Q24	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	It is informal being visited at home The help I get from this is
Q25	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	There is no waiting when the nurse comes to the house The help I get from this is
Q26	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	It's a lot more convenient if the nurse comes to the house The help I get from this is
Q27	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I get treated as an individual when the nurse sees me at home The help I get from this is
Q28	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Coming to the house the nurse can concentrate just on me The help I get from this is
Q29	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I can talk more openly when the nurse visits at home The help I get from this is
Q30	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The nurse visits on a friendly basis when she comes to the house The help I get from this is

Name \_\_\_\_\_

Date \_\_\_\_\_

Assessment occasion

















EAST HOSPITAL - DAY CARE PQRS INPUT DATA

Responder Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	No. of Visits	M	C				
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Scores are 0 - 9; disagree with statements are 88; missing scores are 99

EAST HOSPITAL -- HOME VISITING PQRST INPUT DATA

Responder Number	Question numbers																														No. of Visits	N	C
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30			
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Scores are 0 - 9; disagree with statements are 88; missing values are 99

WEST HOSPITAL - HOME VISITING PORST INPUT DATA

Responder Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	No. of Visits	U	R	S	E	C
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Scores are 0 - 9; disagree with statement are 88; missing values are 99



## APPENDIX 10

The element list used in the two different main study areas.

Element Number	EAST HOSPITAL	WEST HOSPITAL
1	Lithium patient	GP referral
2	Depot patient	Depot patient
3	Other medication patient	HV referral
4	Consultant referral	Consultant referral
5	At risk patient	At risk patient
6	Depressive patient	Depressive patient
7	GP referral	Crisis calls
8	Requested visit	Home Assessment visit
9	Demented patient	Demented patient
10	In-patient contact	Anxiety Management
11	Physically ill	Social visit
12	Out-patient	EW referral
13	New referral	New referral
14	Chronic - actively involved in treatment - likely to change	
15	Chronic - not actively involved in treatment - not likely to change	

## APPENDIX 11

Actual constructs produced by each nurse sorted into headings of the Content Analysis.

1 HOME SITUATION

- FRANK:** practical support at home - lives on own  
lives in owner occupied house - doesn't  
has family support - doesn't  
family pathology - not  
have people to stay with them - live alone  
relatives are patients - not  
have immediate family  
have children - doesn't
- BERT:** relatives know of illness - don't  
hell to live with for relatives - liked as is  
lives with family - lives by self  
small family - widespread family  
looked after by relative - looked after by self  
put in child's position, family speaks for them - doesn't  
relatives keep CPN informed - not  
accept help from family - doesn't
- ADAM:** somebody at home - lives on own  
have child who isn't right - doesn't  
has children - doesn't  
tried to return to parental home - hasn't  
lives on own - doesn't  
distant support - support lives locally  
elusive support as far as CPNs are concerned - access to  
relative easy  
CPN contact with relatives limited - not
- HAMISH:** relative will contact CPN if problems - not  
support at home - lives alone  
family needs help and support - don't
- EDDIE:** gets on with person lives with - doesn't  
responsibilities for looking after a family  
house sparse - house comfortable and clean  
in sheltered housing - not, has responsibilities
- KEVIN:** work with relatives - don't  
have support - none at all  
home situation leaves a lot to be desired - stable household  
relationships are a difficulty - throwback from past
- LESTER:** have a stable background - not  
have reasonable relationships at home - don't have stable  
relationships at home  
have got spouse involvement - not  
have understanding and co-operative relatives - not

HOME SITUATION (Continued)

- IVAN:** families are not supportive - not  
live alone - have family around  
live alone - have relatives nearby  
socially isolated - family close by  
influenced by mother - not  
mother has control - not  
house well kept - lives in appalling circumstances  
have children - not
- GRAHAM:** dependent emotionally on relatives - not  
lives with relatives - lives alone  
past problems with family which require support - doesn't  
need support with family  
relatives have problems, patients actively help - don't  
support at home - lives alone  
have family contact and support - don't  
has home help - doesn't  
has closed family ties - doesn't
- COLIN:** isolated - has family support  
family had experience of caring - family had no experience  
of caring, find it difficult to cope  
family in constant attendance - spends most of day by self  
strain from time to time - continual strain on family  
strain on family - not  
lives alone - doesn't  
protected, lives in sheltered housing - isn't  
lives alone - lives with family  
lives by self - lives with relatives
- DICK:** family support - outside support  
family at home - lives alone  
social services support at home - none  
have immediate family - outside support  
stays alone - stays with family  
have immediate family - have no family  
stays in council house - in sheltered housing  
lives upstairs - lives in flat  
lives with immediate family - lives alone  
easy access to amenities - not  
have phone - not  
at risk due to hearing - not
- JOCK:** lives on own - lives with mother  
lives on own - lives with daughter  
isolated - has family around  
has support of husband - does not

2 ILLNESS

- FRANK:** neurotic overtones - psychotic  
affective component to illness - doesn't  
psychotic illness - hasn't



ILLNESS (Continued)

## FRANK (Continued)

has physical illness - has no physical illness  
 affective disturbance - not  
 psychotic illness - problems of everyday living  
 physically fit - not

BERT: responding to excess anxiety - has psychiatric illness  
 has physical illness - not  
 has periods of paranoid illness - not  
 has insight into illness - not

ADAM: physical illness - doesn't  
 has schizophrenic illness - doesn't  
 have mood swings - not  
 together up top - mentally deteriorating  
 physically well - not

HAMISH: has schizophrenic illness - not  
 hypomanic - not  
 good memory - demented  
 together - has memory blanks

EDDIE: hysterical - not  
 manic depressives - not  
 physical problems - not  
 suicide risk - not  
 diagnosis decided - diagnosis uncertain  
 has temporal lobe epilepsy - not  
 demented - not

GRAHAM: threatens suicide : reacts histrionically to problems - not  
 has insight into present illness and situation - not  
 has psychotic illness - doesn't  
 no dementia - has  
 suicidal - not

COLIN: demented- isn't  
 organic - functional  
 demented - functional  
 arthritis - not  
 had depression - not  
 grief reaction - not  
 demented - no memory impairment  
 sad within self - happy within self

DICK: demented - not  
 physical illness - not  
 has delusions and hallucinations - not

IVAN: been on tranquillisers - not  
 been addicted to tranquillisers - not  
 was addicted to medication - never  
 are phobic - not  
 agrophobic - not  
 have panic attacks - have behavioural problems  
 anxious - isn't

ILLNESS (Continued)

## IVAN (Continued)

understands what's happening to them - don't  
 understands the illness - doesn't think there is anything  
 wrong  
 aware of what should be doing - lacks insight  
 been psychotic - not  
 depressive - not  
 suicidal - isn't

JOCK: psychotic - confused

KEVIN: schizophrenic - anxiety state  
 vague referral - specific referral  
 diagnosis vague - diagnosis specific

LESTER: has a diagnosis - primarily a social problem  
 is psychotic - much more the social situation  
 primarily had a diagnosis - primarily a social problem  
 diagnosed as ill - wouldn't see self as such  
 diagnosed as psychiatric - not  
 diagnosed as psychiatrically ill - not

3A TREATMENT

BERT: treatable disorder - hasn't  
 responds quickly to intervention and help - doesn't  
 interested in continuing to be treated - cavalier attitude  
 to mental illness  
 reluctant to have CPN - happy to have CPN  
 unable to look after treatment if ill - able to look after  
 treatment, can contact CPN  
 actively involved in treatment - not

HAMISH: is regular attender - not  
 stuck in position has been in - is deteriorating

GRAHAM: keen to come to day centre - not  
 responded well to treatment - still delusional  
 drain on day centre resources - not  
 has residual paranoid ideas - doesn't  
 responded to medication - has residual illness  
 listens to what staff say - does not

COLIN: confused at day centre - not  
 dependent on day centre - not  
 enjoys day centre - doesn't

DICK: unwilling to talk readily - gives information freely

LESTER: visits are beneficial - not  
 benefited from CPN intervention - not  
 CPN service is helping - not

ILLNESS (Continued)

## IVAN (Continued)

understands what's happening to them - don't  
 understands the illness - doesn't think there is anything  
 wrong  
 aware of what should be doing - lacks insight  
 been psychotic - not  
 depressive - not  
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 to mental illness  
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 unable to look after treatment if ill - able to look after  
 treatment, can contact CPN  
 actively involved in treatment - not

HAMISH: is regular attender - not  
 stuck in position has been in - is deteriorating

GRAHAM: keen to come to day centre - not  
 responded well to treatment - still delusional  
 drain on day centre resources - not  
 has residual paranoid ideas - doesn't  
 responded to medication - has residual illness  
 listens to what staff say - does not

COLIN: confused at day centre - not  
 dependent on day centre - not  
 enjoys day centre - doesn't

DICK: unwilling to talk readily - gives information freely

LESTER: visits are beneficial - not  
 benefited from CPN intervention - not  
 CPN service is helping - not



TREATMENT (Continued)

IVAN: resistive to suggestions - agrees in principle  
 resistive to suggestions - responsive to suggestions  
 resistive to treatment - co-operative

JOCK: taken a lot of getting to know - not

KEVIN: poor prognosis - will never hear from again

3B TREATMENT

FRANK: been in hospital - not

BERT: never been in hospital - has  
 been certified in past - never  
 attends day centre - not

ADAM: had fair amount of psychiatric input - situational crisis

HAMISH: out patient - in patient  
 been in hospital - never  
 managed to keep out of hospital - not

EDDIE: comes to number seven for treatment - doesn't  
 out patient - in patient

GRAHAM: in hospital - not  
 required home visits - not

COLIN: been in patient - not  
 needs to talk to solve problems - not

DICK: attends day centre - doesn't

LESTER: GP reference - not  
 referred by a psychiatrist - hasn't  
 been seen by psychiatrist - not  
 had admissions - not  
 been admitted to hospital - not  
 have ongoing supportive visits - not  
 has supportive visits - offered active therapy  
 involved in active treatment - not  
 have long term support visits - passed on  
 became ongoing counselling - referred to other agencies  
 needs long term commitment from CPNs - not  
 candidates for group therapy - not  
 I've been involved in inactive work - not

IVAN: attends anxiety management group - doesn't  
 had short stays in hospital - not  
 working with relaxation tapes - isn't  
 would benefit from day care - not  
 comes to social club - doesn't

3B TREATMENT (Continued)

**JOCK:** various admissions to mental hospital - not  
 a lot of admissions to hospital - not  
 have the service that require - doesn't  
 needs watching - doesn't  
 I go in and see how getting on - requiring weekly injection  
 needs counselling - is anxiety management  
 needs regular visiting - comes to group  
 patient needs talking - mother needs talking  
 patient needs support - relative needs support  
 needs reassurance - doesn't

**KEVIN:** I work on my own - I work with psychologist  
 work by self - work with another professional  
 short term - will be difficult to discharge

3C MEDICATION

**FRANK:** on psychotropic medication - is not  
 should be on medication - should not  
 on lithium - not

**BERT:** on lithium - is not

**ADAM:** unreliable in terms of medication - reliable  
 on long term medication - isn't  
 on injection - not

**HAMISH:** on lithium - not  
 on medication for years - not

**EDDIE:** on IM - not

**GRAHAM:** on lithium - not  
 keen to take depot - not  
 on depot - not  
 takes medication regularly - doesn't  
 on oral medication - not  
 poor pill takers - isn't  
 no difficulty with tablets - has

**COLIN:** on-going psychiatric illness - stabilised on medication

**DICK:** on psychotropic medication - not

**IVAN:** on depot injections - not

**KEVIN:** on drugs - target is to come off drugs

**JOCK:** on depot - on oral medication  
 on depot - isn't  
 on depot - I visit socially  
 needs watching - looks after medication by self

3D TIME ORIENTATION

- BERT:** always been something going on - recent illness  
long history - short recent illness  
suicidal in past - not  
recently ill - stable for many years
- ADAM:** lengthy experience of psychiatric care - recent contact with  
psychiatric care  
will need supervision for long time - will be well soon  
long term patient - future unsure  
for CPNs will be around for a while - not
- HAMISH:** chronic - support patient  
recent history of hospitalisation - not  
here for past year - chronic  
chronic patient - acute  
recently attending - been for some time
- EDDIE:** chronic - not
- GRAHAM:** long history of illness - recent referral  
contact will be reduced in time - will always need support
- DICK:** long history - short history
- KEVIN:** first referral - known to service  
future will have continued hospitalisations - will never
- LESTER:** have easily identified history - not  
have psychotic background - not  
will pop up again - working things out
- IVAN:** won't be on the books for long - neurotic
- JOCK:** been on the go for years - recent contact  
chronic - GP referral

4 SOCIAL INTERACTION

- FRANK:** enjoys going out - not  
has social outlets - doesn't  
have interests - don't  
relies on public transport - has a car  
drives - doesn't
- BERT:** lot of people around them - hasn't  
difficult personalities to get along with - not  
gives information freely about background - doesn't  
goes out a lot - socially inactive  
outgoing - never been life and soul  
has hobbies - doesn't have interests outside selves
- HAMISH:** vocal - quiet  
social - not  
will tell you if have problems - needs probing



SOCIAL INTERACTION (Continued)

EDDIE: can be verbally aggressive to the nurses - not

GRAHAM: socially isolated - outgoing  
socially active - isolated  
sociable - withdrawn socially

COLIN: joins in company - doesn't  
joins in socially - doesn't  
deaf - not

DICK: housebound - fully ambulant  
housebound - capable of going out by self  
mobility problems - fully ambulant  
deaf - not

LESTER: has fitting into the community problems - not

IVAN: socially isolated - not  
socially isolated - goes out and about  
has no-one - has friends to go out with

5 WORK - MONEY

FRANK: has job - doesn't  
employable age - OAP  
works - doesn't

BERT: financed by self - supported by another  
financially well off - isn't  
retired - working  
manages money - financially subsidised  
in debt - not

ADAM: in long term treatment - hopefully will go back to work

EDDIE: unemployed - works  
housewife - not  
works full-time - doesn't

GRAHAM: finances a discomfort - not  
long term candidate for day care - hope will get a job  
apt at handling money - not  
can handle finances - cannot cope  
keen to get to work - not  
can budget - cannot  
difficulty with money - not

IVAN: unemployed - has a job  
working - not

JOCK: comfortably off - has money worries

SELF SUFFICIENCY

- BERT: appears to run life OK - doesn't  
likes to run life for self - draws on helping agencies
- EDDIE: needs bribing to have a bath - not  
black - looks clean
- GRAHAM: lacks personal hygiene - doesn't  
needs baths - doesn't  
at risk in community - not  
realistic about life - isn't
- COLIN: needs reminding to do daily activities - can cope on own  
expects as much as possible to be done  
by family - independent  
copes with everyday living - doesn't  
preoccupied with past - isn't  
can cope with everyday living - can't cope with minor crisis
- DICK: continent - isn't
- IVAN: dependent - lives a normal life  
resistive to doing anything on own - not
- JOCK: adjusted to retirement - hasn't
- LESTER: dependent - not  
keen on being in sick role - not  
mature - not

FACT

- FRANK: male - female  
young pensioner
- BERT: working class - upper class
- EDDIE: male - female
- GRAHAM: smokes - doesn't  
normal intellect - average IQ
- COLIN: working class - middle class
- DICK: male - female
- ADAM: young - old
- IVAN: bright - borderline  
intelligent - slow

SELF REFERENCE

- FRANK: irritates me - I warm to him/her  
lives in same place I do - not
- HAMISH: I know well - don't  
I've known for some time - getting to know
- EDDIE: I know well - don't know well
- IVAN: I feel I'm getting somewhere - I have given up  
is working at improving - I don't see improvement

VALUE JUDGEMENT

- FRANK: manipulative - honest/open  
acts how feel - says how feel  
hostile and dependent on professionals - not  
self-centred - puts others first  
overweight - skinny  
nice basic people - upper class  
impulsive - not  
seeks professional advice ad nauseam - not
- EDDIE: personality nice when well - neurotic  
can be touchy and aggressive - not  
fat and healthy - gets emaciated
- GRAHAM: pre-occupied with illness - isn't  
sexually disinhibited - not
- COLIN: restricted by religion - not
- IVAN: manipulative - not  
amenable - not, is a lot of hard work  
easy to communicate with - not  
attention seeking - not

PROBLEMS ISOLATED

- FRANK: sexual problems - doesn't  
has money problems - doesn't  
has drinking problem - not  
physical problems - not
- ADAM: has drink problem - not
- HAMISH: has weight problem - not
- GRAHAM: psychopathic problems  
problems with verbal communication - not  
has overt behavioural problems - not  
has identifiable problems - not  
organic cerebral problem - not  
has personality problems



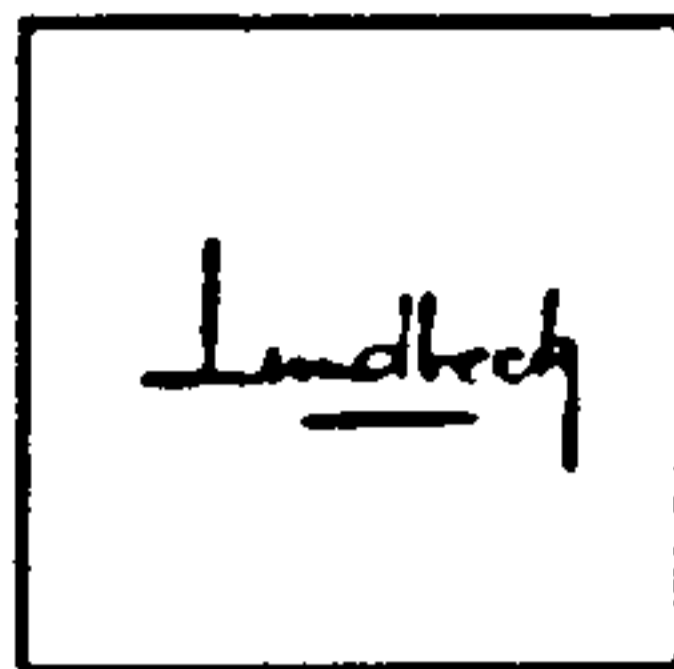
PROBLEMS ISOLATED (Continued)

IVAN: . have family problems - don't

KEVIN: has problems with relatives - not  
has relationship problems - has problems coping

LESTER: is a social problem - not  
has real social problems - not  
main involvement to help cope with problems - not  
has long term problems - new problems  
reasons for problems obvious - not

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THE LUNDBECK LEADING ARTICLE

### AN EVALUATION RESEARCH STUDY OF COMMUNITY PSYCHIATRIC NURSING EMPLOYING THE PERSONAL QUESTIONNAIRE RAPID SCALING TECHNIQUE

*In the following paper Linda Pollock presents part of the findings of a three-year research project. The Personal Questionnaire Rapid Scaling Technique was completed by twenty-four carers. It addressed three main issues: the families' perception of the CPN; identified patient problems; and the families' subjective experience of caring. Relatives found access to a CPN helpful in a crisis situation and they were described as 'easy to talk to'. Other results indicated divided opinion on the help offered by CPNs to alleviate specific patient problems.*

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#### Review of the Literature

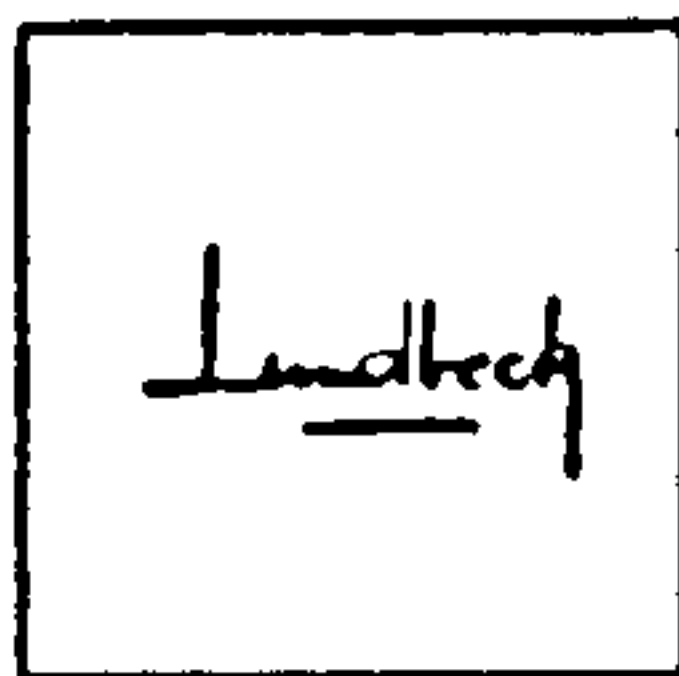
CPNing was recently described in the nursing press as a 'burgeoning' speciality (Devlin 1985). Anecdotal evidence would appear to support this statement although there is a dearth of quantitative evidence to testify this claim. Although the 1950s saw the inception of CPNing, since then, only three surveys have been conducted on CPNing (Parnell 1974; CPNA 1981 and 1985). Only two of these referred to Scotland and these were carried out in 1981 and 1985 respectively by the CPNs' professional organisation; these surveys illustrate that across all grades of CPNs over the previous five years, the numbers of CPNs have increased by 65%.

These surveys (CPNA 1981 and 1985) also suggest that CPNing service development is of a local nature and ad hoc in character. Review of the literature indeed suggests that CPNing services have developed differently in varying geographical areas. Much of the literature consists of subjective descriptions of CPN services; this literature, although lacking in objectivity provides a measure of the scale of the development of CPNing, gives an indication of the form which this is taking and is evidence of the practitioners' and managers' enthusiasm to share experience and build up a body of knowledge about CPNing. The studies demonstrate a concern to detail the work of CPN services which does not appear to be matched by a broad examination of resources being applied to CPN activity. It is not clear how far existing knowledge of CPNing is being utilised by CPNs to evaluate effectiveness of such services and authors devote little attention to examination of assumptions behind CPN practices.

CPNing appears to share with other British social and health services a common history of isolated experimental development leading incrementally and without the benefit of clear policy guidelines to national provision; there is a great diversity in the range of patients managed, in the therapeutic settings in which CPNs work and in the forms of intervention offered by CPNs.

Suchman (1967) proposed a distinction between 'evaluation' as the general process of judging the worthwhileness of an activity regardless of the method employed, and 'evaluative research' which is the specific use of the scientific method of the purpose of making an evaluation. This definition separates 'evaluation' as a goal, from 'evaluation research' as the means of attaining that goal. Most of the evaluative work in CPNing falls into Suchman's first definition of evaluation.





Diers (1979), commented that "without study the answer will be simply guesswork". Bearing this comment in mind much of the writing on CPNing would be described as mere guesswork. The wealth of descriptive work and 'guesswork' however is giving way to demands for more objective research and recent studies fall into the category of evaluation research: Altschul 1972 and 1973, Parnell 1974, Hunter 1978, Sladden 1979, CPNA Surveys 1981 and 1985, Mangan and Griffiths 1982, Paykel et al 1983, Skidmore and Friend 1984 and Marks 1985.

Donabedian (1966) offers a framework around which evaluation research in CPNing can be summarised: research can focus on structure, process or outcome. Research into 'structure' involves the study of factors of the system such as equipment, staffing levels and patterns and attitudes and training, styles of supervision and management, or characteristics of the care-givers. As far as CPNing is concerned the research of Parnell (1974), CPNA Surveys (1981 and 1985) and Skidmore and Friend (1984) fall into this category.

Research into 'process' involves the 'process of giving care' - what the nurse does; this includes not only visible behaviour but also invisible behaviour like decision making. Altschul (1972 and 1973) was the first researcher to look at the work of the CPN and her work falls into this category, as does the research of Sladden (1977 and 1979) and McKendrick (1980 and 1981).

The third category of research outlined by Donabedian is 'outcome', where the results of care are examined in terms of change in the recipient of care. The studies by Hunter (1978), Paykel et al (1982 and 1983) and Marks (1985) are examples of CPN 'outcome' research.

In summary, as far as evaluative research work in CPNing is concerned, there are presently moves towards examination of the structure of CPNing (Korner Report 1984 and CPNA Surveys). Studies examining the 'process' of CPNing have tended to be quantitative rather than qualitative in nature, and the very few 'outcome' studies that have been undertaken have been on specialised patient populations (defined by diagnosis) - schizophrenic and neurotics and researcher-defined measures of outcome have been used.

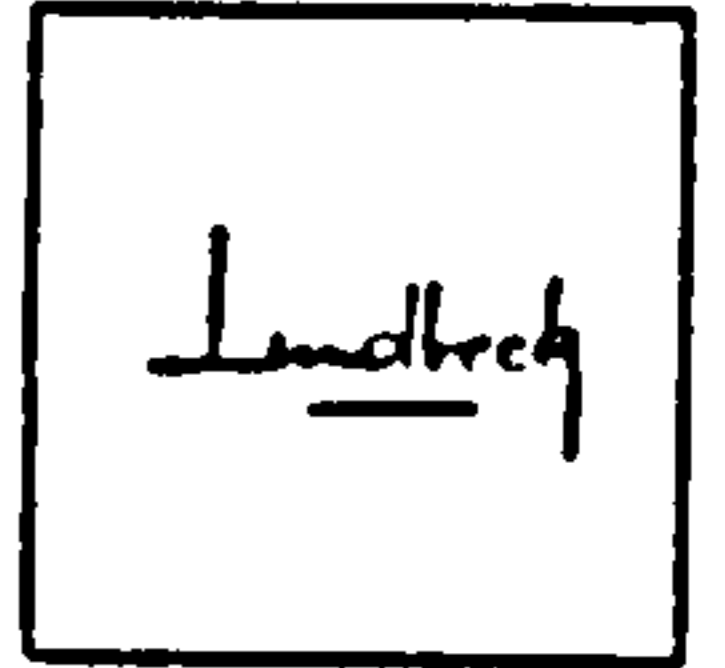
### **Background to the Present Study**

My research study focuses on the areas of deficit at present evident in the literature and I have conducted a piece of evaluative research focusing on the 'process' and 'outcome' of CPNing.

I have studied CPNs who worked from a hospital base in two different regions of Scotland. I conducted structured interviews with the CPNs in an attempt to investigate the 'process' of CPNing. These interviews were conducted in accordance with the format outlined by Bannister and Fransella (1977) - namely utilising the repertory grid technique and the laddering procedure. These structured interviews aimed to look at the work of individual CPNs to find out their working patterns and particularly to find out the rationales and assumptions behind their activities. The results of this part of the study will be detailed at a later date.

I also investigated 'outcome' in terms of families' view of the nursing service received and the families' view of the 'process' of CPNing. This was stimulated





by the literature on community care approaches in psychiatry: this suggests that one of the major effects of the change in orientation of care is that patients spend less time in hospital and more time with the people with whom they live. This effect of placing more responsibility on the family is loosely described as 'burden' in the literature. This term first coined by Grad and Sainsbury (1963, 1968) and elaborated later by Hoenig and Hamilton (1965, 1967, 1969) refers to the hardship families suffer in adjusting their life style to accommodate a mentally ill person. One of the rationales for developing CPNing has been to support families and carers of the mentally ill. My research aims to explore CPNing activity and find out how families perceive CPNs and how carers' experience of problems were relieved by CPN intervention.

The patients' view of CPNing was also obtained because I considered it unethical to approach relatives without permission of the psychiatric patients in the study. I also wished to identify the relative who was most in contact with the mentally ill person and the patient furnished me with this information. I am at present only going to focus on the preliminary findings regarding family outcome in one hospital.

#### Method

The method used for this part of the study was PQRST. Personal questionnaires were designed by Shapiro (1961) to measure patients' experiences, particularly symptoms, and their improvement. The original method was revised by Mullhall (1968) and called Personal Questionnaire Rapid Scaling Technique (for case this is usually referred to in its abbreviated form - PQRST). PQRST is capable of measuring beliefs, feelings and attitudes.

I have modified the list to suit the present study. Instead of symptoms being listed, I used statements about the CPN or statements about patients' problems and carers experience of caring. Families were asked to agree or disagree with the statements and then rate the CPN on a scale of 'helpfulness'.

I developed three types of PQRST - one as just described for the carers and two for patients; one for patients who attended day centres and the other for patients who were visited exclusively at home by CPNs. The findings below are for the family PQRST alone.

There are a number of advantages in using PQRST:

- The procedure has been validated in previous work.
- The design is considered beneficial in reducing response bias.
- The logic of PQRST is that in normal conversation feelings are quantified by adjectival phrases and that these are closer to the normal process of describing quantity than the necessary abstraction of using numbers or length of lines.
- The adjectives have been extensively tested. These are: absolutely none, very little, little, moderate, considerable, very considerable. They are considered to be on an ordered metric scale.
- All possible pairs of adjectives are used ensuring that the whole scale



is used and the central bias of traditional questionnaires is hence avoided.

- The questionnaire is simple and rapid to use.
- The scoring is both simple and expeditious (a scoring key is used - the ordinal scale of six adjectives is expanded into a ten point scale).

Advantage number three and six were especially relevant in this study involving psychiatric patients and relatives, some of whom were also psychiatric patients.

The family PQRST is grouped into three sections, as illustrated in Figure 1. Questions 1-26 (section one) consisted of aspects of the CPN: what the CPN does and what the carer feels about the CPN. These statements were derived from the pilot study involving 25 families. It proved difficult to gain statements about 'problems' from families during the pilot study and sections two and three of the PQRST therefore were derived partly from relatives comments during the pilot study and also from past research on family burden (Grad and Sainsbury 1963 and 1968, Hoenig and Hamilton 1969).

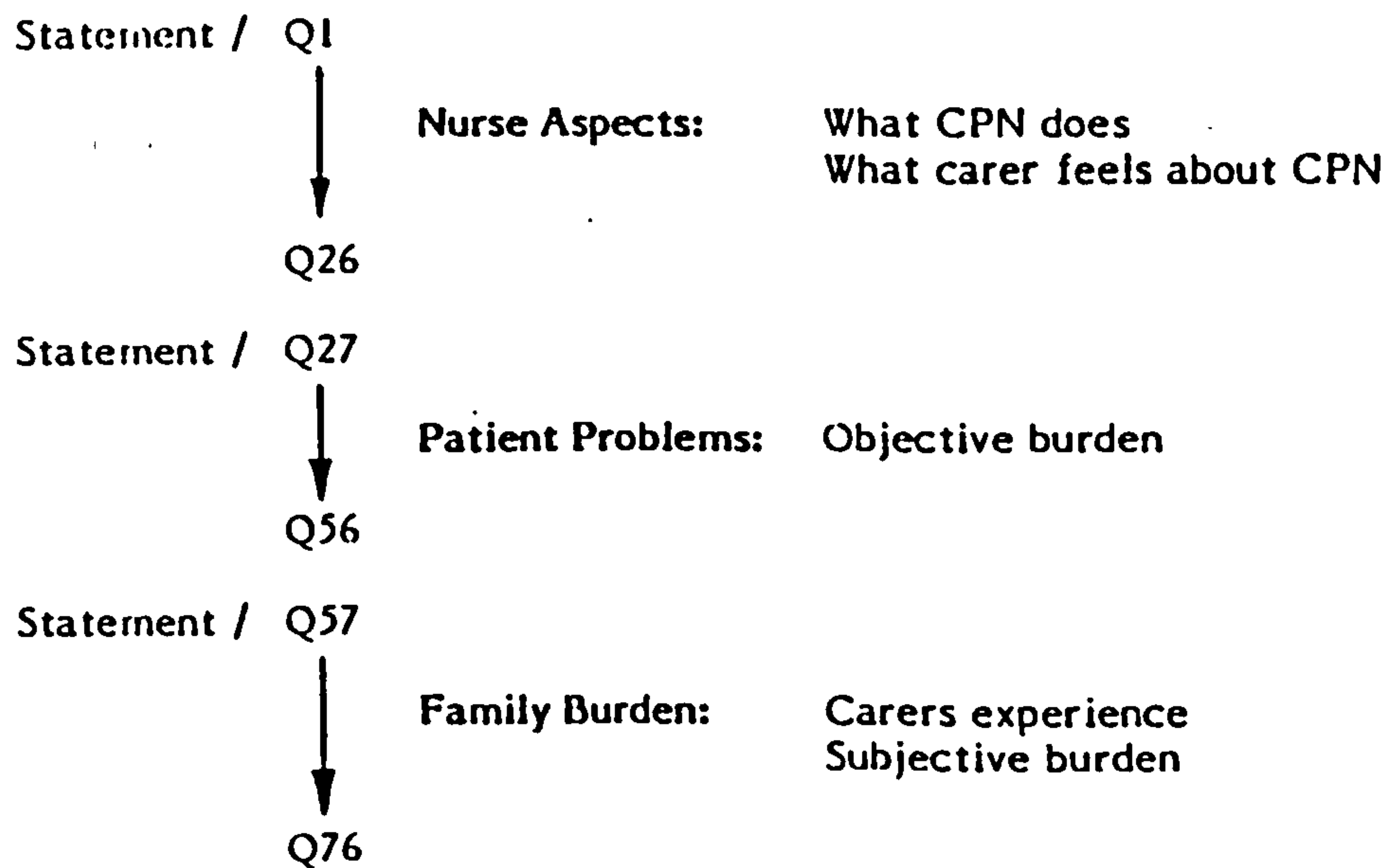


Figure 1. Family PQRST

Section two, questions 17-56 comprised questions on patient problems (described as objective burden in the literature) I have called this section 'patient problems'; section three questions 57-76 comprised questions on families' comments on coping with the strain of caring (described as subjective burden in the literature) I have called this section 'family burden'.



### Main Study - sample

I involved all the CPNs in one hospital and chose a sample stratified on the basis of frequency of visits; for each of the eight CPNs, seven patient and family pairs were chosen for the main study. This resulted in 56 families being available for inclusion in the study. Eleven patients refused permission for me to contact their respective relatives. 45 families were then available to complete the questionnaire, of these 10 did not complete the questionnaire (3, one in their 80s, did not understand the task, and 7 refused). Out of 35 families who returned the questionnaire only 24 carers completed the whole questionnaire. From an original sample of 56 families the final number available for analysis was considerably reduced.

To summarise, carers used PQRST which consisted of a questionnaire of three sections: the first concerning statements about CPN aspects - what the CPN did and the families' perception of the CPN; the second regarding statements about patient problems and the third regarding statements about the families' subjective experience of caring. These statements were agreed or disagreed with and the CPN was then rated on a scale of helpfulness. At the end of the day I obtained answers to questions on a scale of 0 (absolutely no help) to 9 (a very considerable help).

### Analysis - patient problems and family burden sections of the questionnaire

By taking each question individually and using frequency counts of the scores of 0-9, the majority of the answers have a low score: there is a general tendency for patient problems and family burden not to be helped by CPN contact (see Figure 2).

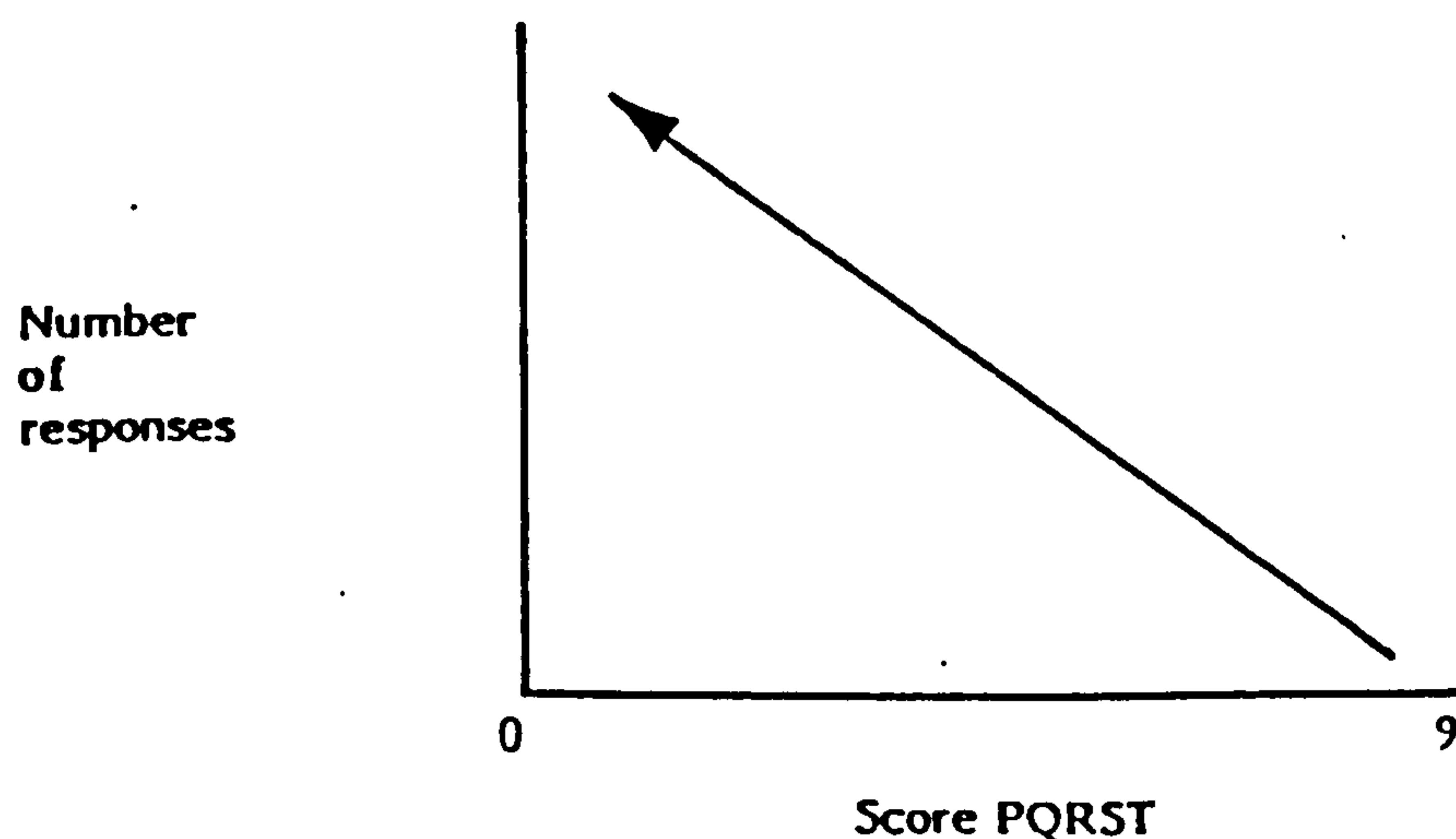
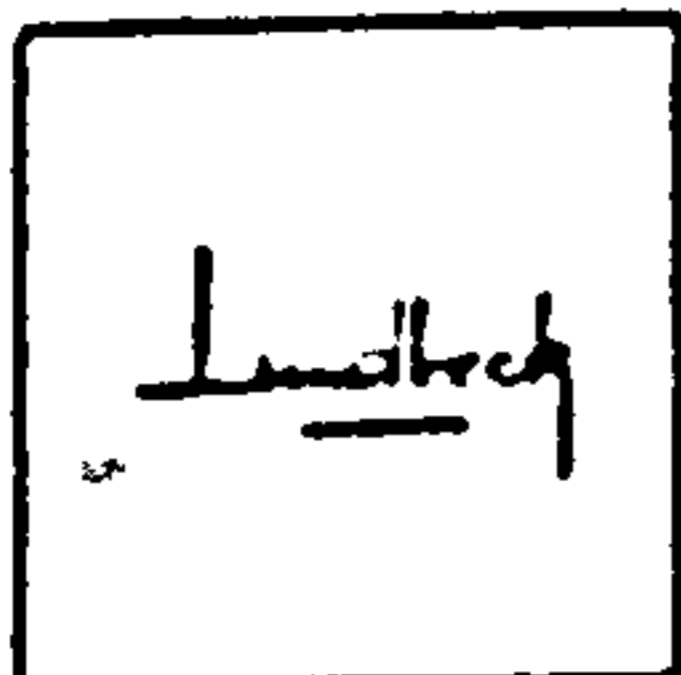


Figure 2. Showing scaled distribution of answers to individual questions for sections Patient Problems/Family Burden.





Closer examination revealed however, that for certain questions, the trend was less marked - the responses were polarised. In other words, for some problems, some carers were helped, others not (see Figure 3).

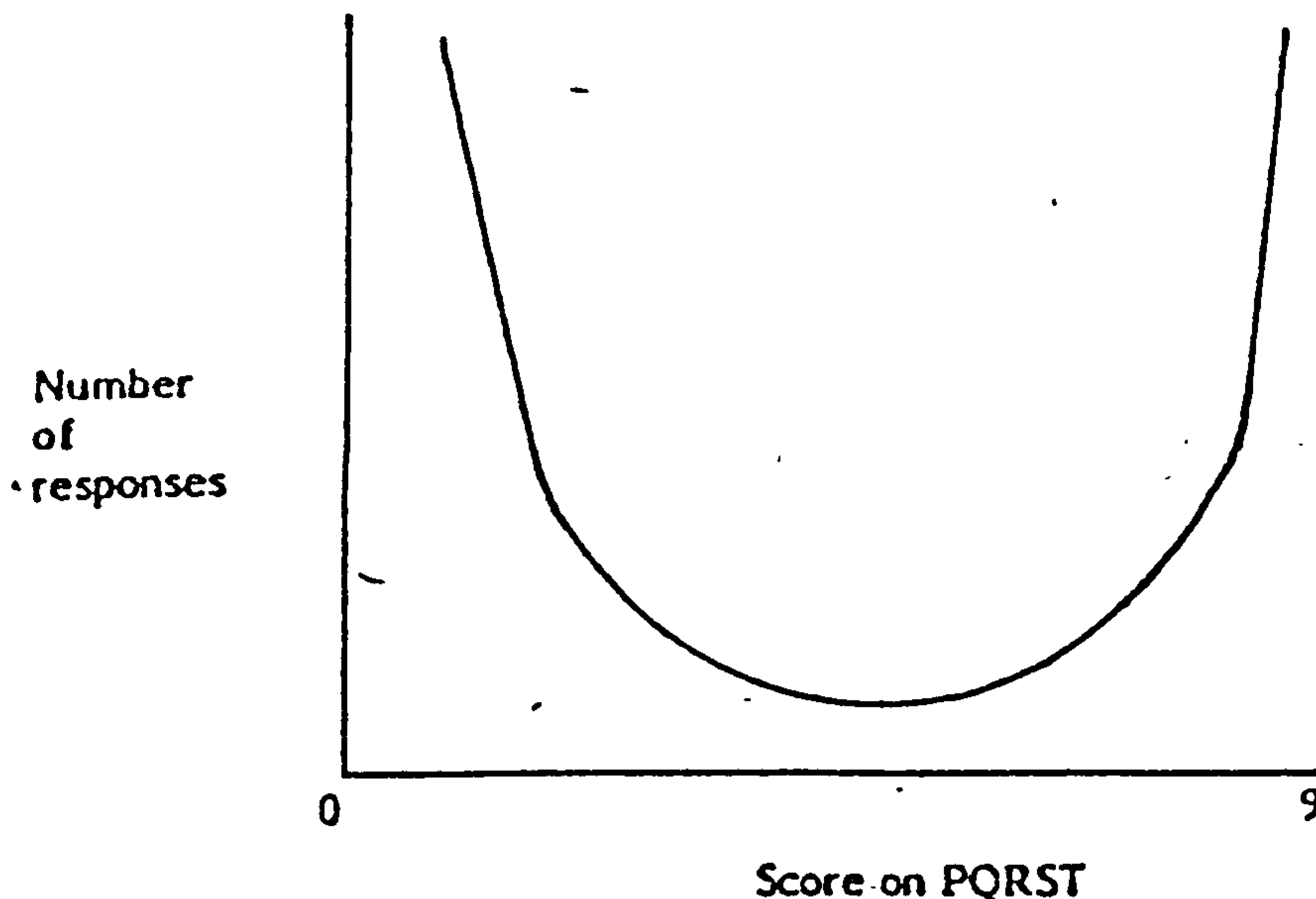


Figure 3. Showing polarised distribution of answers to certain questions.

Questions which had polarised distribution in 'Patient Problem' section.

- Patient is stubborn
- Gets into arguments
- Behaves strangely
- Aggressive to relative
- Demanding relatives company
- Has odd ideas

Questions which had polarised distribution in 'Family Burden' section.

- I feel on edge
- I have to be careful not to upset the patient
- The patient is not the same person I used to know

If one looks at these questions in more detail it is interesting to find that the type of patient problems helped, are behaviours that could be described as the most extreme behaviours listed in the questionnaire (see Table 1); the behaviours helped could be described as 'typical' psychiatric problems and could predictably have been regarded as behaviours that would have caused relatives problems, e.g. odd behaviour and ideas, arguments, aggression (see Figure 3). Why were

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these specific problems helped? Was this because the CPN acted on problems mentioned by the relatives? Did the relatives' perception of what the CPN can do thereby determine the work of the CPN? Or was it that the CPN was most able to help with these problems? Did the CPN feel most skilled to deal with these specific problems?

Indecision	63%
Personality change	57%
* Stubborn	51%
* Demanding carers company	49%
Unpredictability	46%
Forgetfulness	
Keeps self to self	43%
* Behaves strangely	
* Aggressive to carer	40%
Cannot manage money	37%
Hypochondriasis	
Cannot cope with DHSS	34%
* Gets into argument at home	
Cannot be left alone	31%
Eats too much/too little	
Poor Hygiene	29%
Disturbs carer at night	
Hides what feeling	26%
* Has odd ideas	23%
Over talkative	23%
Needs help with dressing	
Is incontinent	20%
Refuses medication	
Lacks insight	17%
Wandering	
Suicidal	14%

**Table 1** Types of problems faced by families (listed as %).

\* indicates some carers helped with this problem.

One could make similar queries of specific questions in the family burden section of PQRST, which also suggests that only certain aspects of the experience of caring were helped by the CPN. Could it be that carers are encouraged to voice feelings that are socially acceptable rather than acknowledge deep feelings of frustration, anger, fear, or misery?



It seems that the CPNs in this particular hospital however, do not help with the daily drudgery of caring and it seems that carers are not helped with a large part of the 'experience' of caring for a mentally ill relative.

#### **Analysis - nurse aspects section of the questionnaire**

These questions were universally scored positively. Most relatives found it particularly helpful however, to be able to call the nurse and for the nurse to visit if something was wrong, suggesting that the service is seen as a specialist, crisis service. It is interesting however that not all carers felt that they were able to call the nurse, suggesting that there is selectivity in whether CPNs make themselves available in this way.

One of the rationales behind CPN practice is that CPNs prevent patients from going into hospital. As far as the carers in this study were concerned, 82% of the carers disagreed with this statement. 62% of the carers did not feel that CPN contact prevented relapse or onset of illness but of those who did agree, arranged admissions and day care placements (by CPN) were considered helpful.

The service appears to have been perceived by relatives as a patient orientated service (judging by the content of most of the questions in this section) although 50% considered that CPNs helped them understand the patient's illness and made them feel that they were not alone - these could broadly be described as supportive functions of the CPN. The statement 'the CPN tells me I am doing OK' - 50% of the relatives disagreed with this, suggesting indeed that this element of support by CPNs was not universally provided by CPNs, or at least not to all carers. The statement 'the CPN is an outsider' aroused disagreement in 60% of relatives, suggesting that carers see the CPN as a friend or one of the family - this is of interest when, as professionals, we are trained to be distant and uninvolved. Perhaps this reflects the feelings of the carers that a relationship of trust and care have developed with the CPN, which in turn enables sharing of problems.

In addition to looking at the answers to individual questions I grouped answers 0-4 as unhelpful and 5-9 as helpful. I looked at male and female carers, old and young carers, nurses with large and small caseloads, CPNs who visited frequently and those who visited infrequently and also the individual CPNs to find out if there were specific aspects of the nurse or carers that affected helpfulness. The only aspects that proved significant on a chi-squared test were as follows:

1. In relation to the statement 'I have to take care not to upset the patient' - busy nurses were seen as significantly less helpful than quiet nurses.
2. In relation to the statement 'I don't know if I do the right things' female carers found CPNs significantly less helpful than male carers.
3. In relation to the statement 'the nurse is easy to talk to' all but one of the nurses were considered significantly helpful.

The numbers involved in each case were small and further groupings of questions were attempted to try and identify general trends.

The three different sections of the PQRST were grouped together and they illustrated the trend first discussed that CPN aspects were considered helpful and patient problems and family burden by contrast were unhelpful (see Figure 4).

I also used a chi-squared test using the grouping CPN Aspects with Patient Problems; CPN Aspects with Family Burden; and Patient Problems with Family Burden. The association between patient problems and patient burden was very significant



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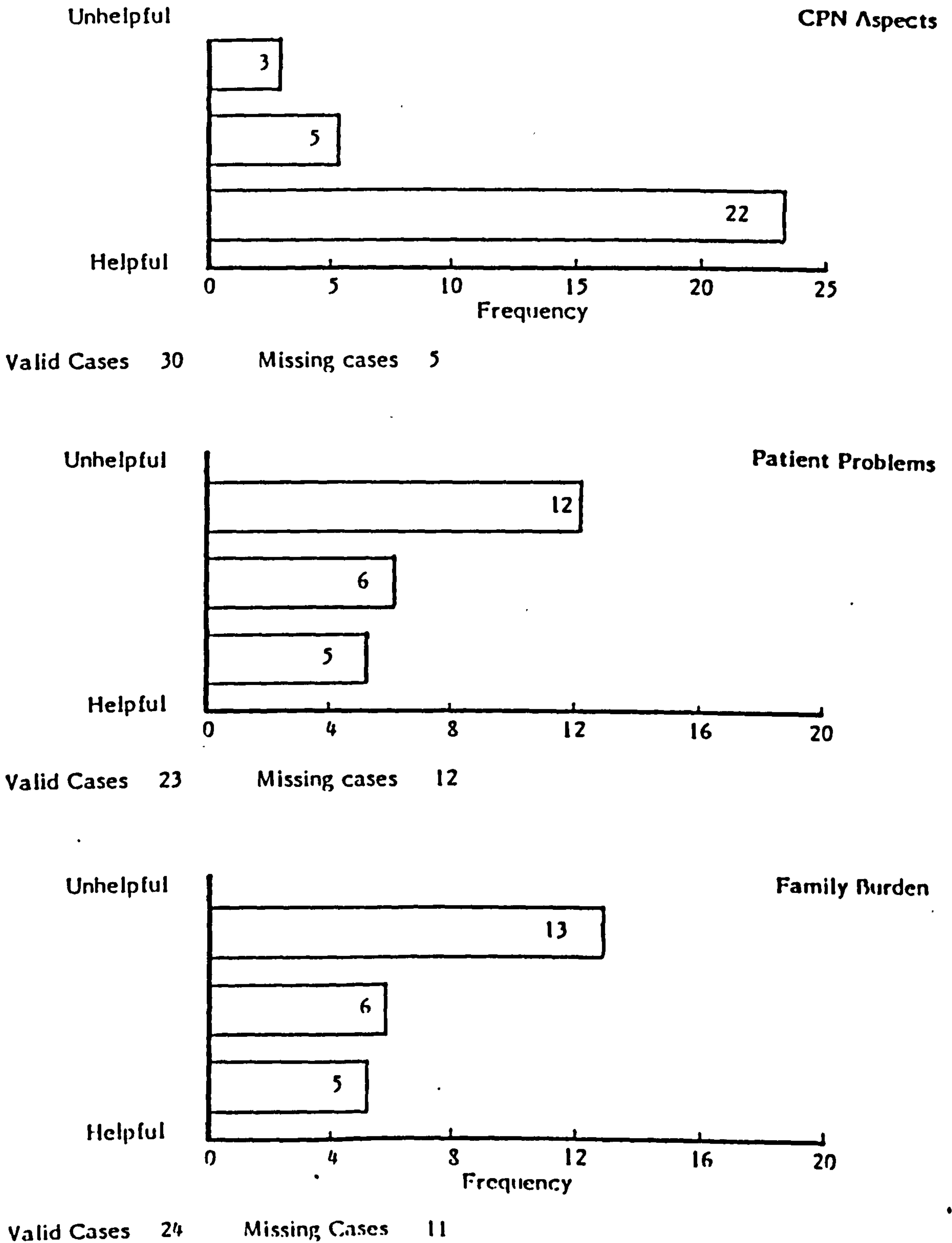


Figure 4

Grouped scores for the CPN aspects, Patient problems and Family burden sections of the PQRST.



- relatives who felt helped with patient problems were also helped to cope with the experience of caring. This may not be news but at least it shows that the interview scheme has been sensible and is valid.

In conclusion then, I have illustrated the rationale for conducting the present study on CPNing and have presented a method which is of use in evaluating perceptions. Further analysis will reveal patients' perceptions of CPN contact and will provide information about problem relief in terms of frequency of CPN visiting.

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