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TITLE

PSYCHIATRIC NURSING IN THE COMMUNITY: THE APPLICATION OF NEW TECHNOLOGIES TO AN ORGANIZATION IN TRANSITION.

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SUMMARY

This thesis is a detailed account of an Organizational Development programme within a District Health Authority. The study, set in an action research framework, applies selected technologies to an organization in transition from a hospital based to a community based service in psychiatric and mental handicap nursing.

Beginning with a review of the development of psychiatric nursing, the study suggests that the emergent community nursing services are faced with a series of paradoxes and are not equipped to deal with their new role.

Following a series of pilot studies a problem orientated case method is applied in tandem with in-service training and developing operational philosophies. There is particular development which relates to incidents arising during the course of the study where new elements require attention. These are significantly to do with casework supervision and identifying short term casework.

Data from problem orientated casework is presented in detail and the teams are analysed at the beginning and end of the study for evidence of change. A number of features are identified in the casework data, 1) clients do well in terms of problem resolution when in contact with community nurses, 2) nurses show evidence of a wide range of intervention techniques in casework, 3) problem orientated data allows an auditing of casework activity to monitor shortfalls in provider performance, 4) nurses are given considerable freedom of action to commission their referrals.

The study offers problem orientated approaches and audit procedures as a means of setting an ideological base for practice and recommends that casework supervision and in-service training be an integral part of community nursing development.

KEY WORDS

ORGANIZATIONAL DEVELOPMENT (O.D.)

NURSING, P.O.R., PSYCHIATRY

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SECTION ONE

INTRODUCTION

CHAPTER ONE

DEVELOPMENTS IN PSYCHIATRIC NURSING

CHAPTER ONE

DEVELOPMENTS IN PSYCHIATRIC NURSING

1.1

HISTORICAL DEVELOPMENT

It has been argued by Carr[1] and others that the social reform movements of the eighteenth and nineteenth centuries gave birth to present day psychiatric nurses. Pinel and Pussin, two of the fathers of 'moral' treatment of the insane encouraged the casting aside of chains and fostered humane regimes in their respective institutions. These examples set by the French were mirrored in the United Kingdom by the setting up of institutions where similar care could be provided. St. Luke's Hospital, London (founded 1751), Manchester Lunatic Hospital (founded 1763) and the York Retreat (founded 1792) are examples quoted by Walk[2] in his examination of the history of mental (psychiatric) nursing. Nurse leaders of note appear from this time onwards, or more accurately 'Superintendants' and 'attendants' as the emphasis was not upon nursing but upon secured observation. Carpenter[3] in his unique historical study on Asylum Nursing describes how institutions for the insane required "a sober, orderly and bland invironment" as the opinion was widely held that inmates needed a muted environment to regain self control. Self control was seen as imperative to life within

an individualistic, competitive society which held 'rationality' so dear. Producing total dependence within the Asylum environment was considered important in order to produce circumstances which would replicate "the intimacy of family relations with the lunatic as a dependent child and himself(Tuke - a doctor) as the authoritative patriarch".(3) In a revealing reference to the siting of county asylums which helps to explain their geographical isolation today, the physician William Battie suggested "treatment requires the patient being removed from all objects that act forcibly upon the nerves and excite too lively a perception of things .....(including) effecting friends as well as enemies, all visits should be barred and the place of confinement should be at some distance from the home" (Carpenter quoting Battie). The achievement of 'moral based' order within institutions could only be realised by the employment of attendants who could maintain an orderliness with only minimal use of seclusion and an abolition of mechanical restraint. The first in a series of paradoxes arises at this point namely, how to give the appearance of moral order and cleanliness in a society which (culminating in a Victorian obsession for thrift) demanded economy of expenditure. A final unhappy compromise was reached whereby attendants worked long hours for little pay, were tightly controlled by extensive rules and regulations, helped in the widespread utilization of patient labour and suffered commonly with the unhappy lot of the incarcerated inmates. Asylums were in truth "punishment centred bureaucracies".(4)

PSYCHIATRIC NURSING IN HOSPITALS: PAST AND PRESENT

The metamorphosis from asylum attendant to hospital psychiatric nurse is complex and the product of many forces. The asylum attendant was drawn from what was generally recognised as the lower order, servant market. Pay was poor and consequently did not attract. It was possible to draw much higher wages in an emergent industrial society. In order to improve the "quality" of the attendants, attempts were made to attract trained general nurses to be Matrons of asylums and some asylums instigated training courses for attendants. This contributed to an ideological shift. On the one hand to female nurses motivated by "vocational ideals who would view asylum nursing as a calling"(3) and on the other towards rudimentary training courses based upon health, cleanliness and an awareness of disease toxonomies. These influences led asylum nurses closer to a general medical model of care. Many of Nightingales' trained nurses had become matrons of general hospitals throughout the country and for continued promotional prospects these nurses turned to the asylums. Carpenter argues that by 1914 the female sides of asylums (the sexes were kept well apart) had become a recognised part of the nursing universe. Male sides had not been changed but were nontheless affected by this nursing evolution. To generate interest within central Government and stimulate a 'professional' development two organisations were attempting to improve the lot of attendants and nurses but each had fundamentally different aims. One, the Asylum Workers' Association, was born out of a combined front between medical

staff and asylum superintendants and sought to identify themselves with general nursing. This group made approaches to the Royal British Nurses Association for recognition and affiliate membership. The approach was greeted with uproar and rejection by the R.B.N.A. which was seeking to promote the registration of trained general nurses. Indeed Adams,(5) quoting a journal of the day, records no less a person than Mrs. Bedford Fenwick as saying "considering the present class of persons known as male attendants, one can hardly believe that their admission will tend to raise the status of the association". So no attendants were admitted to the R.B.N.A. Thus the A.W.A. took on its own task of improvement and with principles which owed much to general nurses, sought to enhance the professional status of attendants. Their work was not appreciated by the rank and file attendants who wished for better conditions not professional status and so a rank and file union, the National Asylum Workers Union, was formed. Great acrimony existed between the employers and the Union but after much strife general recognition was given to the N.A.W.U. In 1919 the N.A.W.A. made many recommendations to a Joint Consultative Committee set up to examine asylum services. One interesting claim was that the term "attendant" be finally abolished and be replaced by "Mental Nurse". The A.W.A. finally dissolved in June of the same year but its patron, the Medico-Psychological Association (M.P.A.), maintained links with the renamed Mental Nurses. The M.P.A. had developed a 3 year training for mental nurses and based much of it upon studies in anatomy, physiology and hygiene. Some rudimentary psychology was included. Thus the institutions remained staffed by Mental Nurses, a minority of

whom held the M.P.A. certificate. The care they gave was largely custodial and containment was the prime objective. A system of custodial care allied with occupational skills for the physically well and basic nursing care of the physically weak continued until the 1930's. Davies and Lindsey[6] suggested that "Skills at football and cricket or the ability to play a musical instrument, was often the criterion for selection as a nurse and having been accepted, the new employee was judged on his ability to keep the ward clean and the patients quiet, and, if he excelled in these respects, promotion followed in due course ".

From 1930 to 1945 changes in methods of care were precipitated by the introduction of physical treatments. Electroconvulsant therapy, hydrotherapy, malarial therapy, leucotomy and insulin coma therapy all increased pressure on mental nurses to become more orientated towards physical nursing care. The preparation and aftercare of patients involved in these procedures carried with it the trappings and mystique of a more glamorous arena, that of general medicine. It also provided a welcome relief from the monotomy of asylum life. Burr[7] states that "custodial care was out. The patient must be nursed. The nurse must do things for him to bring about his recovery". Mental nurses began to develop skill and competence in these physical procedures, however more sweeping change was on the way.

The mass production and prescription of tranquillizing drugs brought a reformation to mental hospitals. They were being used widely by 1953/4 and it has been estimated by Lader[8]

that in the first 10 years of production, 50 million patients worldwide were treated with tranquillizing drugs. The effects were dramatic. Long term, disturbed and hallucinating patients were transformed into people who could speak, feed themselves and live normally without the aid of physical treatments. "Originally hailed as wonder drugs, their place in therapy remains assured but their application is tinged with a greater realism."(Lader). The role of the mental nurse extended to cover drug administration and monitoring. This, along with passive supervision and diversionary therapy, was the focus of the mental nurse's life.

Institutions began to reduce in size and with the introduction of the Mental Health Act in 1959 large numbers of patients were discharged into the community. This decanting exercise was greeted with great enthusiasm and there were optimistic suggestions that the large mental hospitals would be gone by 1980.[9] Not all mental hospital activity was so productive however and the darker side of asylum life was exposed in a series of public and private enquiries so clearly described by Beardshaw.[10] The precipitant causes of ill treatment and criminal neglect were often due to poor training, the institutionalisation of the staff and the "closed door" effects of institution life. It was scarcely surprising that policies encouraging community care were greeted with welcome relief by many of the more enlightened staff.

Professionalization of the mental nurse has kept time with other developments in psychiatric practice. The Nurse Registration Acts of 1919 stated that a register for nurses

was to be kept and that a supplementary part of the register was to be provided for nurses "trained in the nursing and care of persons suffering from mental disease". In 1921 nurses were admitted to the register if they held a certificate from the Medico-Psychological Association. Additionally the General Nursing Council devised its own separate training for mental nurses. Professionally acceptable qualifications were available from both the G.N.C. and the (now 'Royal') Medico-Psychological Association. This practice continued until 1941 when the Athlone Committee recommended that the G.N.C. take over total responsibility for the training of mental nurses.

The G.N.C. exercised its power to mental nurses through a Mental Nurses Committee. A common first year of training was held for all nurses whether they worked in general or mental hospitals. The training became noticably biased towards physical nursing and following an experimental trial a separate training for mental nurses was devised and brought into use by the G.N.C. in 1964. This new taining although devised specifically for mental nurses was often a 'nursing version' of a medical curriculum and included a great deal of general medicine, disease taxonomies and nursing procedures for caring for the physically sick.

The 1960's brought not only a community perspective but introduction to new therapeutic techniques available to patients now able to participate more actively in the treatment process. Therapeutic communities, psychodynamic therapies, behavioural techniques and 'fringe' therapies all

contributed to a changing environment within the mental hospital. A new awareness amongst patients of their 'consumer' rights led to the development of self help and rights groups such as the National Association for Mental Health. The mental nurse although not always an innovator of these changes was usually a willing participant and often became a focal agent of change. This was particularly so in movements to community care.

Research about psychiatric nurses has been of little significance until recent times and very limited in quantity. Such studies as there have been, give witness to the conflicting demands and pressures placed upon mental nurses. These conflicts are often a result of inappropriate training, an absent or poorly defined ideology and a tendency for nurses to be led and influenced by other professionals. What Carr[1] has called 'an ideology free environment'.

There have been some notable attempts to describe the work of mental nurses as agents of treatment and givers of care. Altschul[11] attempted to investigate the nature of nurse-patient relationships. This was done through observing nurse to patient interactions. She noted significant difference according to diagnostic category and that nurses used symptomatology as a descriptive method. Towell[12] a sociologist suggested that nurses were influenced by the prevailing treatment ideology on a given ward and noted differences between wards which had a prescribed therapeutic milieu where nurses related to patients differently than those wards which had a more traditional custodial regime. This

could well be prevailing ideology filling the free space described by Carr. Cormack[13] suggested that nurses did not use opportunities for therapeutic work to full advantage . In a more recent extensive study of the role of the psychiatric nurse Cormack[14] sought to report activity required to be undertaken by nurses in order to provide, in the opinion of the repondents, effective nursing care. This study confirmed that many nurses find difficulty in describing their role with precision but using a critical incident approach he demonstrated the possibility of making inferences about the nature of psychiatric nursing and the value of varied approaches. These and other studies show that psychiatric nurses do not have a clearly defined ideology and that they are open to strong influence from other professionals, most commonly psychiatrists. Mental nurses have followed psychiatry from the large mental hospital into the psychiatric unit within the district general hospital (D.G.H.P.U.). The D.G.H.P.U. was seen to be part answer in making services more locally available and removing the social stigma from admission to big mental hospitals. This has doubtless contributed further to a re-affirmation of medical influences. With all the medical paraphernalia of physical medicine on hand, such as X-rays and pathological services, mental nurses begin to display yet more of the general nurse imagery. In a study of these newly sited mental nurses working in District General Hospital Psychiatric Units Carr[15] could find little innovative change in work practices and goes on to say "mental nurses are actors in a sub-system - cultural system - i.e. that they perform a role which is ideologically neutral" also "the role of the mental nurse 'qua' social interaction agent

is functionally diffuse in that interaction per se in the nurse-patient situation appears ill-defined; and that it is marked by affective neutrality". Although difficult to substantiate it is possible that these District General Hospital Psychiatric Units have influenced mental nurses to be more commonly known as psychiataric nurses and although the official title for registration is REGISTERED MENTAL NURSE, they are seldom referred to as such and daily parlance is of "psychiatric nurses".

Thus does the present day psychiatric nurse in hospital appear to have developed a custodian working in patriarchal, rule bound asylums. From there in order to achieve professional recognition they have taken on the guise of general nurses bringing them up to the present day psychiatric nurse struggling without an ideological anchor. The implementation of a new basic training curriculum[16] may provide some much needed direction towards humanistic-interactive skills but further proposed changes may cloud the issue further with the possibility of common entry training for all nurses (both general and psychiatric) under active consideration.[17]

1.3.

PSYCHIATRIC NURSING IN THE COMMUNITY

In recent years psychiatric nurses have moved in considerable numbers from hospital to community based work. This move has exposed even further the frailties of working without an ideological base but equally has generated some intelligent

attempts to put psychiatric nursing within a more appropriate paradigm. A review of change and the influencing forces gives important clues.

The Mental Health Act of 1959 gave expression to the tremendous pressures for change in psychiatric care, which surfaced throughout the preceding decade. The revolutions in chemotherapy and treatment changes wrought by the behavioural scientists meant that the existing patterns of care under the 1930 Mental Treatment Act were inappropriate.

In the place of 'certified', 'voluntary' and 'temporary' patients, the 1959 Act talks of 'informal' and 'sectioned' patients, and allows for the increased use of community facilities which should form an integral part of the care of mentally disordered people. Although the 1959 Act encouraged the spirit of change and indeed gave it legislative backing, resources - both human and financial - were further depleted in 1970 by the Local Authority Social Services Act which created what is commonly known as the 'generic' social workers who now had overall responsibility for children, the elderly, the mentally ill and welfare rights. The hospital based psychiatric services were quick to feel the 'wind of change' and followed the example of a number of pioneer hospitals who used psychiataric nurses to follow up discharged patients at home.

The effects of legislation were matched by changes in approach to the care of the mentally disordered. Bellack[18] had called this the "third psychiatric revolution". The community

mental health movement (the third revolution) in the United States of America grew in strength from changes in ideology which surfaced as a response to John Kennedy's call for a "bold new approach" to the care and treatment of the mentally ill in the U.S.A. Baker and Schulberg[19] even went so far as to develop a Community Mental Health Ideology Scale which they claim "supports the hypothesis that there exists a relatively coherent belief system that differentially characterises todays mental health professionals".

Psychiatric nurses in the United Kingdom had already realised the potential in 'community care'. May and Moore[20] described a service which started at Warlingham Park Hospital in 1954. It was developed for two main reasons: "shortage of psychiatric social workers" and "the recognition of a continued need for supervision of discharged patients". Green[21] described a service at Moorhaven Hospital in 1957, also created to fill a shortage of social workers, but as Green points out "There remained a group of patients who needed the kind of attention that only psychiatric nurses could supply". He does not go on to specify what this special help is. From 1969 onwards, community psychiatric nursing teams were set up within most Health Districts. The use of these services was looked at in some detail by Hunter[22] and many papers have been produced which describe the setting up of such services. Among these are Willey,[23] Henderson,[24] Leopoldt[25] and Hacker et al.[26] Differences are apparent in their methods of operation and structural relationships.

CHAPTER TWO

DESCRIBING THE COMMUNITY PSYCHIATRIC NURSE

CHAPTER TWO

DESCRIBING THE COMMUNITY PSYCHIATRIC NURSE

2.1

OVERVIEW OF PREVIOUS RESEARCH

The suggestion has already been made that research into hospital psychiatric nursing has been limited. The growth in community psychiatric nursing prompted an increase in research effort. There have been many descriptive papers which outline the role of individual services and the nurses within them. The papers are varied in quality but all attest to the considerable interest generated in community psychiatric nursing. (Griffiths and Mangen[27])

The first substantial research study was carried out by Parnell.[28] She surveyed 147 CPN Services through the use of work diaries and detailed questionnaires given to other professional groups. She defined and compared the work of full-time community nurses with those who combined community work with hospital or out-patient department work. Most of the patient care activities were seen to be within the following groups: supportive discussions with patients; counselling; administration of injections; supervision of medication; relative support and counselling; advising on social problems, physical health, nursing and behaviour therapy. This study carried out in 1975 showed a sharp contrast between the training that nurses had received within

previous work experience and the new roles they were expected to carry out.

Sladden[29] studied the work of one community psychiatric nursing service in Scotland. The study which was descriptive in nature gives a detailed account of the service which she suggests operated as a part of the hospital where the general psychiatric services were based and the community nurses did not have a fully legitamised role. The service had obvious operational difficulties generated by an inability to relate the service and its objectives to an indentifiable model of community care within psychiatry. A phenomenon not unrecognised by other professional groups. Other studies have examined particular facets of community psychiatric nursing. Sladden's research produced a wealth of detail about the intra-team dynamics of a C.P.N. service.

Hunter[30] through a retrospective controlled study, investigated the effect of CPNs on the aftercare of schizophrenic patients. He found that patients receiving CPN care were likely to spend more time in hospital care, day care and out-patients. His study provided a first milestone in describing the work of the C.P.N. with the long term mentally ill.

Paykel and Griffiths[31] carried out a detailed study in which neurotic patients requiring follow-up were assigned either to routine out-patient care by psychiatrists or to care from community psychiatric nurses as their principal treating agent. In follow-up over an 18 month period there were little

differences between the two groups, however, the patients seeing the CPNs reported greater satisfaction with treatment. Nurses initially saw their patients more frequently that did the psychiatrists but in the long term achieved more discharges. Hunter[30] has also argued that closer surveillance leads to more treatment but as Paykel and Griffiths point out this may well be that CPNs may be referred those patients with the worst prognosis and potential which therefore warrants an intensive care service.

Examining other facets of the work of CPNs Skidmore[32] suggests that there are various problems associated with their work. In a series of articles generated by a longitudinal study he points out that CPNs are beset by a number of problems notably, training, a lack of skills needed to carry out their stated objectives, a philosophy of care which is unclear and an inability to describe with accuracy their day to day activity.

2.2

MANPOWER AND SERVICE GROWTH

Manpower studies demonstrate the explosive growth in CPN services.

In 1966 a report of a national survey to the Royal College of Nursing which had examined the role of psychiatric nurses in the community showed the following:-

42 Hospitals used nursing staff for community work.

35 Hospitals used nursing staff for follow up work.

22 Hospitals used nursing staff for drug supervision in the community.

12 Hospitals used nursing staff for injections in the community.

26 Nurses were used on a full-time basis.

220 Nurses were used on a part-time basis.

In 1974 Parnall wrote in the Queens Nursing Journal that of the 15 Regional Health Authorities all have a service in operation and of the 96 Area Health Authorities (with 200 District Health Authorities) 150 services are in operation. More localised surveys have taken place. In 1977 Shore[36] showed that in the North West Regional Health Authority there were 84 full-time staff carrying an average caseload of 35 to 40 patients each.

The Community Psychiatric Nurses Association has carried out 2 national surveys to estimate the number of CPNs in the United Kingdom. One was carried out in 1980 and the other in 1985. These are known to be the only reliable national surveys of service growth. These 2 surveys give witness to the growth in CPN Services in the last quinquenium,[33] and three tables reproduced from the survey serve to illustrate the point.

TABLE 2.1

TOTAL C.P.N. MANPOWER FIGURES (1980 & 1985)

1980 TOTAL	1985 TOTAL	n	%
1,667.0	2,758.0	+1091.0	+65.0

TABLE 2.2

POPULATION RATIO PER C.P.N. (1980 & 1985)

	1980 RATIO	1985 RATIO	CHANGE
NATIONAL (ENGLAND)	1 : 50,000	1 : 23,000	- 27,000
NORTH WEST REGIONAL H.A.	1 : 37,000	1 : 22,300	- 14,700
YORKSHIRE REGIONAL H.A.	1 : 75,200	1 : 34,500	- 40,700
EAST ANGLIAN REGIONAL H.A.	1 : 74,000	1 : 20,000	- 54,000
TRENT REGIONAL H.A.	1 : 72,400	1 : 27,150	- 45,250

TABLE 2.3

AVERAGE C.P.N. TEAM SIZE WITHIN U.K. 1980 & 1985

	SIZE 1980	SIZE 1985	NET CHANGE
TOTAL U.K.	7.0	12.7	+ 5.7
NORTH WEST REGIONAL H.A.	7.1	11.3	+ 4.2
YORKSHIRE REGIONAL H.A.	3.8	8.9	+ 5.1
EAST ANGLIAN REGIONAL H.A.	4.6	13.5	+ 8.9
TRENT REGIONAL H.A.	5.9	15.2	+ 9.3

This dramatic increase in manpower during a period of national recession must be set against a backcloth of policies from central government which encourage community care for all health care agencies and a remit to close old long stay psychiatric hospitals. This has led to a redirection of resources from institutional to community initiatives.

2.3

MANPOWER PROJECTIONS

The National Health Service is now obliged to plan intermediate and long term strategies for health care.

Current projections are now being made into the 1990's. The policy of community care has not unnaturally had its effect upon the long term planning of CPN Services at a Regional level. The projected plans are often based upon an estimated requirement of one CPN per 10,000 population, a formulae first proposed by the author in 1979.(1) This formulae is based upon population statistics and the incidence of mental disorder in a given community.

The ratios suggested were based upon researched data, while there may be localised significances the end results were based upon the following:-

i) Morbidity Studies

ii) Prevalence Rates

iii) Estimated Referral Rates from GP's to CPN's

iv) Administrative Loading

Morbidity Studies and Prevalence Rates are notoriously fickle in psychiatry and the most celebrated work since 1978 (Goldberg and Huxley 1981[41]) still puts the one-year period prevalence of conspicuous psychiatric morbidity of 140 per 1,000 at risk, a figure upon which the authors' previous work was carried out.

Referral Rates from GP's to CPN's are equally difficult to determine but in a recent paper (Robertson and Scott 1985) the adjusted referral rate from GP's to CPN's is approximately half that used in the original calculation and using this new much lower referral rate the amended calculation will appear thus:-

One CPN per 10,000 population

1. Conspicuous psychiatric morbidity = 1,400 in a population of 10,000
2. Referral rates to CPN from GP = 7% of conspicuous psychiatric morbidity
   = 98 patients per CPN
3. + 5% Administrative loading (Jamison Report for Health Visitors)
4. + An unspecified in-patients population currently being decanted into the community.
5. + Referrals from other sources.

National figures will vary considerably given the variety to be expected at point 4 and point 5.

Any further detailed prognostication is pointless given our

"state of the art" knowledge about psychiatric morbidity and the referral patterns of CPN's. Manpower planners require some form of best estimate for their future projection and it would appear that one CPN per 10,000 population is a good figure on which to base manpower projections.

Using one Regional Health Authority as an example a pattern of development at Regional and District Health Authority level can be demonstrated.

TABLE 2.4

NORTH WESTERN REGIONAL HEALTH AUTHORITY

COMMUNITY PSYCHIATRIC NURSES

(Excludes: Managers, Learners and Unqualified Staff)

Health Authority	Staff in Post at 31.3.84	Staff in Post at 30.9.84	Target*	Difference +/-
Lancaster	14.6	15.6	19.0	- 3.4
Blackpool, Wyre and Fylde	10.0	12.0	52.2	- 40.2
Preston	12.0	10.0	21.1	- 11.1
Blackburn, Hynburn and Ribble Valley	14.0	16.0	45.1	- 29.1
Burnley, Pendle and Rossendale	7.0	8.0	38.5	- 30.5
West Lancashire	2.0	2.0	17.1	- 15.1
Chorley and South Ribble	7.0	8,0	30.9	- 22.9
Bolton	8.0	9.0	42.5	- 33.5
Bury	7.0	7.0	28.3	- 21.3
North Manchester	12.2	16.7	25.0	- 8.3
Central Manchester	9.0	10.0	20.0	- 10.0
South Manchester	14.0	13.6	28.2	- 14.6
Oldham	8.0	7.0	35.7	- 28.7
Rochdale	4.0	4.0	34.9	- 30.9
Salford	18.0	26.0	39.6	- 13.6
Stockport	13.0	12.0	45.2	- 33.2
Tameside and Glossop	6.0	6.0	38.8	- 32.8
Trafford	8.0	8.0	32.9	- 24.9
Wigan	9.0	10.0	50.8	- 40.8
NWRHA	182.8	200.9	645.8	-444.9

The projected figures are based upon R.A.W.P. weighted population estimates. The target is based upon one CPN per 10,000 population, plus 1 extra CPN per 3,000 population over 65. Some 20% of psychiatric in-patient beds are expected to disappear during the time scale indicated. (The figure does not appear particularly high when compared to the rest of England, but this is likely to be because the N.W.R.H.A. takes 82.5% of its acute admissions into District General Hospital Psychiatric Units compared to 38.7% on a national average.)

It is perhaps unwise to predict national growth but there is no doubt that the manpower increase is likely to continue for the forseeable future. It has been suggested (C.P.N.A.[34]) that there may be as many as 8,000 CPNs in post by 1993.

2.4

EDUCATION AND TRAINING

Post qualifying education and training for community psychiatric nurses has been available since 1975. Originally under the auspices of the Joint Board of Clinical Nursing Studies this training has been drawn into the new professional National Boards for Nursing, Midwifery and Health Visiting.

Approximately 240 training places are available in England and Wales with 6 of the 10 training centres based in Colleges of Further and Higher Education. Post registration training is for one academic year and is a mixture of academic theory and practice experience. In the decade 1975 to 1985, 1,095 nurses

have attended these courses. It is interesting to note however, that only 22.4% from a total of 2,758 nurses in practice are shown to be qualified[33] which may indicate a substantial movement to management and teaching posts by these nurses.

This low number of appropriately trained nurses is recognised to be an undesirable state of affairs and there have been calls for mandatory training as a pre-requisite for practice.[35] Reasons for this demand vary but CPNs and nurses working with the mentally handicapped in the community are now the only groups of nurses who are not obliged to take further training as a pre-requisite to practice in the community. Before the necessary ammendment to the Nurses Act can be made to accommodate mandatory training certain established precedents must be considered. These precedents were noted during the recent negotiations undertaken by district nurses to achieve mandatory training status. It has been suggested that 70% of the existing workforce must have already undergone some 'suitable' training. With an almost exponential growth in the creation of new CPN posts there is little chance of realizing this requirement.

Secondly, a suitable training must be available. The existing training may or may not be considered 'suitable' by the workforce. Skidmore[32] has argued that the present training has deficiencies and does not prepare the workforce sufficiently. His study suggests that "of the 40% of nurses who had done the E.N.B., half still felt unprepared for their role". Conversely, the effect of positive change upon nurses

who have undertaken the E.N.B. course has been documented and the author has noted in earlier pilot studies[37] evidence of more comprehensive thinking on the part of nurses who had undertaken post registration training.

Thirdly, the author amongst others has argued for a credible career structure for CPNs to give a suitable foundation for practice. (Butterworth C.A.[37a])

National and local initiatives have started to fill training gaps, with the provision for an E.N.B. Short Course and Regional and District Health Authority Short Courses.

Publication of the Social Services Select Committee Report[38] has added weight to the arguement for suitable training and education. The report states in one of its recommendations "we recommend that funds be earmarked by Health Authorities and the E.N.B. for the future training of CPNs and that the Government undertake to find the funds necessary to provide training over a period of years". The state of flux which is reflected by demands for education and training has in part to do with the lack of research into the skills which CPNs need and a general unease with post qualifying education amongst psychiatric nurses themselves.

CHAPTER THREE

THE DILEMMAS OF PSYCHIATRIC NURSING IN THE COMMUNITY

CHAPTER THREE

THE DILEMMAS OF PSYCHIATRIC NURSING IN THE COMMUNITY

3.1

DEMANDS OF THE NEW ENVIRONMENT

In her description of the social work task Goldberg[39] refers to "the vastness and vagueness" of social work. CPNs are presented with a similar vastness and vagueness in their new arena when they move away from the protection and orderliness of hospital life. The imprecision of casework, the indeterminate nature of community care and a "systems" effect of community cases all combine to challenge the existing skill repertoire of CPNs.

3.2

ORGANISATIONAL RESPONSE

To meet the demands of the new environment CPNs and their managers have in some instances tried to employ institutional methods and organisational frameworks which are more appropriate to a hospital than a community setting. Although the response is often locally determined, three common types of service may be observed. Each carries with it various advantages and, paradoxically each one generates problems of its own making. The author has worked with others in describing these service structures.[1] More recently the

C.P.N.A. national survey has demonstrated great regional variation in the numbers of CPNs by base.[33]

Three main types of services are presented and the inherent advantages and problems of each are discussed.

3.2.1 THE HOSPITAL/CONSULTANT ATTACHED TEAM

This is the commonest type of team structure. It asks little in terms of organisational change, does only small damage to existing power structures and can be developed with minimal effort. Todd[40] describes this type of service at High Royds Hospital in Yorkshire. He showed that work was domiciliary in nature and consisted of 5 psychiatric nurses accepting follow-up referrals of patients being discharged from hospital and other referrals from the psychiatric out-patients' department.

Features of the Structure

Usually one community psychiatric nurse is attached to a consultant psychiatrist and most referrals are given from doctor to nurse. The psychiatrist may or may not be geographically attached. There is little organized contact with the primary health care team and the CPN service is physically and ideologically fixed within the specialist psychiatric services.

Structural Problems

The CPNs are effectively limited in their work. As all referrals come from the consultant psychiatrist it is he who is in effect determining their role. As there is limited contact with the Primary Health Care Team and other community services, liason is piecemeal and fragmented.

Nurse managers in the psychiatric hospital often have little or no experience of community work. It follows that their concepts of it are limited and they may disagree fundamentally with the needs perceived by the CPNs.

Comments

In this system the CPNs have often been 'added on' to an existing psychiatric service. Relationships which need to be developed to realize the potential of community care are not fully explored. The consultant has a 'netting' effect upon casework and this will exclude the CPN from dealing with many psychiatric problems which other disciplines might happily refer for non-medical attention. It has been suggested by Goldberg and Huxley[41] that specialist psychiatric services see only 17 per 1,000 patients at risk from an estimated 250 per 1,000 demonstrated in morbidity studies from random community samples. In the service described here, no inroads are made into disorders at primary care level, the service is often domiciliary in nature and only supports the work of the specialist psychiatric services.

3.2.2 THE COMMUNITY BASED TEAM

This approach has the hallmarks of a more radical change to community care. In efforts to detach from psychiatric institutions some CPN services have moved into the community setting and allied themselves with primary health care and community services. This type of service has often developed where nurses work from health centres and take open referrals from any source.

Features of the Structure

The CPNs are based within the community they serve. They may be attached to primary health care teams, placed within community health centres or social service offices. The nurse will know the specialist psychiatric services and may receive notification of discharge from hospital by letter from the consultant. Smith[42] has described such a service in Central Manchester.

Structural Problems

CPNs may feel that they are cut off from their professional colleagues in the specialist psychiatric services. The special relationship they may have had with one consultant is likely to be absent. Senior managers of these services are likely to have no experience in psychiatry. The CPN may have problems of identity in generic casework which is presented to them. Responsibility for case management is very much their own and reference to specialist advice is not as easily

accessible.

Comments

In this structure nurses have effectively extended their role but at some cost. It requires modification of old relationships and establishment of new support networks with groups who are not necessarily 'expert' in psychiatric services.

3.2.3 SPECIALIST AND COMMUNITY ATTACHMENT

This structure attempts to provide a district psychiatric service to cater for all needs both from the hospital and community services.

Features of the Structure

In this system CPNs, although attached to the specialist services, have an outline responsibility towards nominated health centres and community agencies. They are likely to be geographically sectorized. The emphasis is upon integration of specialist psychiatric services at a local level and a strengthening of links between services and thereby offering easier access to those in need. Pope[43] has described the problems and benefits of such a service in South West England.

Structural Problems

The main consideration would appear to be one of manpower.

Given sufficient numbers of nurses this structure provides a satisfactory and comprehensive service. Other professionals have objected to this suspected 'dilution' of services. In a recent paper Goldberg[44] has proposed that CPNs should "be part of multi-disciplinary community care teams with access to supervision of their work from both psychiatrists and clinical psychologists". This comment assumes that the work that CPNs carry out is amenable to supervision by medical staff and psychologists. However, the general width of CPN casework may not be amenable for specialist supervision of this nature.

Comments

This third structure is becoming the one of choice for most District Health Authorities. The change of base is a likely consequence of moves to give a joint specialist and community attachment.

Leavitt[45] puts forward a theory of "goodness of fit" between aspects of an organization, namely technology, people and tasks. These facets are subject to various effects from external sources. Tasks are affected by growth and diversification. People are affected by changing attitudes and expectations and technology is affected by innovation. Knowing these effects he argues that a structure must be able to change. Equally Lawrence and Lorsch suggest it is possible to examine the interface between the organization and the environment, groups and the individual and the organization.[46] These paradigms are amply demonstrated in the search for a suitable base and structure for CPN teams.

Service structures are important because they determine to a very large extent what sort of referral a CPN will get and which agents will refer them for advice or to pass on cases.

Service bases have also contributed to elements which are developed further in this thesis namely: interprofessional strain and organizational and professional paradox.

3.3

INTERPROFESSIONAL STRAIN

The developing role of the psychiatric nurse has produced destabilising of previously steady states between professional groups.

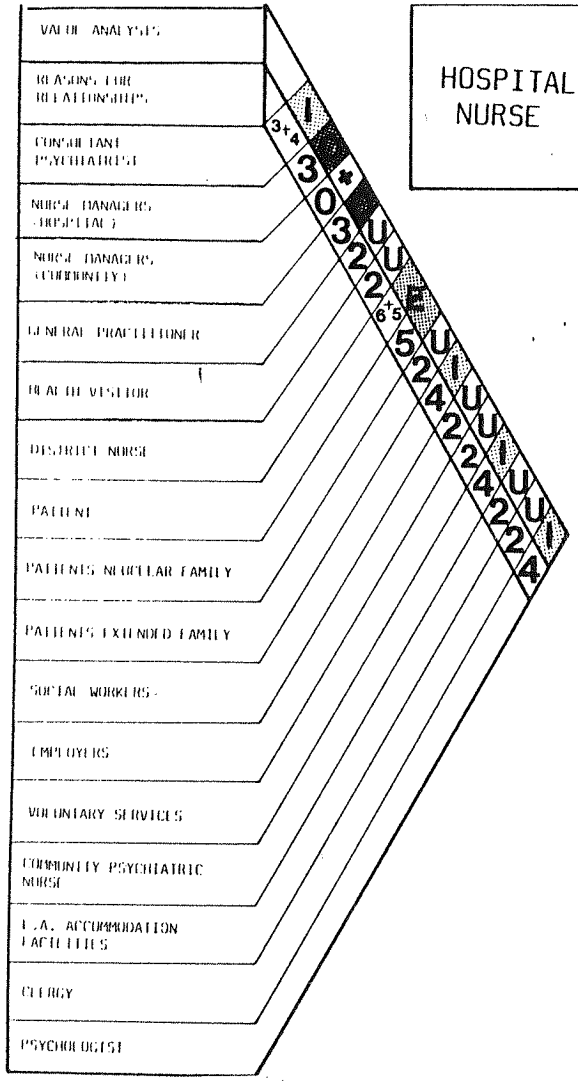
Professionalism and professionalization has been minutely examined by social scientists. Commmunity psychiatry provides a living example of some of the theoretical perspectives accorded to professional occupations. Johnson[47] states that "In Britain auxiliary health professions are defined by statute as 'professions supplementary to medicine' this indicates that (these auxillary professions) may carry out treatment only in respect of prior diagnosis by a doctor.". The author proposes that the power which medicine has to maintain control of the professional-client relationship in psychiatric practice is being debased by the shift towards community care. Equally consumer choice has created a tension in the previous wide control of medicine over psychiatric services. Psychiatrists are usually located in in-patient

facilities where services are geared towards physical basis of mental illness and use drug therapy as a first choice in the management of psychiatric disorder. Community consumers recognise alternatives to established medical practice and CPNs have become placed in a position where they are allowed to develop the skills the consumer wants. With no ideological anchor to hold them CPNs have begun to offer alternative practices to members of the old in-patient population but equally to new cases "uncontaminated" by the specialist services.

As psychiatric nurses move to community work relationships with other professional groups change. Old partnerships alter and in a survey carried out by the author in 1978[48] of 50 hospital psychiatric nurses and 50 CPNs a demonstrable shift in alliance was noted. (See Figure 3.1)

Relationship Chart

FIG 3.1



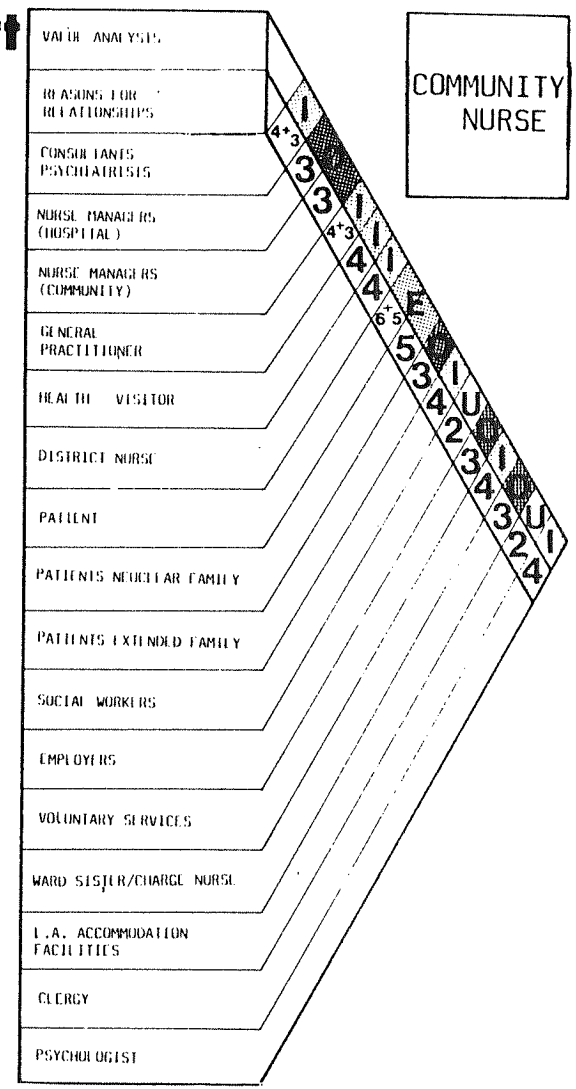
Reasons for Relationship

0	NO CONTENT NEEDED
2	OCCASIONAL CONTACT
3	CO-ORDINATION AND CONTROL PURPOSES
4	'TEAM' CARE RELATIONSHIP
5	ADVICE ON CARE OF MENTAL DISORDER
6	GIVING OF NURSING CARE

(Possibly more than one reason)

Key to value analysis

6 +		
5-6	E	ESPECIALLY IMPORTANT
4-5	I	IMPORTANT
3-4		ORDINARY CLOSENESS
2-3	U	LARGELY UNIMPORTANT
0-2	X	NOT OFTEN NEEDED



This would suggest that the CPNs are in a position where they are exposed to new partnerships, practices and ideologies. Old relationships change and arouse anxieties. This has been seen most often in the changing relationship between the CPN and the psychiatrist. In recent times the CPN has seen fit to shrug off the paternalistic hand of the psychiatrist and given more direct attention to patients and their families through their general practitioners. This 'open' referral system has created heated debate. The debate centres around the competence of the nurse; an accusation of cheap and debased medical psychiatry and a danger of a mass of social problems being off-loaded onto an already overburdened psychiatric service. Weber[49] has observed that the same tasks being performed by people of different training and status is a source of conflict. Blau and Scott suggest that changes which affect status and control are most likely to produce interprofessional conflict.[50]

Psychiatrists suspect that the 'direct referral' of psychiatric problems to CPNs will mean that CPNs are placed in a position of power which they find unacceptable. CPNs are being put in a position where they can filter out referrals which they can deal with themselves. Assumptions are made on the part of the psychiatrists that CPNs are not trained to do this. Interestingly however, as Goldberg and Huxley point out, the "filter agents" at the moment are General Practitioners who may not be particularly distinguished at detecting psychiatric disorder at primary care level[41] and show a wide discrepancy in their ability (or willingness) to diagnose psychiatric problems. The question remains

unanswered as to the ability of CPNs to carry out this function.

The Royal College of Psychiatrists has expressed concern about the developing role of the CPN "Referrals by GPs and their colleagues to the CPN should be viewed as referrals to the psychiatric team and should be discussed in team meetings. When CPNs are a limited resource and demand is great, referrals may best be screened by the consultant psychiatrist".[51] The Social Services Select Committee is less hesitant about the need to open up the referral systems and suggests "we would welcome a statement from the Royal College of Psychiatrists specifically encouraging the idea of direct referral from GPs to CPNs"(52) so the debate continues.

Case management has put CPNs into new situations not previously experienced by psychiatric nurses. Nurses have not previously determined when a case should begin or end or even decide when to withdraw nursing expertise. Such decisions were made in the hospital setting by doctors. Admission and discharge of patients determined the giving and withdrawal of nursing care.

CPNs do have a very wide remit in their care for all the cases they deal with. Interestingly even cases referred by psychiatrists offer considerable space for initiative. Nurses are often asked to 'support' or 'observe' and 'monitor' cases. These non-specific requests give CPNs a free hand in deciding what they can offer to clients. As will be demonstrated from pilot studies for this thesis CPNs undertake a wide range of

activities in commissioning their referrals. This self-determination is not always welcomed. Jeffries[53] observed in 1965 an apparent strain between professionals who were simultaneously but differently determining clients' needs and services. Sladden in her detailed literature review of this subject[29] states that "when nurses change the setting of their work from the hospital to the domiciliary situation, definitions of their function, "attitudes to their work and ideological positions may undergo a sustantial change". She also suggests "Problems of conflict are likely to arise in the community situation in so far as the functions of nurses and of other related professional groups overlap, or are not clearly delimited, particularly if their respective roles or their mutual statuses are uncertain or unstable.".

Since her findings in 1980 the role of the CPN has been validated by professional groups, central government and longitudinal studies but the interprofessional strain continues, fueled by the wide ranging nature of CPN work and the continuing need for definitive statements about their work.

3.4.

ORGANIZATIONAL AND PROFESSIONAL PARADOX

Paradox suggests a situation which is self-contradictory or absurd although initial intentions are possibly well founded or essentially true. Such is the lot of community psychiatric nursing.

The good intention of community psychiatry is self-evident. CPNs are part of a national movement in the 1980's to remove psychiatry from its institutional perspective and replace it with a new model of psychiatric practice in the community it serves. A number of paradoxical situations occur as CPNs develop their practices. These situations have served to generate the questions leading to the initial hypothesis of this study.

The ideological base of psychiatric nursing has always been difficult to define. The CPN movement has brought added imprecision to already vague definitions of practice. Little attempt has been made to provide a conceptual framework for practice and CPNs have either led or been swept along with the "community movement". This paradox is most tellingly described by Kane[54] who suggested "Professionals are staking claims in promising new territory and only later digging the theoretical mines necessary to determine whether they have struck an appropriate task.".

The tools to describe the work of CPNs are limited. The normal I.C.D. (International Classification of Disease) grouping used to classify problems is not appropriate for the patients and problems dealt with by CPNs. Previous studies in this area have provided much needed information about CPNs but the description of problem presentation and progress of casework requires further development. Ethnomethodological and controlled studies are valuable but both present problems. The former may be too "service specific" to generalize from

and the latter can lean towards reductionism which gives only a part-picture of casework.

Paykel [31] and his colleagues note that "psychiatric nurses have extended their roles in psychotherapy psychosocial techniques and family work". This would appear to be at odds with the extensive literature review carrried out by Griffiths and Mangan[27] from this they infer that suitable techniques for CPNs are:- following up of patients, giving advice and support, attending to practical needs, co-ordination of hospital and community services and prompting socialization. These very different descriptions illustrate a paradox in practice for CPNs. While they can demonstrate the techniques described by Griffith, should they make forays into the roles suggested by Paykel ? There is little doubt that CPNs constantly come across cases amenable to family therapy or behavioural techniques but skilled therapists to deal with these are scarce. CPNs therefore see a need to move into these areas themselves, creating doubts about their existing practice skills and fueling interprofessional tensions.

Service structures are in need of redevelopment. The original structures used to provide the infant CPN services are inappropriate for present practice. Many CPN team philosophies are aimed at maintaining the 'status quo' in psychiatric practice. When attempts are made to break out of these structures there is interprofessional conflict and an intraprofessional lack of confidence.

Strauss[55] suggests that nurses do not as a group have

allegiance to any particular model of mental disorder. They have been traditionally exposed to a medical model of care. The medical model postulates a 'sick' person who suffers from an illness which has signs and symptoms. These can be diagnosed, treated and cured. Critics of the medical model have offered alternative paradigms including moral, psychoanalytic, social and conspiratorial (Siegler and Osmond[56]). Thomas Szasz a most vigorous opponent of the medical model seeks definition instead in "problems of living".[57]

Medical practice has made some strides towards a more 'holistic' view as the traditionalist medical model is exposed as too narrow and Wing[58] among others has argued for the usefulness of retaining elements of a disease theory but within a less traditional format.

Ideologies and paradigms receive scant attention in nursing literature but nurse researchers comment repeatedly about the "ideological neutrality" of nurses. Carr,[15] Cormack[14] and Sladden[29] all describe this phenomenon. A 'neutral' practitioner is likely to be persuaded towards a dominant ideology. In hospital this is likely to be a medical model. In the community, nurses are presented with more freedom to choose. This allows them to develop a new ideological stance, maintain a containment/custodial role or demonstrate that which Altschul[59] has described as the psychiatric nurses preference for intuitivism and spontaneity in their relationships. Community care presents psychiatric nurses with a choice, an opportunity to move towards a more

definative ideology which will generate new problems for practice or maintain a traditional role which is likely to underserve the community and already makes CPNs dissatisfied.

The wider conceptual changes which are evident in all nursing specialities are apparant in community psychiatric nursing as well. The changes have to do with the search for "theories" in nursing and systematic approaches in the process of nursing. It has been suggested by the Community Psychiatric Nursing Association that CPNs are trying to adopt a systems approach within a holistic framework. While conceptually this appears a viable model, in practice CPNs display all the paradoxical features shown by other groups of nurses and it is characterised by a deep rooted conservatism towards practice based in a quasi medical model. Conventional psychiatric nursing is based upon these lines. The model postulates an essentially linear causality theory. This is described as A causes B, B causes C and if D is done to C, E will follow. The inadequacy of the model is self-evident and it loses much of its precarious validity in the community setting. Linear causality requires a controlled environment, predictable consequences of action and this can be found in the hospital or institutional setting. Community care shakes the constancy of the old model and many community nurses would subscribe to the view of Mayer(60) who says "we can no longer trust to psychiatric diagnosis or moral imperatives, the days of linear causality are over, we have to cope with generalism as best we can". The question must then be asked "What can fill the vacuum?, Can the nursing process provide a viable alternative?" There is no evidence as yet to advocate

wholesale change but planned patient care may provide some of the answers. However, Altschul[61] amongst others challenges the application of simplistic planning in psychiatric care, and argues that a corporate approach in the nursing process including assessment, activities of daily living, problem orientated nursing and a systems approach gives a more substantive response.

It would appear that the ideas are around but very few nurses have attempted to replace their old practice ideologies. Reynolds and Cormack[62] show evidence of change in their evaluation of a problem orientated approach to psychiatric nurses education and observe that "many nurses continue to wrongly assume that nursing care is predetermined by patients' diagnoses".

In summary, the paradox of a conceptual framework for action rests in the knowledge that a medical model is inappropriate for community care and that the alternatives may only be developed with education and opportunity to change.

SECTION TWO

GENERATION OF HYPOTHESIS, CHOICE OF METHODOLOGY AND ESTABLISHMENT OF THE STUDY

CHAPTER FOUR

GENERATION OF HYPOTHESIS AND ESTABLISHMENT OF THE STUDY

CHAPTER FOUR

GENERATION OF HYPOTHESIS AND ESTABLISHMENT OF THE STUDY

4.0

INTRODUCTION

There was considerable evidence to suggest that research data was required to cast further light upon the casework activity of C.P.Ns.

The author had been further stimulated by evidence from other professional specialities which were investigating related phenomena from these other groups. Social Work, Health Visiting and District Nursing were producing data about their own particular groups which appeared to address common issues. The investigations of Goldberg[39] in social work proved particularly influential for information on case review systems and the ideological framework of a community based professional. Goldberg at the outset of her study suggested emphasis upon six main areas for a practice orientated researcher and the author identified three of these as central to his own research effort with community nurses.

1) The tasks performed by those who man the C.P.N. services will need to be systematically examined.

2) The skills needed to perform these tasks will have to be defined and tested.

3) Systematic record and review systems need to be developed to provide basic information about nurse activities.

Consequently two pilot projects were carried out to obtain some baseline information about the casework activities of community psychiatric nurses and how these could best be categorized.

4.1.

INITIAL PILOT STUDIES AND PRELIMINARY ENQUIRIES

The first study summarized here formed the basis of a dissertation presented as part of a taught M.Sc. programme undertaken at the University of Aston in Birmingham in 1978/79. The study was set up to gain information about the various facets of casework practice carried out by CPNs. Little was known at that time about the main sources of referral to CPNs, the requests that they made and the techniques CPNs used to commission their referrals. There were three objectives to the pilot study.

1) To provide an information base showing sources of referral, participants in assessment and the format of planning patient care.

2) To investigate the actual (as opposed to the supposed) programmes of care implemented by CPNs following initial referral.

3) To identify any significant inter-relationships between referral source, requested activity and prescribed activities.

Two methods were used to obtain data. A postal questionnaire was sent to a random sample of 200 CPNs drawn from the membership list of a national association (C.P.N.A.). Secondly, two CPN teams were approached and interviewed. A random sample of patients from the nurses' caseloads was chosen for detailed analysis.

There was a 68.5% response from the postal questionnaire, therefore, 137 nurses gave information, 102 patients were analysed from the two teams' caseload.

RESULTS FROM POSTAL QUESTIONNAIRE

The 137 respondents from the survey were asked questions about case management, assessment and evaluation of patients.

i) All respondents in the sample said they assessed patients regularly and used planned patient care procedures.

ii) 59.5% of the sample felt that basic nurse training has provided them with the skills to carry out their work in assessing patients.

iii) There was evidence to demonstrate that inexperienced CPNs assess clients by themselves but are more inclined to "share" cases as they become more experienced.

iv) Doctors often ask CPNs for opinions about cases but rarely as a written request. Most interprofessional communication is verbal.

v) There was a demonstrable significance (less than 0.02%) between nurses who held the R.M.N. certificate only and those who had attended a post qualifying CPN course when examining their parameters for assessment. Nurses holding a post registration qualification used much less 'medical' terminology. R.M.N. only nurses showed a marked preference for measures of "illness and wellness".

RESULTS FROM THE PATIENT SURVEY

102 patients formed the sample for the survey.

i) One of the most significant findings from the patient survey was the action requested by the referring agent. The two most commonly occurring requests for action were for "follow up" (45 from n.102) and "support with medication" (42 from n.102). Neither of these terms were adequately explained. In using this quite non-specific terminology CPNs were given a free hand to interpret this into such action as they saw fit.

ii) Table 4.1 demonstrates the differences observed between requested activity and action implemented by the CPN. The 'freedom of action' was most frequently translated into 'counselling' and 'supportive psychotherapy', support with oral medication, social skills training and resocialization programmes and observation for clinical signs and symptoms.

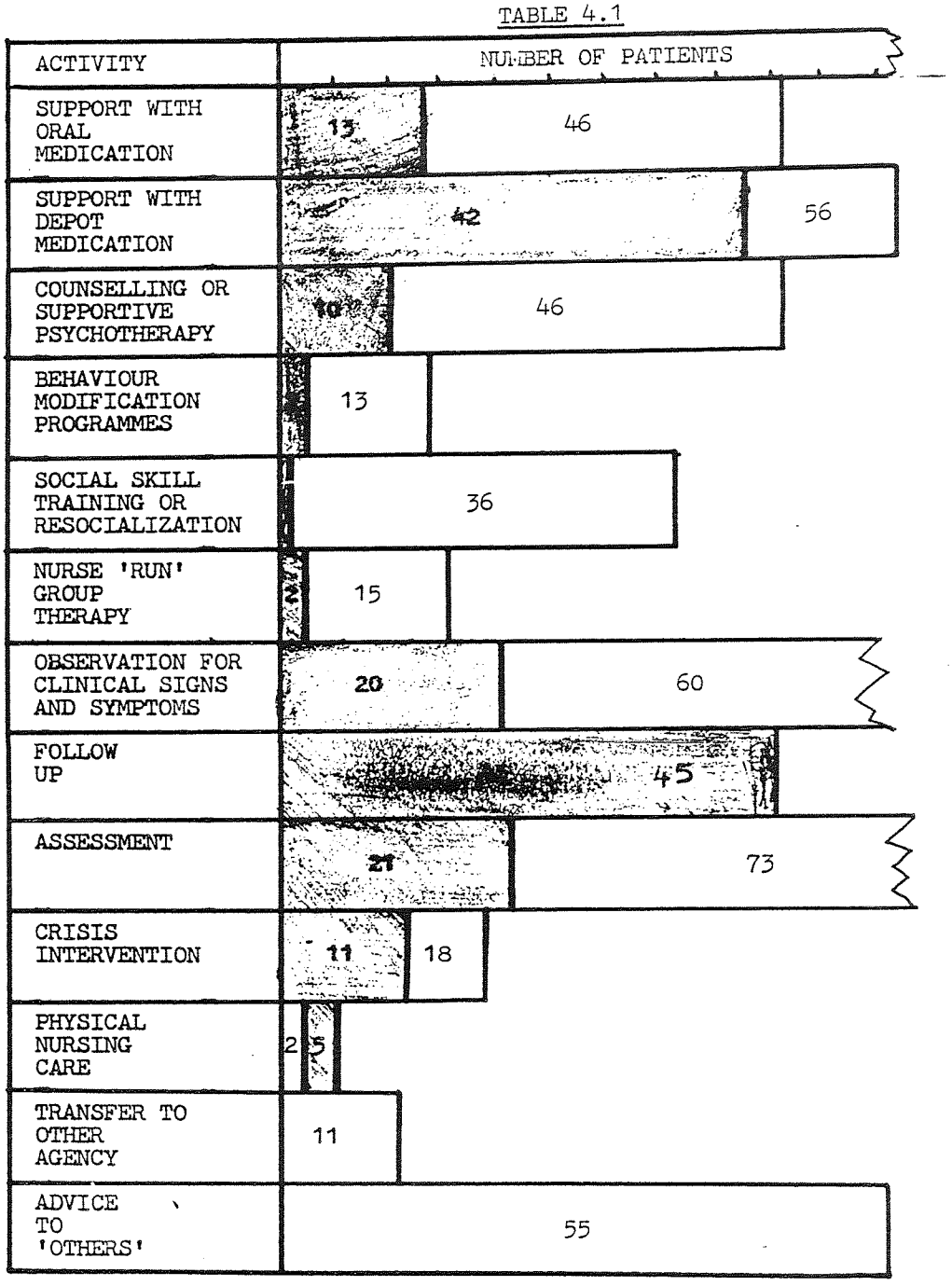
iii) There were major problems identified in the pilot study when asking nurses to verbalize about the activities they engaged in with patients and their families. There was found to be a general inability to describe nurse-patient exchanges and when nurses described using behavioural and psychodynamic methods their explanations were not always consistent with 'recognised' therapeutic schools.

iv) The most frequently cited reasons for referral to a CPN team fell into 2 main categories a) when specific action was requested (as seen at table 4.1) and b) where patient behaviours fell into 3 other indentifiable groups i) appointment defaulted, ii) giving signs of socially unacceptable behaviour, iii) demonstrating overtly obvious

signs of mental disorder.

v) CPNs were asked to identify the most pressing primary problems as defined by them and their patients following engagement with cases. These are shown at Table 4.2. The primary problems were seldom consistent with those identified by the referring agent.

TABLE 4.1



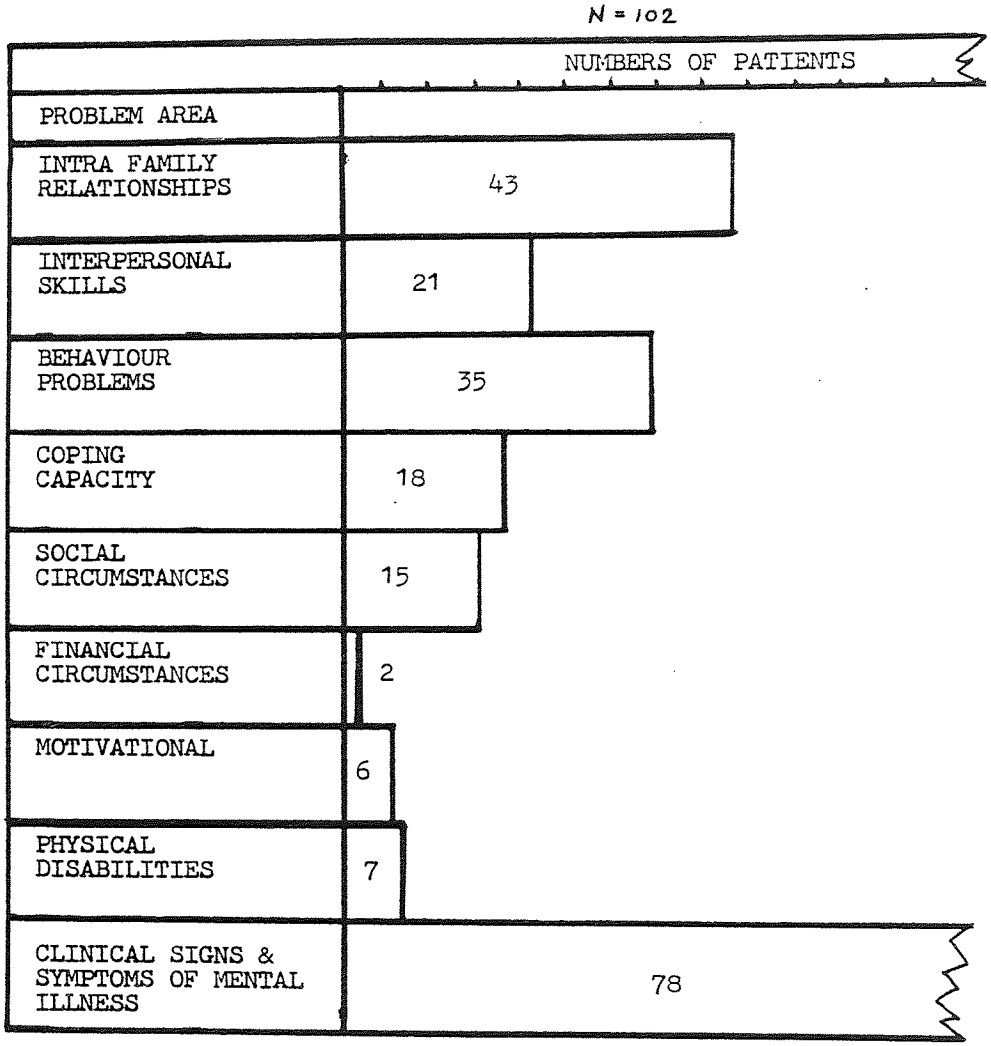
ACTION REQUESTED BY REFERRING AGENT AND ACTION IMPLEMENTED BY C.P.Ns. N=102

ACTION REQUESTED

ACTION BY THE C.P.N.

TABLE 4.2

PRIMARY PROBLEM AREAS AS PERCEIVED BY C.P.Ns



vi) It was possible to postulate that a proportion of the identified primary problems should be ammenable to psychodynamic or behavioural psychotherapies. None of the CPNs interviewed had received formal training in these methods, but were nonetheless attempting to gain experience and expertise in more constructive therapeutic methods.

vii) When describing their casework CPNs often used similar imprecise terminology as the referring agents, words such as support, maintenance, supportive therapy and follow-up.

viii) When asked for details about case involvement CPNs were demonstrably surprised when casework activity was laid out in detail. A typical example is shown at figure 4.1.

FIGURE 4.1

THE REFERRAL PROCESS

REFERRAL SOURCE	REQUESTED TASKS	ASSESSMENT	POST ASSESSMENT ACTIVITIES
CONSULTANT PSYCHIATRIST	SUPPORTIVE AND FOLLOW UP WITH DEPOT MEDICATION FOLLOWING PSYCHOTIC EPISODE	C.P.N. ASSESS THE CASE FOLLOWING REFERRAL	1) SUPPORT WITH DEPOT MEDICATION 2) GIVE SUPPORTIVE PSYCHOTHERAPY TO RELATIVES 3) INSTIGATE SELF HELP SOCIAL SKILLS TRAINING PROGRAMME 4) OBSERVE FOR SIGNS AND SYMPTOMS OF RELAPSE

GENERAL SUMMARY FROM FIRST PILOT STUDY

i) Mechanics of referral to CPNs are rudimentary and do not 'tie down' CPNs to limited practices.

ii) CPNs do not articulate well about their casework. This inability may be a consequence of ideological neutrality or lack of appropriate post qualifying training.

iii) CPNs carry out a great deal of undocumented casework.

iv) The main referral agents to CPNs are psychiatrists and GPs. They use an essentially medical framework of reference and rarely, if ever, ask CPNs to carry out specified theraputic techniques with patients.

v) CPNs have recognised a great amount of intra-family, behavioural and social skills problems amongst their casework. CPNs recognise their own 'skills shortfall' in being able to help in these cases but have expressed a wish to train themselves to help in this sort of casework.

CASE STUDY ANALYSIS - THE SECOND PILOT STUDY

The author has been a course leader to a post-registration training course for CPNs for 6 years.

In a five year period from 1978-1983 the author carried out a content analysis of case studies which students submitted as part of their course work. The content analysis of casework of this nature was considered to be valid but within well recognised constraints. The studies were being carried out by a contaminated sample (students). The students were attenders at one course centre and therefore subject to the same academic influence and constraints of choice. Measured against this was the knowledge that students had a freedom of choice in case selection and their actions (although supervised) were of their own initiative.

Content analysis was therefore considered to be a good pilot study exercise as it would offer insights into a breadth of casework over a period of time, detailed examination of cases and give information about sources of referral, presenting problems, observed medical diagnosis, interventions employed by nurses and case outcomes.

CONTENT ANALYSIS OF THE STUDIES

The case studies were subjected to analysis by the author following discussions with the case presenters. Categorization of the cases was carried out by no-one but the author. The choice of this was deliberate; in order to develop a baseline of information which could then be tested for its validity as a means of categorization by others.

150 studies were examined and information grouped into:-

i) Source of referral

ii) Presenting problems observed

iii) Medical diagnosis

iv) Interventions employed

v) Outcomes

RESULTS OF CONTENT ANALYSIS OF CASE STUDIES

TABLE 4.3 SOURCE OF REFERRAL n = 150

SOURCE	No. OF CASES
CONSULTANT PSYCHIATRIST	86
GENERAL PRACTITIONER	34
HEALTH VISITOR/DISTRICT NURSE	17
SOCIAL WORKER	11
OTHER	2
TOTAL	150

PRESENTING PROBLEMS

The presenting problems were categorized by using principles which are taken from problem orientated methods. The categories owe much to the pioneering work of Ryce and Corser[59] in Scotland. They produced a standard problem checklist for categorizing their community psychiatric contacts. The author took their checklist and modified it slightly for use with the study. The checklist was organized as follows:-

1) SOCIAL PROBLEMS:-

Employment problems, financial problems, recent loss or separation and housing problems.

2) BEHAVIOUR PROBLEMS:-

Alcohol abuse, antisocial behaviour, manifest anxiety, compulsive behaviour, danger to self, emotional immaturity, hostile behaviour, poor impulse control, phobic behaviour, poor personal habits, sexual problems, social withdrawal and interpersonal relationship problems.

3) PHYSICAL:-

Appetite problems, sleeping problems, diagnosed physical disorder, physical disability/handicap.

4) MOOD/AFFECT:-

Depressed mood, sad and unhappy looking, crying a lot, feeling excessively tired, feelings of guilt, feelings of worthlessness, feelings of hopelessness, feelings of anxiety, feelings of fear, inability to cope, feelings of unreality.

5) PROBLEMS OF THINKING:-

Confusion, clouding of consciousness, memory difficulty, obsessive thoughts, impaired judgement and insight, thought disorder, delusions, hallucinations, passivity feelings or impulses, parnoid ideas.

6) FAMILY PROBLEMS:-

Marital problems, child care problems, intrafamily "strain", parenting problems.

TABLE 4.4 TOTAL PROBLEMS PRESENTED

TOTAL CASES = 150

TOTAL PROBLEMS IDENTIFIED = 371

Social Problems	70
Behavioural Problems	53
Physical Problems	25
Mood/Affect	107
Problems of Thinking	75
Family Problems	41
TOTAL	371

TABLE 4.5 MEDICAL DIAGNOSIS

Schizophrenia	37
Depression	21
Psychoneurosis	54
Other Psychosis	2
Dementing Disorders	28
Other and Undiagnosed	8
TOTAL	150

TABLE 4.6 INTERVENTIONS EMPLOYED

TOTAL CASES = 150

TOTAL INTERVENTIONS EMPLOYED = 455

Medication Supervision/Administration	121
Supportive Counselling	136
Behaviour Therapy	34
Family Therapy	8
Other Specified Therapy	6
Physical Nursing Care	12
Co-ordination of Different Community Agencies	138
TOTAL	455

TABLE 4.7 OUTCOMES OF CASES

Discharged Completely	75
Active Therapy Being Continued	23
Supervision Contact/No Active Therapy	44
Patient Terminated Contact	6
Patient Died	2
TOTAL	150



DISCUSSION OF FINDINGS

CPNs demonstrated a wide variety of activity from the case study material.

A problem orientated classification system proved valuable in describing data from the case studies. It was necessary to "compress" data into six headings which did not allow a detailed explanation of the nurses activity. Further reduction of problem groups was difficult because of wide disparities in describing activities from the reporters themselves, meanings were not clear and terminology often imprecise. The studies allowed the author to examine the composition of casework activity undertaken by CPNs and experiment in the collection of data about casework activity.

The data tended to support other work being carried out during the same time span by Sladden and Parnell with regard to referral services and potential tasks. The problem based data demonstrated the possibility of taking cases being managed by CPNs and putting them into a problem orientated format. The reduction of problem areas into more precise descriptons was found to be difficult as the nurses had not been specifically trained in problem orientated approaches and their casework language did not lend itself to the method.

4.2

FORMULATION AND STATEMENT OF INITIAL HYPOTHESIS

Information surfaced from the pilot studies and the broad picture evident from the review of literature demonstrated a number of existing difficulties and potential problems facing CPNs.

It was possible to make a statement of hypothesis which summarized the initial evidence.

'Psychiatric nurses working in the community are in a state of organizational transition, and are presently obliged to use casework methods which appear inappropriate and inaccurate for the work they are expected to do.'

4.3

ESTABLISHING THE STUDY

The evidence from the pilot studies was such, that the author sought to establish a longitudinal study to enable detailed investigation. Dialogue was generated between the author and local health authorities. This dialogue was built upon long established contacts between the author, Regional and District Health Authorities.

The dialogue was timely for two reasons. Firstly, the nurse managers in local health districts were having to prepare forward planning estimates to mirror the shift of psychiatric resources from institution to community. Their estimates were being based upon 'best guesses' of CPN role and capacity. Secondly, the developing role of the CPN was attracting national interest. Indeed the Chief Nursing Officer of the D.H.S.S. pointed out in a circular letter to her Regional Officers "The need for adequate preparation for work in this area (Community Psychiatric Nursing) is paramount and financial dictates should not be regarded as the sole motivation to change.".(64)

The opportunity was obviously ripe for research into community psychiatric nursing and supported by the wide spread agreement about the evolutionary nature of community psychiatric nursing, the author generated a proposal for a 3 year funded programme with a specific aim towards providing greater definition of the work of the CPN. A first step in the

preparation of the proposal was the development of a series of aims for the proposal.

4.3.1

AIMS OF THE STUDY PROPOSAL

The aims were:-

i) To use an organizational development model in an action research programme to assist in and enable the transition of a CPN team from traditional methods to more open and appropriate approaches.

ii) To give support and training to counter observed skill deficiencies and organizational difficulties.

iii) To assess the patency and usefulness of 'technologies' as a means of reporting the transition of CPN Services within a specific time scale.

iv) To apply 'technologies' in order to demonstrate:

a) the presenting problems which are referred to CPNs

b) the goals and methods of intervention employed by CPNs

c) skill deficits shown from the casework methods of CPNs

d) information on the commissioning and disposal of cases

4.3.2

FUNDING THE STUDY

The author extended the study aims into a project protocol and presented the protocol to two bodies. Firstly, as a proposal for an M.Phil/Ph.D protocol to the University of Aston in Birmingham. The propsal was accepted and the author registered as an external, part-time student on the higher degrees programme.

Secondly, it was evident that a project of this type would require research assistance and secretarial help as the author was in full-time employment. Following a series of negotiations and detailed submissions, funding was obtained for the project as shown below.

NOVEMBER 1981	-	FIRST APPLICATION FOR MONIES
FEBRUARY 1982	-	JOINT FINANCE OBTAINED FROM MANCHESTER POLYTECHNIC AND STOCKPORT HEALTH DISTRICT FOR ONE YEAR PERIOD (£6,700)
MAY 1982	-	PROJECT COMMENCED
OCTOBER 1982	-	APPLICATION FOR FUNDS MADE TO THE NORTH WEST REGIONAL HEALTH AUTHORITY

MAY 1983 - PROJECT REFUNDED FOR ONE MONTH

JUNE 1983 - PROJECT REFUNDED BY THE NORTH WEST REGIONAL HEALTH AUTHORITY FOR 2 YEARS (£26,908)

JUNE 1985 - PROJECT COMPLETED

It is important to note that initial funding was made available only upon condition that community mental handicap nurses were included in the study. Although their history and development is distinctly different to that of community psychiatric nurses, their current development was seen as similar and the belief was that this inclusion would not compromise the study.

The data and information about the community mental handicap team is therefore presented separately and any comments presented in the study are done in recognition of the fact that CPNs and CNMHs are working in fundamentally different specialities. They are bound however, by very similar organizational difficulties.

4.4

THE STUDY CALENDER

The study was to be complex in nature and in need of controlled development. A study calender demonstrates the progression of events.

Incidental but important events took place but are not recorded in the calender and these include:-

i) Funding for the programme.

ii) Application for permissions through the District Ethical and Research Committees.

iii) Negotiations with the Health District to allow access to the C.P.N. team.

iv) Staff turnover within the course of the study. During the study there were:-

3 new posts

4 replaced posts

1 new nursing officer (Community Psychiatry)

v) The structure of senior management was radically changed during the study.

A 'flow chart' representation of the proposed project can be seen below.



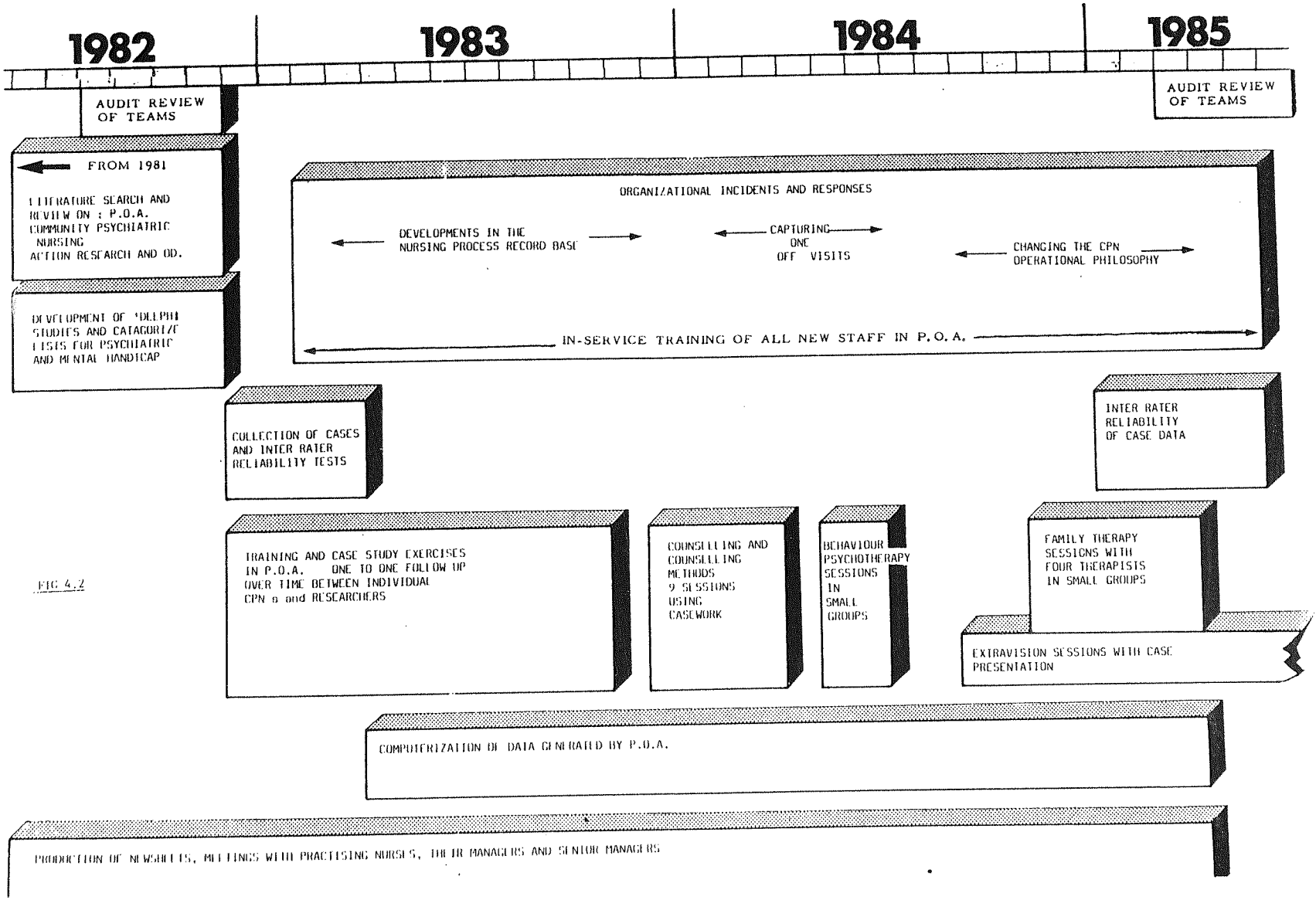

1982
1983
1984
1985
AUDIT REVIEW OF TEAMS
AUDIT REVIEW OF TEAMS
FROM 1981
LITERATURE SEARCH AND REVIEW ON : P.O.A. COMMUNITY PSYCHIATRIC NURSING ACTION RESEARCH AND OD.
DEVELOPMENT OF 'DELPHI' STUDIES AND CATAGORIZE LISTS FOR PSYCHIATRIC AND MENTAL HANDICAP
ORGANIZATIONAL INCIDENTS AND RESPONSES
DEVELOPMENTS IN THE NURSING PROCESS RECORD BASE
CAPTURING ONE OFF VISITS
CHANGING THE CPN OPERATIONAL PHILOSOPHY
IN-SERVICE TRAINING OF ALL NEW STAFF IN P.O.A.
COLLECTION OF CASES AND INTER RATER RELIABILITY TESTS
INTER RATER RELIABILITY OF CASE DATA
TRAINING AND CASE STUDY EXERCISES IN P.O.A. ONE TO ONE FOLLOW UP OVER TIME BETWEEN INDIVIDUAL CPN s and RESEARCHERS
COUNSELLING AND COUNSELLING METHODS 9 SESSIONS USING CASEWORK
BEHAVIOUR PSYCHOTHERAPY SESSIONS IN SMALL GROUPS
FAMILY THERAPY SESSIONS WITH FOUR THERAPISTS IN SMALL GROUPS
EXTRAVISION SESSIONS WITH CASE PRESENTATION
COMPUTERIZATION OF DATA GENERATED BY P.O.A.
PRODUCTION OF NEWSLETTERS, MEETINGS WITH PRACTISING NURSES, THEIR MANAGERS AND SENIOR MANAGERS

FIG 4.2

CHAPTER FIVE

METHODOLOGY

CHAPTER FIVE - METHODOLOGY

INTRODUCTION

Presentation of methodology is done in a way which demonstrates the work done in developing instruments which were eventually used within the project.

Within this presentation, methodology makes a return into reviews of literature and secondary pilot studies. These divergencies are essential to an adequate presentation of the methodological tools used in the project.

5.1

SCOPE OF THE STUDY

One district health authority was chosen for the study which would take place over a 3 year time period.

The construction of the study centred upon a number of methodological approaches which are briefly summarised and then considered in detail individually.

i) The body of the study would be action research delivered within an organizational development programme.

ii) Problem orientated approaches would be used to provide a conceptual framework for practice and as a means for collecting case data.

iii) A system for managing the data generated by the study required detailed development.

iv) Review procedures would be used at the beginning and end of the study to give an indication of the organizational climate.

v) An in-service training programme would be developed for the participating nurses.

vi) Organizational 'incidents' and 'responses' to change would be seen as part of the dynamic exchange between the researcher and the team.

METHODOLOGICAL DETAIL

5.2

ACTION RESEARCH AND ORGANISATIONAL DEVELOPMENT

The author gave detailed consideration to a choice of philosophical framework for the study.

A number of issues are debated continuously in nursing which have to do specifically with the place of research within the profession. There are continual calls for more research activity (Bond[65]); suggestions that nursing must be a researched based profession (Carr[1]); optimism that theories developed in nursing can be developed by researchers into

practice (McFarlaine(66)), coupled with warnings that there is an absence of theoretical sophistication (Inman[67]). Most of these demands can be heard in professions other than nursing, however, requests for theoretical sophistication are often mistakingly linked with high levels of technical/experimental construction. Dickoff[68] amongst others takes issue with this stance saying that there is an addiction to a "pseudo-technical mentality" in nursing and asks for new approaches in developing research methods in nursing. The call has been answered to some extent by Cormack[14] and others as they have sought new methods to carry out research in natural settings. Practising nurses operate in these natural settings which exclude tight control and finely tuned experimental methods.

The author recognised these inherent difficulties and chose a methodological approach through Action Research. Action Research is designed to develop new skills and approaches to solve problems with direct application to the working world setting. Lauri[69] defines this further and says "Action research is a very good starting point for developmental work because its purpose is to solve practical problem situations.". The author shared these sentiments in relationship to the study being undertaken and saw a research/practice partnership as fundamental to progress in the study.

Action research was particularly suitable because the method offers a coherent sequence of events within its framework namely:-

i) A preliminary diagnosis of the target area - a baseline assessment

ii) Utilization and presentation of the baseline survey to the target area

iii) Re-planning and implementation of new or changed activity

iv) Assessment and utilization of the result

(Adapted from French and Bell[70])

Consensus with the target area is of central importance to action research. Constant monitoring and evaluation of activity is undertaken and the knowledgeable participation of the target is central to success. Action research offered a skeleton framework for the study but the author recognised a parallel debate in organizational development (O.D.).

Chapter 3 of this thesis has already postulated the organizational difficulties faced by CPNs. The constraints of organizational response to change have been challenged in recent years by the rise of planned organizational development programmes (O.D.). Practitioners of O.D. have found an important niche in the applied social sciences and the intellectual foundations of O.D. are becoming well established.

O.D. owes much to the pioneering work of Beckhard[71] who had defined O.D. as "an effort 1) planned, 2) organizational wide and 3) managed from the top to 4) increase organizational effectiveness and health through 5) planned interventions in the organizational processes using behavioural sciences knowledge". This somewhat cumbersome definition has been refined in recent years to a conceptual emphasis upon 'transition management'. Transition management recognises the problems of organizational change which are present in role confusion, decision making and role re-establishment. Issues in transition management include; determining that which needs changing, where to intervene and chosing intervention techniques.

In the case of community psychiatric nursing the first issue is already decided, namely the shift of care from hospital to community care. Knowing where to intervene and the provision of intervention technologies is the substantive thrust of this thesis. In more recent work [72] Beckhard and Harris propose a sequence of events in transition management. This framework added to the emergent framework for the study is demonstrated in the figure shown below.

FIGURE 5.1.0

ACTION RESEARCH	DIAGNOSIS OF TARGET AREA - BASELINE ASSESSMENT	UTILIZATION AND PRESENTATION OF BASELINE SURVEY TO TARGET AREA	REPLANNING AND IMPLEMENTATION OF NEW OR CHANGED ACTIVITY	ASSESSMENT AND UTILIZATION OF THE RESULT
ORGANIZATIONAL DEVELOPMENT	DEFINING THE PRESENT AND FUTURE - DEFINING NEEDS FOR CHANGE - DETERMINING DESIRED STATE - DEFINING PRESENT SYSTEM	THE TRANSITION STATE - WHAT NEEDS CHANGING - WHERE TO INTERVENE - CHOOSING INTERVENTION TECHNOLOGIES	DEVELOPING AN ACTIVITY OR PROCESS PLAN USING INTERVENTION TECHNOLOGIES	MONITORING AND EVALUATING CHANGE STATEMENT OF EVALUATION

It is possible to see the reflection of the methodological stance in the title of the thesis 'Psychiatric Nursing in the Community, The Application of New Technologies to an Organization in Transition'. The initial choice of technologies was made from information generated by the initial pilot studies and known problems experienced by practicing CPNs discussed in the Chapter 2. Further technologies and needs would be defined as the project proceeded.

The choice of technologies can be seen below and addition of time scales gives further detail to the study framework.

FIGURE 5.1.1

TIME SCALE	JUNE 1982 - SEPT 1982	SEPT 1982 - JAN 1983	JAN 1983 - JAN 1985	JAN 1985 - APRIL 1985 + PERIODIC REVIEW
ACTION RESEARCH	DIAGNOSIS OF TARGET AREA - BASELINE ASSESSMENT	UTILIZATION AND PRESENTATION OF BASELINE SURVEY TO TARGET AREA	REPLANNING AND IMPLEMENTATION OF NEW OR CHANGED ACTIVITY	ASSESSMENT AND UTILIZATION OF THE RESULT
ORGANIZATIONAL DEVELOPMENT	DEFINING THE PRESENT AND FUTURE - DEFINING NEEDS FOR CHANGE - DETERMINING DESIRED STATE - DEFINING PRESENT SYSTEM	THE TRANSITION STATE - WHAT NEEDS CHANGING - WHERE TO INTERVENE CHOOSING INTERVENTION TECHNOLOGIES	DEVELOPING AN ACTIVITY OR PROCESS PLAN USING INTERVENTION TECHNOLOGIES	MONITORING EVALUATING CHANGE STATEMENT OF EVALUATION
TECHNOLOGIES	1) AUDIT REVIEW 2) STATEMENT OF ORGANIZATIONAL CLIMATE	1) STAFF MEETINGS 2) NEWSSHEETS 3) GROUP DISCUSSIONS	1) TRAINING IN AND ESTABLISHMENT OF PROBLEM ORIENTATED METHOD 2) COMPUTERIZED DATA COLLECTION 3) IN-SERVICE TRAINING	1) AUDIT REVIEW 2) STATEMENT OF ORGANIZATIONAL CLIMATE

The suitability of the methodological framework was reinforced by a review of change management methods. This is well encapsulated in a paper by O'Brien et al[73] where they review change management and the implementation of the nursing process. They suggest three common approaches to introducing change. A power coercive system where power is exercised to exert change. The power may be manifested in expert power, coercive power or reward power. Secondly, there exists a rational-empirical strategy which is based upon the assumption that individuals are rational and always act upon reasoned decisions. Rational-empirical methods attempt to demonstrate the benefits to be gained from instituting change. Finally, normative - re-educative methods recognise the complexity of change in organizations which are not easily solvable by coercive or rational-empirical methods. The normative - re-educative method incorporates i) systematic collection of information that can serve as feedback, ii) analysis of data and problem indentification, iii) generation of possible solutions to identified problems. The chosen methodology stood firmly in the 'normative - re-educative camp and as such recognised the complexity and holistic presentation of community psychiatric nursing in its natural setting.

5.3

PROBLEM ORIENTATED METHODS

Research into psychiatric nursing, community psychiatric nursing and the pilot studies for this thesis highlighted a fundamental difficulty in the casework activity for CPNs.

This was an absence of conceptual frameworks for practice.

The author recognised that the introduction and development of a conceptual framework was essential in order to counter some of the problems of working without an identifiable ideology. These problems manifest themselves in community psychiatric nursing by nurses showing an inability to describe with accuracy their casework activities; vague terminology, and no central purpose to casework.

There was a need to provide i) a language that nurses could use to describe their casework activity, ii) provide a conceptual framework for practice, and establish iii) a useable documentaton system that lent itself to storage and handling. Problem Orientated Approaches were chosen to provide these things.

The author scrutinized a variety of methods before chosing Problem Orientated Approaches. Having provisionally decided upon P.O.A. as a method, the author carried out a detailed literature review to fully assess its suitability.

Using normal library searching techniques and the computer based 'Dialog' search system, the author scanned summaries of some 1,711 potential articles and texts. From this 217 were selected and reviewed in detail. The review allowed ideas to be formulated about the development and presentation of problem orientated approaches and their suitability for the study.

Problem orientated methods were introduced by Weed[74] in 1968 through problem orientated records. Weed argued that source orientated records were a hindrance to good medical practice and rather than being an aid to effective treatment, actually contributed to poor care. His suggested alternative was to provide a system of records and practice which centred around the presenting problems of patients. Weed made plain his commitment to the concept of comprehensive care when he contended that practitioners had a responsibility for "meaningful and comprehensive care and the scientific responsibility for understanding the relationship amongst the parts" (of the patient). Weed's development of a recording system widened out to include a whole practice approach. Stratman[75] argues that it is vital to distinguish between a problem orientated record and the problem orientated approach to care delivery. "The former is a tool; the latter, a comprehensive set of clinical and administrative guidelines." This thesis is presented in the belief that the problem orientated approach is more profitable than the mere implementation of a record system, and refers to the system hereinafter as problem orientated approaches (P.O.A.). P.O.A. asks practitioners to define and follow problems one by one and organize them for solution. Its component parts are as follows:-

i) Data Base ii) Problem List iii) Initial Plans
iv) Progress Notes.

Data Base A data base contains defined subjective and objective data on each client. Data is obtained on first contact and may be built up over a period of time. It may be obtained through a structured assessment format or by 'free-interview' methods.

Problem List A continually updated list of all problems identified from the data collected is placed at the front of the record. A 'master problem list' is often the first page in a client's record and will denote active, inactive and resolved problems. The list will be dated and each problem numbered.

Plan A problem orientated plan follows the list. It normally consists of numbered and titled problems. It is possible to vary the presentation of the plan. The author chose to use the plan to indicate goals and treatments proposed for each problem.

Progress Notes Problems are followed up at each contact with the patient, however, some problems may not be tackled and will not therefore, warrant any commentary. Problems which have been processed are subjected to a procedure often referred to as 'S.O.A.P.ing'. S.O.A.P. is an acronym for Subjective and Objective observations from the practitioner and client, an Assessment of the data by the practitioner and a Plan of how the problem is to be dealth with on that occasion. This might include what the client is told, what therapy or treatment is prescribed and goals which may be set for the next occasion.

The review of literature showed that much attention has been given to the use of problem orientated approaches. It is apparent that without users accepting a problem orientated care philosophy, its chances of success are minimal. Once committment has been given there is general consensus that P.O.A. has value in a number of areas; for example, i) as an educational tool (Margolis[76]); ii) as a 'total' approach in the clinical setting (Fowler[77]); iii) and as an audit procedure to correct discrepancies in provider performance (Longabough[78]).

In the early 1970's P.O.A. appeared in psychiatric literature in the U.S.A., Grant and Maletzky[79] produced a paper outlining the usefulness and Longabough and Ryback[80] produced an article which gave a detailed account of P.O.A. in a psychiatric setting. Interest gathered momentum and 1974 saw the publication of a workbook for the use of P.O.A. in psychiatric settings. The thrust of the text encouraged practitioners to use P.O.A. and gave examples of P.O.A. in practice.[81] The author argued that the value of P.O.A. lay in a number of areas. Firstly, as a means of accountability. Secondly, as a means of classifying clinical issues, which allows practitioners to build up a common psychiatric language which is more useable than the traditional I.C.D. classification of psychiatric disorders. Finally, P.O.A. is seen as a means of moving towards an effective recording system which lends itself to computerization.

It is a happy coincidence that the burgeoning interest in computer based patient records was concomitant with developments in P.O.A. A series of accounts appeared between 1974 and 1980 which contended that P.O.A. lent itself to computerization of patients' records and staff accountability. (Accountability, although in its infancy in the U.K., has been of focal interest in the U.S. health care services.) Gifford and Mayberry[82] give a detailed account of the C.H.A.R.T.S. programme (Community Health Automated Record and Treament System) in Texas which was developed from a multi-disciplinary P.O.A. committee working with a software company to produce a patient tracking system. They argue that the system reduced routine charting, enhanced clarity of purpose, raised accountability to clients and contributed directly to a saving of $42,385 in drug prescribing during a calender year. Margolis and his colleagues in Israel[83] contend that P.O.A. lends itself to five types of analysis when used in tandem with an automated system namely; administrative; patient care; epidemiological; demographic; and clinical research. The literature suggested experimentation in a number of areas which could all be included under the umbrella term of P.O.A.

1) Problem orientated medical records
   - where doctors were trying to change their source orientated system.
2) Problem orientated records where whole multi-disciplinary teams of many professionals were trying to use a common recording system.

3) Problem orientated approaches where there was not only a change of recording system but the introduction of a problem orientated philosophy to the care of the client group.

The problem orientated approach had generated some opposition from a number of sources. These objections were based upon two clearly definable areas. Firstly, that an essentially prescriptive approach is less substantial than nomothetic diagnostic methods. Secondly, that a search for the problems that clients have is negativistic and condems the client to a series of problem based hurdles.

The first objection appears to have done little more than expose the frailties of the diagnostic model. The traditional diagnostic model bases its conceptual approach on the belief that clients assigned to the same category are presumed to have common characteristics and will therefore, be similarly responsive to treatment. Evidence for this is not strong in medical psychiatric practice. There is evidence of poor inter-judge reliability (Beck[84] and Nathan[85]) and the supposed relationship between diagnosis, outcome and treatment does not exist in practice (Frank[86]). It appears therefore, that the diagnostic model in psychiatry is a leaky boat and any improvement should be welcomed.

The second criticism of P.O.A. is more substantive. Weed[74] demands a rigid application of his original system but its applicants in psychiatry recognise the limitations of P.O.A. without the inclusion of goals for client and professional.

There has arisen therefore, a development in goal specific methods. In the second edition of their book, Ryback et al[87] pay some attention to the development of goal orientated systems. They demonstrate that with a goal orientated approach, the attention of the practitioner and the client is drawn towards what the client wants to accomplish not what problems he has. Two distinctive methods have been developed; goal attainment scaling, and goal planning.

Goal Attainment Scaling (G.A.S.) explicitly and operationally defines the expected level of outcome. Outcomes are specified from the least favourable expected to the most favourable. G.A.S. argues that practitioners and clients are forced to be explicit and objective in their stated outcomes.[88]

Goal Planning devises a strengths-needs list jointly developed by the practitioner and the client. Strengths lists demonstrate all the assets that a client has; needs are those things that the client and practitioner should do more often.

There is general recognition that goal and problem orientated approaches have desirable qualities that should be combined. Attempts are documented of this and Meldman[89] describes a system where the two approaches have been amalgamated and computerized.

Methods of establishing problem orientated approaches are extensively available in the literature. Much detail is given on the establishment of P.O.A. committees which did not offer

a great deal of helpful advice but there are seen to be a number of vital components for the development of P.O.A. systems. These may be summarised as follows:-

1) The need for a focal point for the programme. This can be either a single person or a committee.

2) The need to develop commitment to the system. Encouragingly, Ryback suggests that nurses "are the most comfortable in accepting and applying P.O.R." this is "perhaps related to their training in record keeping" a reference to nursing's current pre-occupation with the nursing process, a conceptually similar system.

3) A data base must be established. The data base forms the language of P.O.A. and is as important as the problem list. If systematic collection and presentation of data is to be implemented, then a means to present that data must be found.

The P.O.A. system was identified by the author as being a commendable system but one point of concern was outstanding. The author was concerned to use a method which did not intrude upon any practice technique which nurses had already developed as it was most likely that not all practitioners would be conceptually barren and some would have developed a methodology for practice. It was important to provide a system which allowed both psycho-dynamic and behavioural expressions. Sheeny and Charles[90] assessed a modified P.O.A. to treatment planning in out-patient psychotherapy. In comparison to a four year period prior to its implementation,

there was a 50% reduction in patient drop-out but no change in clinician rated condition of clients at termination of therapy. "Contrary to expectations, staff acceptance of P.O.A. was good." Dryringer[91] compared P.O.A. in physicians, psychiatrists, pastoral counsellors and chaplains and argued the efficacy of P.O.A. in all settings. Grant[92] says that P.O.A. is suitable as a vehicle in behaviour therapy training and in an earlier article[93] advocated its suitability in what he refers to as psycho-social care. With this apparently wide ranging acceptance of P.O.A. in a spectrum of therapeutic methods, it satisfied the need to allow practitioner expression in the project.

This extensive review of literature clearly demonstrated to the author that P.O.A. provides a potential means of articulating the work of CPNs and could, at the same time, lay a conceptual framework for practice.

Two actions were taken to develop this part of the project methodology, 1) points of principle were established for the use of P.O.A. in the study, 2) P.O.A. data sheets were developed for nurses' case notes.

Points of Principle

1) The P.O.A. method would reflect and provide a composite statement upon clients' problems, goals to be achieved and treatment methods to be used.

2) Nurses must be properly and extensively trained in the use of P.O.A. The project would adopt and develop a formal teaching programme, combined with in-team teaching and case study work.

3) The focal agent for the establishment and maintenance of the P.O.A. would be the research team. The team would act as both a resource and as promotors of the innovative process of change.

4) The P.O.A. system would not be multi-disciplinary. It would be confined to CPNs only.

The Data Sheet

A data sheet was developed which nurses could use in their case notes. These sheets were of carbonless paper and allowed researchers to keep one copy and the nurses to keep the other. (See below)

P.O.A. DATA SHEET

Reasons For Referral As Seen By Referring Agent	Date Of Completion	C.P.N. Code	Client Code
	Date Of First Referral		
	Date Of Discharge/Dormancy		

Problem No.	Date Opened	Description Of Problem	Description Of Goals	Treatment Plans	Date Of Prob. Resolution

5.4

MANAGEMENT OF DATA

Data generated by the P.O.A. and general information from the study demanded a system of storage and presentation. A number of sub-systems were developed to manage this.

i) A delphi study was undertaken to provide a series of agreed definitions for data handling.

ii) A computerized storage system was used to manage data from the P.O.A.

iii) A 'project information system' was organised to inform the workforce and managers of the progress of the study.

5.4.1 DATA HANDLING SYSTEM

This thesis has already described an absence of agreed 'practice based' language for CPNs. If nurses were going to use P.O.A. then problems they described would be wide ranging and varied. This range of problems was likely to present some difficulty in storing in an electronic system. The route from practice to storage was seen as follows:-

1) NURSE-PATIENT INTERACTIONS



2) NURSE COMPLETES A PROBLEM ORIENTATED DATA SHEET



3) THE DATA SHEETS ARE STORE IN AN ELECTRONIC SYSTEM FOLLOWING CATEGORIZATION



4) CATEGORIZED DATA PRESENTED AS A PICTURE OF C.P.N. ACTIVITY

The categorization of case data depended upon some agreed list of problems into which 'live' case data could be accommodated. The alternative would be to spontaneously develop a list from the data being generated. This was rejected as being too cumbersome and difficult to manage. Having decided to opt for a 'categorization' method the author recognised a need for meticulous development of a list to enable categorization to take place.

The author chose to use a modified Delphi method to design the list.

The Delphi method is used where a situation or problem does not lend itself to precise analytical judgement techniques but can benefit from subjective judgements on a collective basis. The intention is to arrive at a consensus of 'experts' or informed individuals. Linstone and Turoff[94] propose a series of events in a Delphi study.

Firstly, a small monitor team designs a list or questionnaire which is sent to a larger respondant group for comment. Secondly, the monitor team summarizes the results, develops a new questionnaire. Finally, the respondent group 'responds' again.

Using a 'delphi' approach a programme of events was devised as follows:-

1) A literature search was to be made of existing problem categorization lists and a 'first version' presented for Delphi processing.

2) A second list was then to be devised from the delphi processing and a pilot run of P.O.A. data sheets subjected to the list.

3) Following a short trial run a batch of data sheets were to be given to independent raters for inter-rated reliability tests and comment.

4) It would be necessary to categorize subsequent data using the agreed list. Amendments and additions could be made by researchers as the project proceeded.

5) Final testing of the problem categorization list would be made following an elimination of the redundant or redefined categories. This would be carried out by independent raters for inter-rater reliability testing.

Delphi Method Detail

In the search of existing literature some existing problem categorization lists were found. Amongst the most useful were those employed by Corcer and Ryce,[63] Meldman,[89] Sladden,[29] Ryback[87] and Lindly.[95]

Many of the categories used were behaviourally determined and also used medically generated terminology. The two most useful category lists were found to be those used by Corcer and Ryce (already described in Section 4.1.6 of this thesis) and Sladden. She categorized problems under the following headings:-

Intra-family relationships
Personality problems
Distress anxiety or strain
Lack of social contact
Difficulties in coping
Neglect of self care
Housing/accommodation
Coping with physical illness/disability
Job finding/keeping
Financial
Restriction/disruption of social life
Marital relationship
Mental disorder in household member other than client
Care and management of children
Misuse of drugs or alcohol
Crime delinquency/conflict with authority
Bereavement
Legal problems
Problems of sexual behaviour

Sladden used this list to categorize data in her study of a CPN Service in Scotland. The terms which were considered useful from all the lists were abstracted and combined with terms collected from the case study/pilot studies (Section 4.1.6). A first master list was formulated and then presented to a group of practicing nurses. 25 CPNs and 15 CNMH in

practice were randomly selected and given the category list combined with a rating scale.(See Figure 5.2) Problems were rated by the practitioner as to whether or not they were commonly found in practice. New problem areas the practitioners wished to add were collected and collated. The amended list (See figure 5.2) was sent out to another randomly selected group of nurses chosen in exactly the same way as the first and a final list change was made using their returns. Each problem was rated using the scale shown below.

FIGURE 5.2

COMMUNITY CARE "CLIENT" 'PROBLEMS' RATING LIST

The questionnaire is an attempt at defining the most commonly presenting "client" problems encountered in your practice. Please examine the stated problem in the left hand column. Rate each problem by entering a tick on the scale on the right hand side.

N.B. Example Only — Please Place Your Tick In The Appropriate Box

PROBLEM	1 Never Presents as a Problem	2	3 Occasionally Presents as a Problem	4	5 Commonly Presents as a Problem
No 00000 Hyperactivity			✓		

Family-Social Problems

PROBLEM	NEVER PRESENTS AS A PROBLEM 1	2	OCCASIONALLY PRESENTS AS A PROBLEM 3	4	COMMONLY PRESENTS AS A PROBLEM 5
MARITAL RELATIONSHIP					
CARE OF CHILDREN					
REJECTION BY FAMILY					
OVER PROTECTIVENESS BY FAMILY					
INCESTUAL BEHAVIOUR					
INTRA FAMILY 'STRAIN'					
EXTENDED FAMILY 'STRAIN'					
FRIENDSHIP					

PROBLEM	NEVER PRESENTS AS A PROBLEM 1	2	OCCASIONALLY PRESENTS AS A PROBLEM 3	4	COMMONLY PRESENTS AS A PROBLEM 5
SOCIAL ROLE PROBLEMS					
LACK OF SOCIAL CONTACT					
WORK RELATIONSHIPS					
SOCIAL SKILLS					
MOBILITY / TRANSPORT					
GEOGRAPHICAL ACCESSABILITY					
LACK OF HELPING SERVICES					
LACK OF 'SITTING' SERVICES					
MISHANDLING BY OTHER AGENTS					
'OVER' INTERVENTION FROM CARING AGENTS					
NON ACCIDENTAL INJURY					

Physical Criteria

PROBLEM	1	2	3	4	5
DIAGNOSED PHYSICAL DISORDER/ DISABILITY					
WEIGHT DISTURBANCE					
SLEEP PROBLEM					
EATING PROBLEM					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
HEADACHES	1	2	3	4	5
RESPIRATORY PROBLEMS	1	2	3	4	5
CIRCULATORY PROBLEMS	1	2	3	4	5
BLADDER/BOWEL PROBLEMS	1	2	3	4	5
DIZZINESS	1	2	3	4	5
DRUG SIDE-EFFECTS	1	2	3	4	5
PREGNANCY	1	2	3	4	5
PHYSICAL TENSION	1	2	3	4	5
BLINDNESS	1	2	3	4	5
DEAFNESS	1	2	3	4	5
MOTOR SKILLS DIFFICULTY	1	2	3	4	5
FEEDING DIFFICULTIES	1	2	3	4	5
HYPERTONIC PROBLEMS	1	2	3	4	5
TICS / TORTICOLLIS	1	2	3	4	5
UNATTRACTIVENESS					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
PRESCRIBED DRUG DEPENDENCY	1	2	3	4	5
DRUG / ALCOHOL ADDICTION	1	2	3	4	5
NEGLECT OF SELF-CARE	1	2	3	4	5
Cognitive Problems					
THOUGHT DISORDERS	1	2	3	4	5
HALLUCINATIONS	1	2	3	4	5
UNUSUAL THOUGHT CONTENT	1	2	3	4	5
DISORIENTATION	1	2	3	4	5
MEMORY IMPAIRMENT	1	2	3	4	5
OBSESSIVE THOUGHTS	1	2	3	4	5
SUICIDAL THOUGHTS	1	2	3	4	5
REASONING DIFFICULTIES	1	2	3	4	5
CONCENTRATION	1	2	3	4	5
PROBLEM SOLVING	1	2	3	4	5
RECURRENT NIGHTMARES	1	2	3	4	5
Emotional Problems					
ANXIETY					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
EMOTIONAL WITHDRAWAL	1	2	3	4	5
DEPRESSION	1	2	3	4	5
HOSTILITY / ANGER	1	2	3	4	5
MOOD ELEVATION	1	2	3	4	5
GUILT FEELINGS	1	2	3	4	5
TENSION	1	2	3	4	5
FEELINGS OF INFERIORITY	1	2	3	4	5
LACKING IN CONFIDENCE	1	2	3	4	5
NOTIONS OF UNREALITY	1	2	3	4	5
LACKING IN EMOTIONAL EXPRESSION	1	2	3	4	5
EMOTIONAL ABILITY	1	2	3	4	5
DEPERSONALIZATION	1	2	3	4	5

Behavioural Criteria

IMPULSIVE ACTS	1	2	3	4	5
COMPULSIVE ACTS	1	2	3	4	5
ATTENTION SEEKING BEHAVIOUR					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
THREATENING BEHAVIOUR	1	2	3	4	5
SUICIDAL ACTS	1	2	3	4	5
PHOBIC BEHAVIOUR	1	2	3	4	5
SEXUAL DYSFUNCTIONING	1	2	3	4	5
SEXUAL DEVIATION	1	2	3	4	5
COMPULSIVE RITUALS	1	2	3	4	5
COMPULSIVE SLOWNESS	1	2	3	4	5
OBSESSIVE RUMINATIONS	1	2	3	4	5
HYPERACTIVITY	1	2	3	4	5
PSYCHOMOTOR RETARDATION	1	2	3	4	5
ROCKING	1	2	3	4	5
SELF MUTILATION	1	2	3	4	5
PICA	1	2	3	4	5
COPROPHAGIA	1	2	3	4	5
DESTRUCTIVE BEHAVIOUR					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
STAMMERING	1	2	3	4	5
INSTITUTIONALISM	1	2	3	4	5
'Life Tasks' Problems					
LEGAL	1	2	3	4	5
TENENCY	1	2	3	4	5
ILLITERACY	1	2	3	4	5
INNUMERACY	1	2	3	4	5
FINDING/KEEPING EMPLOYMENT	1	2	3	4	5
UNEMPLOYMENT	1	2	3	4	5
CRIME/DELINQUENCY/CONFLICT WITH AUTHORITY	1	2	3	4	5
SHOPLIFING	1	2	3	4	5
FEELINGS OF HELPLESSNESS	1	2	3	4	5
SOCIAL WITHDRAWAL/ISOLATION	1	2	3	4	5
VOCATIONAL ROLE DISSATISCATION	1	2	3	4	5
DISSATISFACTION WITH LIVING ENVIRONMENT	1	2	3	4	5
CULTURE SPECIFIC PROBLEMS					

PROBLEM	NEVER PRESENTS AS A PROBLEM		OCCASIONALLY PRESENTS AS A PROBLEM		COMMONLY PRESENTS AS A PROBLEM
LIABILITY TO EXPLOITATION	1	2	3	4	5
BEREAVEMENT	1	2	3	4	5
RETIREMENT	1	2	3	4	5
SCHOOL ATTENDANCE	1	2	3	4	5
HOUSEKEEPING	1	2	3	4	5
DOMESTIC MANAGEMENT	1	2	3	4	5

Rating was calculated on a simple percentage agreement system. A problem was considered to be a viable entry using a simple formulae with a cut-off point of rejection at a score of 2 or below.

FIGURE 5.3 THE FIRST DELPHI LIST

FAMILY/SOCIAL PROBLEMS
SOCIAL ROLE PROBLEMS
LACK OF SOCIAL CONTACT
WORK RELATIONSHIPS
SOCIAL SKILLS
MOBILITY/TRANSPORT
GEOGRAPHICAL ACCESSABILITY
LACK OF HELPING SERVICES
LACK OF 'SITTING' SERVICES
MISHANDLING OF OTHER AGENTS
'OVER'INTERVENTION FROM CARING AGENTS
NON ACCIDENTAL INJURY

PHYSICAL CRITERIA
DIAGNOSED PHYSICAL
DISORDER/DISABILITY
WEIGHT DISTURBANCE
SLEEP PROBLEM
EATING PROBLEM
HEADACHES
RESPIRATORY PROBLEMS
CIRCULATORY PROBLEMS
BLADDER/BOWEL PROBLEMS
DIZZINESS
DRUG SIDE EFFECTS
PREGNANCY
PHYSICAL TENSION
BLINDNESS
DEAFNESS
MOTOR SKILLS DIFFICULTY
FEEDING DIFFICULTIES
HYPERTONIC PROBLEMS
TIC/TORTICOLLIS
UNATRACTIVENESS
PRESCRIBED DRUG DEPENDENCY
DRUG/ALCOHOL ADDICTION
NEGLECT OF SELF CARE

COGNITIVE PROBLEMS
THOUGHT DISORDERS
HALLUCINATIONS
UNUSUAL THOUGH CONTENT
DISORIENTATION
MEMORY INPAIRMENT
OBSESSIVE THOUGHTS
SUICIDAL THOUGHTS
REASONING DIFFICULTIES
CONCENTRATION
RECURRENT NIGHTMARES

EMOTIONAL PROBLEMS
ANXIETY
EMOTIONAL WITHDRAWAL
DEPRESSION
HOSTILITY/ANGER
MOOD ELEVATION
GUILT FEELINGS
TENSION
FEELINGS OF INFERIORITY
LACKING IN CONFIDENCE
NOTIONS OF UNREALITY
LACKING IN EMOTIONAL EXPRESSION
DEPERSONALIZATION

BEHAVIOURAL CRITERIA
IMPULSIVE ACTS
COMPULSIVE ACTS
ATTENTION SEEKING BEHAVIOUR
THREATENING BEHAVIOUR
SUICIDAL ACTS
PHOBIC BEHAVIOUR
SEXUAL DYSFUNCTIONING
SEXUAL DEVIATION
COMPULSIVE RITUALS
COMPULSIVE RUMINATIONS
HYPERACTIVITY
PSYCHOMOTOR RETARDATION
ROCKING
SELF MUTILATION
PICA
COPROPHAGIA
DESTRUCTIVE BEHAVIOUR
STAMMERING
INSTITUTIONALISM

'LIFE TAKS' PROBLEMS
LEGAL
TENENCY
ILLITERACY
INNUMERACY
FINDING/KEEPING EMPLOYMENT
UNEMPLOYMENT
CRIME/DELINQUENCY/CONFLICT WITH AUTHORITY
SHOPLIFTING
FEELINGS OF HELPLESSNESS
SOCIAL WITHDRAWAL/ISOLATION
VOCATIONAL ROLE DISSATISFACTION
DISSATISFACTION WITH LIVING ENVIRONMENT
CULTURE SPECIFIC PROBLEMS
LIABILITY TO EXPLOITATION
BEREAVEMENT
RETIREMENT
SCHOOL ATTENDANCE
HOUSEKEEPING
DOMESTIC MANAGEMENT

Interestingly little difference was demonstrated in the development of a list for community mental handicap nurses which was subjected to the same procedure by using 'expert' community mental handicap nurses. In the end the lists were so similar a common list was used for both groups. As will be demonstrated later in the study, the final lists do have differences in certain areas but initially the common list proved valid for both groups in the collection of data. These lists became known as 'delphi lists' and are referred to as such throughout the study. The first delphi list is shown above (5.3) The final delphi lists are shown in Chapter Eleven.

5.4.2 INTER-RATER RELIABILITY

A deliberate choice had been made not to observe nurses interacting with patients at first hand. There are good arguments against observation and in favour of self-reporting methods. Previous studies in psychiatric nursing using observer methods had not demonstrated the authors own interpretations of observed activity. Sladden[29] reports great difficulty in maintaining a 'neutral observer' posture at community visits. This difficulty had also been experienced by the author in observing students undertaking fieldwork practice upon post qualifying courses. The temptations to intervene, be used as an 'expert' adviser and be drawn into the dynamic exchange between the nurses and the client is great. This is particularly true in a small two way exchange in the patient's home. A visitor can scarcely be ignored in your own front room. The study data became dependent upon the reporting skills of the nurses themselves.

The categorization of the reported data into the 'right' problem area was then carried out by the researchers. It was necessary therefore, to reach a level of accuracy in nurses reporting skills and to assess the reliability of the researchers as 'categorizers' of problems. The first problem was managed by intensive training in P.O.A., the second by inter-rater reliability testing. It can be argued that this method of categorization is an unwieldy and unnecessarily complicated way of establishing a problem categorization system. The need for this approach was based upon two fundamental issues.

i) When presented with case information would community nurses agree about how this information shoud be categorized. If agreement can be achieved then it must indicate a commonly understood language and possible ideology.

ii) The nature of the category list made it important that it be tested and developed by those with time to do so. The first hand categorization of cases would have demanded too much in the way of practitioner time and the essential goodwill of the practitioners in the trial areas towards the project would have been jeopardized.

Inter-rater reliability can only be assessed by statistical analysis of the response of a group of raters categorizing the same information.

The P.O.A. data collection sheets were used on a first run of 40 cases from the community psychiatric and 20 cases from the mental handicap teams. The problems identified in these 60 cases were categorized by the researchers and 6 practitioner raters independently. This was achieved by taking all the problems thrown up by the data sheets and transferring them into the categories defined by the delphi studies. The practitioner raters were randomly chosen, practising community nurses. 3 were selected from the psychiatric field and 3 from the mental handicap field. All had 2 years practice experience and held a post qualifying certificate from the English National Board.

Two methods were selected to assess inter-rater reliability; percentage agreement and Kappa.[96]

Percentage agreement was decided using a formulae of

$$100 \times \frac{\text{Number of cases where raters agreed on categories of data}}{\text{Total number of agreed and disagreed cases}} \%$$

A known problem with percentage agreement is its inability to account for chance agreement amongst raters. 'Kappa' was chosen to provide a measure of agreement corrected for chance agreement.

A known problem with percentage agreement is its inability to account for chance agreement amongst raters. 'Kappa' was chosen to provide a measure of agreement corrected for chance agreement.

$$\text{Kappa} = \frac{\text{obtained \% agreement - expected \% agreement}}{\text{100 - expected \% agreement}}$$

There is some conventional recognition (Hartman[97]) that an acceptable level of agreement is represented by a Kappa of 0.6 or above.

Percentage Agreements

Percentage agreements were obtained as a first measure of agreement and as a component part of the data base for the Kappa formulations.

The percentage agreement showed as follows:-

Table 5.1

Percentage Agreement for Psychiatric Nurses

Categorizing Sample Cases

RATERS	TB	DR	A	B	C
TB		72.3%	50%	69.3%	62.3%
DR			42.01%	61.3%	56.31%
A				51.36%	54.67%
B					48.24%
C					

AVERAGE % OF 5 X 5 = 56.7%

TABLE 5.2

KAPPA ADJUSTED AGREEMENTS FOR COMMUNITY PSYCHIATRIC NURSES

RATERS	TB	DR	A	B	C
TB		.726	.493	.6804	.6148
DR			.4142	.600	.5503
A				.5031	.5333
B					.4948
C					

Kappa of 5 X 5 = 0.55 (figures rounded up to the nearest two decimal places).

The final Kappa score was insufficient to give total confidence in the validity of the category list, however, a decision was made to proceed in the knowledge that

1) The delphi lists would be amended and modified with additions as the study progressed.

2) The small sample of cases and the closeness of the Kappa score to an acceptable level.

3) A repeated test for validity would be carried out at the end of the study using a new team of independent raters and a larger sample of cases.

Percentage Agreement for Mental Handicap Nurses Categorizing Sample Cases

Using the same formulae the following scores were obtained:

1) Average % agreement 61.63%

2) Kappa score 0.65

This indicated a suitable level of confidence in inter-rater reliabiltiy for the group.

5.4.3.

Computerized Storage of Data

Using a primos mainframe computer at Manchester Polytechnic, data generated by casework was stored using an S.P.S.S. system. S.P.S.S. (Statistical Package for the Social Sciences) is a program designed to compute statistics typically used by social scientists.

Each nurse was allocated a patient coding book which noted all client code numbers (to preserve anonymity), the patient's name, consultant, age, sex and diagnosis. The books were kept by nurses as a means of checking on patients and only code numbers were given to the computer. In this way no traceable confidential information left the Health Authority.

Nurses were given file space in the computer and each patient had a space for presenting problems, and status of problems on discharge (active, resolved or redefined). Nurses were divided into three main groups, i) generic CPNs, ii) CPNs working with the elderly severely mentally ill, and iii) nurses working with the mentally handicapped.

This method of data storage allowed production of frequency counts, cross tabulation of data and statistical testing.

The problem specific information from each case was categorized by the research team within a list of 166 potential problem area using the category list developed by the delphi study.

5.5

INFORMATION SYSTEM

A vital component of an action research programme is the dissemination of information between the researchers and the organization.

Information flow was promoted in three ways.

i) It was decided that a 'newsheet' was to be produced at regular intervals. The 'newsheet' would be presented to the nurses and their managers and become a focus for requests, information and comment. (Examples are reproduced in the appendix.)

ii) Regular meetings were to be instituted between the researchers, nurses and their managers and senior managers.

iii) Constant almost daily contact was to be maintained between the practicing nurses and the researchers.

5.6.

AUDIT REVIEW AND ETHNOMETHODOLOGICAL OBSERVATIONS

The methodological framework for the study demanded an initial 'diagnosis' of the target area which would be complemented by an assessment and evaluation of change at the end of the study.

Two systems were selected for this element of the study, ethnomethodological observations and audit review.

i) Ethnomethodological observations were seen as an integral part of the study. These observations were to be a product of discussions amongst the researchers, nurses and their managers.

ii) All nurses were to be interviewed by means of a structured questionnaire. The questionnaire was developed from audit review procedures and sought information about allocation of time, general administration, legislation and policies, problems encountered during visits, practical fieldwork supervision, in-service training and research.

Although originally produced as a qualitative control, recent developments in audit instruments have pointed to its usefulness as a state of 'health' of an organization. Phaneuf[98] states that one of the major uses of audit procedure is the "resulting institutional or agency profiles of quality that it yields". Audit has been developed on a piecemeal basis in the health service and has fluctuated in

its popularity as a measure of organizational 'status'. It has been tried as a total health care system as reported by Smith in Doncaster[99] and as a more selective approach such as those reported by Wiseman in Blackpool.[100] Coulter[101] tested an audit approach with a CPN Service in Blackpool and found a usefulness in the picture which the service provided through audit books. The author took up the broad areas tested by Coulter and used the questions to build up an audit review which was applied at the beginning and end of the study. The audit questionnaire book may be seen in the appendix.

5.7

IN-SERVICE TRAINING

It was originally hoped that the evidence gathered from the P.O.A. data would indicate areas of skill deficit which could then be remedied by in-service training. This approach had to be abandoned early in the project because of a time lag in the production of case outcomes. Importantly however, the audit of both CPNs and CNMH revealed a desire for skills training from the majority of nurses. Although the skills training was not to be related to identified outcomes and shortfalls from case data, the training programme was based upon the expressed needs of the workforce.

Training was made available in counselling techniques, behavioural psychotherapy, family therapy methods and a number of specialist interest areas such as drug and alcohol abuse

and the management of suicidal behaviour. The importance of this training is detailed further on in this study and a presentation of the programmes is given in Chapter 8 and the appendix.

5.8

ORGANIZATIONAL INCIDENTS AND RESPONSES

The interactive nature of organizational development and action research puts the organization and the research team in a situation of dynamic exchange.

The author recognised that events taking place outside the immediate research project would directly affect the study itself. Professional and personnel changes, District Health Authority planning, Government directives and many other indirectly related matters would affect the organization. While central elements of the study would remain constant (P.O.A., data collection and in-service training) around this constancy changes would be taking place.

The research team set out deliberately to become a resource for the organization, to assist in and advise upon development and planning of services in its fullest sense. When asked, the team would assist in the production of papers and data. When problems arose the researchers made themselves available to contribute wherever possible.

Some of the incidents and responses are documented further in the study and are a product of organizational and research team interaction, others a retrospective response to various situations.

SECTION THREE: DATA PRESENTATION

SUB-SECTION 3A

DEFINITION AND DIAGNOSIS OF THE PRESENT SYSTEM

IDENTIFYING THE TRANSITION STATE

CHAPTER SIX

CHARACTERISTICS OF THE OBSERVED ORGANIZATION (1982)

FIGURE 6.1

The North Western Region

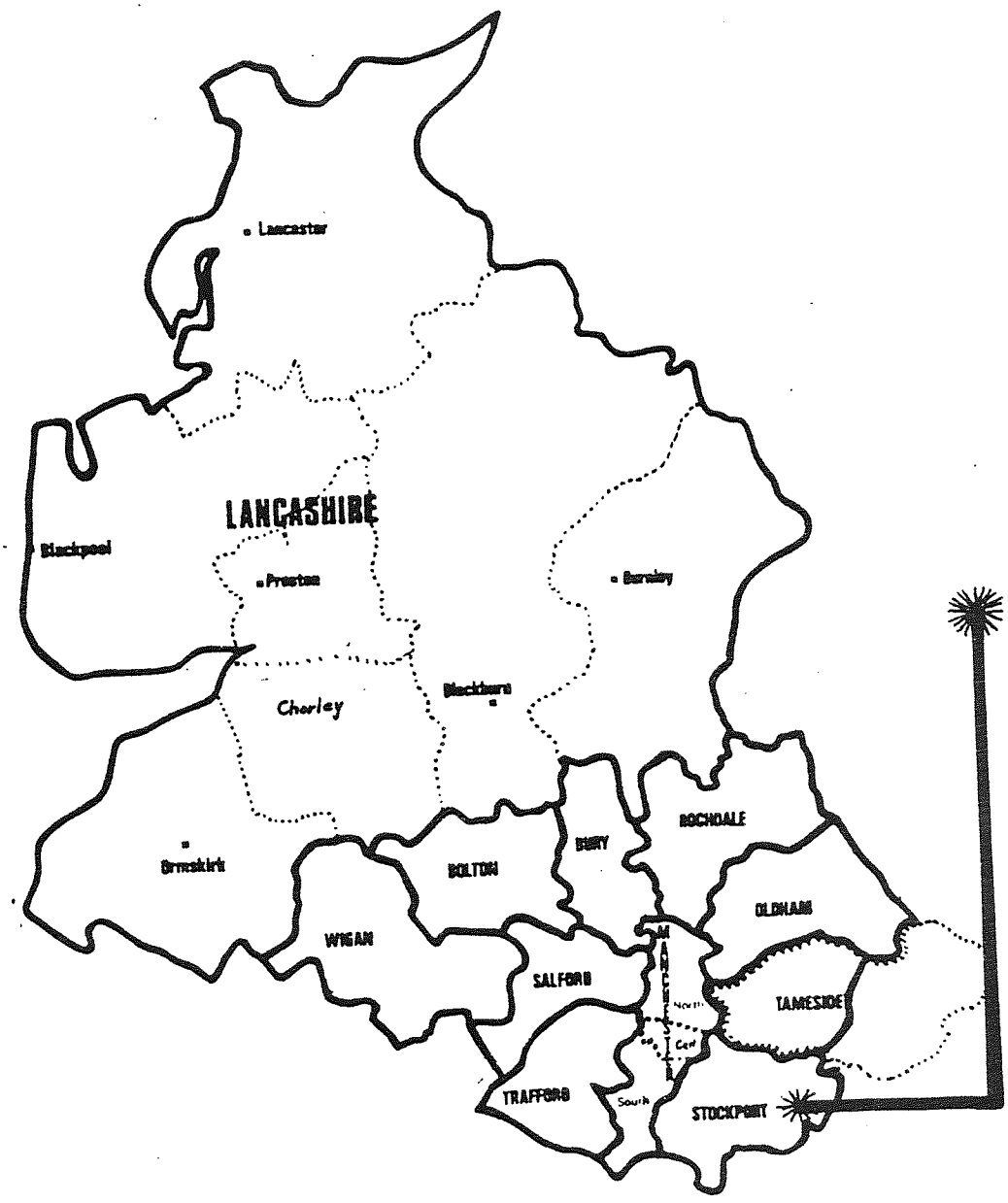
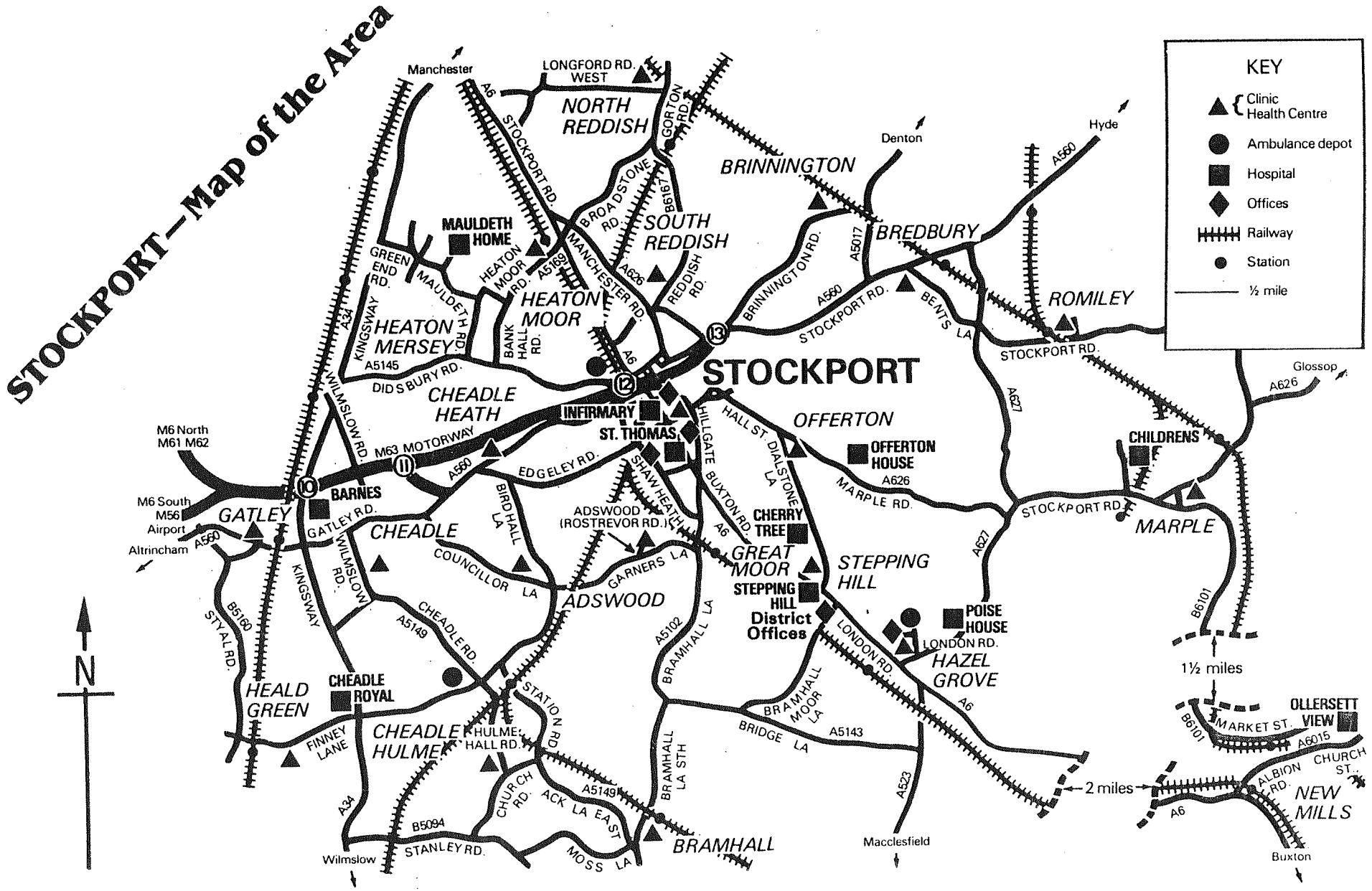


FIGURE 6.2


STOCKPORT—Map of the Area
KEY
Clinic
Health Centre
Ambulance depot
Hospital
Offices
Railway
Station
½ mile
STOCKPORT
NORTH REDDISH
SOUTH REDDISH
BRINNINGTON
BREDBURY
ROMILEY
MAULDETH HOME
HEATON MOOR
HEATON MERSEY
CHEADLE HEATH
INFIRMARY
ST. THOMAS
OFFERTON
OFFERTON HOUSE
CHILDRENS
MARPLE
BARNES
GATLEY
CHEADLE
ADSWOOD
CHERRY TREE
GREAT MOOR
STEPPING HILL
STEPPING HILL District Offices
POISE HOUSE
HAZEL GROVE
HEALD GREEN
CHEADLE ROYAL
CHEADLE HULME
BRAMHALL
OLLERSETT VIEW
NEW MILLS
Manchester
Denton
Hyde
Glossop
Buxton
Macclesfield
Wilmslow
Altrincham
Airport
M6 North
M61 M62
M6 South
M56
M63 MOTORWAY
LONGFORD RD. WEST
GORTON RD.
BROADSTONE RD.
REDDISH RD.
MANCHESTER RD.
HEATON MOOR RD.
BANK HALL RD.
GREEN END RD.
MAULDETH RD.
KINGSWAY
DIDSBURY RD.
WILMSLOW RD.
EDGELEY RD.
BIRD HALL LA
COUNCILLOR LA
GARNERS LA
SHAW HEATH
HILLGATE
BUXTON RD.
HALL ST.
DIALSTONE LA
MARPLE RD.
STOCKPORT RD.
BENTS LA
BRINNINGTON RD.
LONDON RD.
BRAMHALL LA
BRAMHALL MOOR LA
BRIDGE LA
BRAMHALL LA STH
STATION RD.
CHURCH RD.
ACK LA EAST
MOSS LA
STANLEY RD.
CHEADLE RD.
HULME HALL RD.
FINNEY LANE
STYAL RD.
MARKET ST.
CHURCH ST.
ALBION RD.
A6
A34
A5145
A5169
A626
A5017
A560
A627
A5149
A5102
A5143
A523
A6015
B5160
B5094
B6167
B6101
1½ miles
2 miles
N

6.0 CHAPTER SIX

CHARACTERISTICS OF THE OBSERVED ORGANIZATION (1982)

6.1

THE HEALTH AUTHORITY

The focus of the project was Stockport Health District. Situated in the South East corner of the Greater Manchester County, the Metropolitan Borough of Stockport is placed between the industrial and commercial centres of the region and the rural counties of Derbyshire and Cheshire. It is a thriving community of almost 300,000 people. Once a cotton area it has adapted fairly well to the technological revolution and electronics, plastics, engineering, printing and foodstuffs have gained a foothold in the Borough's industrial estates. Like all post-industrial small towns it shares focal centres of urban deprivation and bad housing.

Over two thirds of the population live in owner-occupied homes and the local authority housing stock is fairly well divided between high rise accommodation and single semi-detached estates.

Stockport Health District is one of 19 Health Districts in the North West Regional Health Authority. The Authority administrates 9 hospitals, 12 clinics and 11 health centres. Stepping Hill Hospital is being developed as the District General Hospital for the area and currently contains 818 beds. The other main acute hospitals are Stockport Infirmary (163

beds) and Cherry Tree Hospital (101 beds). St. Thomas' Hospital (275 beds), Mauldeth Home (77 beds) and Ollerset View (60 beds) cater for other mentally ill, geriatric, psycho-geriatric and chronically sick patients. Offerton House is the District's mental handicap hospital for adults (167 beds) and Treetops is a new unit for mentally handicapped children, providing 22 beds with facilities for long and short term care.

THE MANAGEMENT STRUCTURE

The management of the Authority's services has been formed into six new management units. In common with all other Health Districts in the country, Stockport Health District was in the process of reorganising its management structures into units based upon physical cohesiveness and servicing rather than upon specialist function. The restructuring left some specialities in a 'specialist' group as before and others divided between new units. Mental handicap services were left largely alone but psychiatric services were divided between two units, one essentially kept the acute and community services, the other, took the long-stay services into a new management unit.

The units are as follows:-

UNIT 1 (936 beds) - general medicine, paediatrics, general surgery, opthalmology, gynaecology, geriatrics,

E.S.M.I., acute psychiatry (including community psychiatric nursing), dermatology, infectious diseases, accident and emergency, orthopaedics and E.N.T.

UNIT 2 (138 beds) - maternity services.

UNIT 3 (171 beds) - rheumatology, rehabilitation.

UNIT 4 (189 beds) - mental handicap (including community mental handicap nursing).

UNIT 5 (412 beds) - geriatric, long-stay psychiatric, psycho-geriatric.

UNIT 6 (11 health centres and 12 clinics) - community services.

There are 3,900 whole-time equivalent staff employed in the authority.

INTRODUCTION TO THE PROJECT

The researchers attended team meetings for the C.P.N. and C.N.M.H.teams. Nurses were asked, and gave, permission for the researchers to interview them all using the audit questionnaire and informal discussion. The researchers were given open access to all team activities in both psychiatry and mental handicap.

An outline programm of events was discussed with the nurses and the philosophy of the project presented. There was a total expression of willingness to participate in and help with the project.

6.2.

DEFINITION OF THE EXISTING SERVICES (1982)

6.2.1 'AUDIT' OF COMMUNITY PSYCHIATRIC NURSES

All community psychiatric nurses were interviewed using the 'audit' questionnaire shown in the Appendix. The data generated from the interviews was combined with observations gained from informal discussions with service staff and their managers. The researchers also attended, as observers, meetings with staff and their managers.

The combination of these informal observations and the equivalent of 36 hours of interview contact time with C.P.Ns allowed the researchers to build up a composite picture of operational philosophy, work methods and aspirations for personal and team development. The critique is presented in the 'present tense' as formulated at the time frame portrayed (Nov. 1982).

'The team of 10 C.P.Ns is divided into 2 main groups. 8 of the ten are referred to as 'generic' C.P.Ns and the remaining 2 are known as the 'E.S.M.I. team' (nurses caring for the

elderly severely mentally ill). The service is a precise example of consultant/hospital attachment. Referrals are tightly controlled and come directly from medical staff, ward sisters and charge nurses and the out-patients' department. The service is administratively responsible through a nursing officer (who also manages the O.P.D. and E.C.T. services) to a senior nursing officer who controls the whole of the D.G.H. psychiatric unit. He in turn is responsible to a Divisional Nursing Officer responsible for all psychiatric nursing services in Stockport.

C.P.Ns are attached to individual consultants with the exception of the E.S.M.I. service who take referrals from all consultants.

The service has what is described as a 'philosophy of care' which is reported as follows "the majority of our involvement at present is with clients who are recovering from various types of mental illness, it is hoped that more of our energies can be directed in the area of preventive involvement". This care philosophy is an accurate reflection of the status of the team and the nucleus of C.P.N. activity is seen to be the areas of medication giving, counselling and support, some behavioural programmes and the maintenance and support of the long term mentally ill in the community. The E.S.M.I. team are generally recognised as being 'different' in some ways but it is as yet difficult to verbalize these differences. It is possible to postulate that the perceived difference is based upon their relationship with consultants, management of short term care and specialist assessment procedures of their

clientele using scoring systems and a rating scale. A team philosophy as such is hard to pin down. There is no document which is a statement of operational policy and so the aims and objectives of community psychiatric nursing in Stockport are a composite picture of different statements and documents.

The whole C.P.N. team meet with their nursing officer once per month to discuss what they refer to as 'clinical and administrative matters'. The substantive part of recent meetings appears to have revolved around a reconstruction of nursing process record sheets and administrative matters. Subjects are rarely 'clinical' or 'casework' based. C.P.Ns share a series of offices on the same corridor and use this close proximity to discuss case related matters informally as they arise. There is no structured system for casework supervision amongst the team, but this is not to suggest that cases are not discussed. Casework discussions are primarily related to 'problem cases', 'interesting cases' and cases being handed on from one C.P.N. to another. The nursing officer is not seen as 'clinically expert' in case related matters but is used as a mediator in problems of conflict between disciplines and as advisor on legal/organizational parameters in casework practice. The nursing officer has considerable difficulty (both reported and observed) in dividing his time between the C.P.N. service and his other responsibilities. In organizational terms he has no 'goodness of fit' between his expected responsibilities.

Case notes are based around a nursing process approach and much energy has been expended upon their development. Although the mechanics of the process are evidenced in case notes, the process itself would appear to be ideologically arrid (it is recognised that the nursing process has severe limitations if merely used as a 'case notes' approach. Many would argue (McFarlane[102] and Castledine [103]) that the nursing process must be ideologically 'fixed' in a model of nursing). The majority of cases have previously been in-patients in the psychiatric services, however, the E.S.M.I. team estimate some 40% of their caseload have never had in-patient care. This measures against 8% for the generic team. The nursing officer has produced a list of 'specialisms' which the C.P.Ns can give advice about and lectures to other groups of students. This somewhat ambitious list shrinks when discussed with the C.P.Ns. Rather than being seen as 'experts' the C.P.Ns indicated that they had expertise and experience in alcoholism, disorders of old age, child psychiatry, agoraphobia, peurperal disorder and health education.

The service produces statistical data which is controlled by the nursing officer. It includes data on caseload size, numbers of patients seen in various locations, mileage, time spent in meetings and medication management.

The data is compiled onto a master chart which demonstrates quantitative rises and falls but little else. The emphasis upon tasks and mileage is a manifestation of a management approach which demands accountability of action which is task

determined rather than being qualitative and developmental. Nurses are expected to report to their offices each morning and again at night, equally they may come back at lunchtimes and ring in for messages through the day. As nurses are not geographically based but consultant attached, this system demands a great deal of mileage to cover the Stockport area and reporting back to base. There is evidence of a lack of trust on the part of managers about the activities of C.P.Ns and the reporting in system is one method of maintaining control over more autonomous practitioners. This phenomenon is reported by Skidmore[104] who states "Another instance of management restriction was 'time watching'. The nurses were expected to make only 8 visits a day, also expected to 'clock on' every morning and 'clock out' at the end of the day. This caused many of them (C.P.Ns) to feel they were under suspicion or being accused in some way."

There is an experimental attachment to 2 health centres of 4 C.P.Ns. The C.P.Ns will go to the health centre to take referrals from G.Ps and other health centre staff. The attachment is seen as an 'open referral' experiment, however, the C.P.Ns are expected to carry out their normal consultant referrals at the same time as this experimental trial.

The 'audit' questionnaire allowed the researchers to look in more detail at certain elements of the C.P.Ns work. The results are presented in broadly grouped areas and as collective comments rather than as numerative data, as the objective of the questionnaire was to gain a reflection of organizational climate not a measure of numerical data.

Allocation of Time

Nurses were asked for a subjective estimate of time spent per week on various activities. The allocation of time to tasks bears interesting comparison to other studies. The studies produced by Parnell[28], Sladden[29] and Skidmore[104] are used to compare data.

TRAVELLING TIME

STOCKPORT (1982)	PARNELL (1978)	SLADDEN (1979)
23%	22.5%	20%

Stockport nurses are known to have travelled to base from home for 30 minutes to report in and then 25 minutes out to their first visit when a shorter journey from home to the first visit would be 20 minutes.

WARD ROUND TIME

STOCKPORT (1982)	PARNELL (1978)	SLADDEN (1979)
9.8%	16.6%	14%

Ward rounds were justified by some nurses who stated the importance of following up clients who had been admitted to hospital. They also state the value of being on hand to 'advise' on the role of the C.P.N. Others see ward rounds as unproductive but feel obliged to attend in line with common policy.

CLIENT CONTACT TIMES

STOCKPORT (1982) (reported estimate)	PARNELL (1978) (reported estimate)	SLADDEN (1979) (reported estimate)	SKIDMORE AND FRIEND (1981) (observed estimate range)
40%	33%	18%	18% - 60%

CLERICAL WORK TIME (REPORTED)

STOCKPORT (1982)	PARNELL (1978)	SLADDEN (1979)
20%	9%	22%

Clerical work is always claimed to be extensive. Stockport nurses are no exception and have a comprehensive reporting and record system which is followed diligently.

There is a general satisfaction with time allocation and there is a fairly strong expression that nurses manage casework without much difficulty.

There is no evidence to suggest that nurses' work standards are checked by observed performance and there is no 'live' system to enable it.

General Administration and Records

The team have a well established procedure of case management using the nursing process and nurses have a general satisfaction with the case records they keep although half the C.P.Ns consider that there is room for improvement, particularly in the area of inter-professional communication.

Nurses state that patients problems and goals are identifiable from their records but upon examination not all records support this claim. While most patients have been 'processed' using the recording system, there are a number of cases where problems and goals are not identifiable. This has to do in some instances with a shortage of contact in order to be explicit enough about practice and some other cases are by their very nature so complex that precision in records is impossible. Specific therapies are not identifiable and nurses use the same terminology as that reported in the pilot studies (Chapter 4).

Legislation and Policy Formation

All nurses are familiar with Legislative Acts which impinge upon their practice. They were happy about their involvement in policy formation which affected their practice.

Problems encountered during visits

The 'support network' for C.P.Ns which helps them with 'problem patients' or cases where they are 'stuck', is a product of accident rather than design. Nurses do not traditionally have a practice/supervisor relationship such as that found in social work or youth and community work. The traditional route for assistance is by some informal means or from medical staff. The C.P.N. team in Stockport are no exception to this method. Although the nursing officer may be used occasionally, more often than not other members of the C.P.N. team are used for case discussions about problems. The

mechanism is generated by the occasion and opportunities for discussion are managed and then dismantled by the team when the problem is resolved.

There is a reluctance to admit to being 'stuck' with cases and a traditional nurse reluctance to show emotional 'kickback' from casework. (See Menzies[105])

Job responsibility/Supervision

There is universal satisfaction with the job of community psychiatric nursing. The majority of the team (70%) expressed a wish to move to the Primary Health Care setting and to develop specific therapeutic techniques or focus upon specialist client groups.

Student Supervision

The team take students on placement from the nurse training school and from Manchester Polytechnic. None have been trained specifically as fieldwork teachers. The team would like further training in teaching methods (75%).

In-Service Training

There is wide-spread expression (85%) of a need to develop skills based expertise. This is seen as a fundamental need for the team to develop greater expertise. The most frequently quoted 'needs' are training in:-

behaviour therapy

family therapy

counselling

psychotherapy

There is evidence that nurses can name therapies but are unclear about the theoretical basis behind them. The aquisition of 'skills' is seen as more important than a knowledge of the theoretical framework and a conceptual framework for practice. This makes them display a current hallmark of psychiatric nursing, namely the 'doing' of therapy as fundamental to progress. The appropriateness and theoretical basis is not questioned. The encouraging thing is that this is one hopeful step away from the 'arrid functioning' described by Carr[15].

Audit Summary

A number of key factors arise from the audit review:-

i) The management of the C.P.N. team is being carried out by methods more appropriate to a hospital based mileau. There is a mistrust of autonomous practice manifested by a daily checking in system. The present statistical data collected by managers has limited usefulness as it is a statement of 'events' rather than a picture of casework activity or a means to promoting team development.

ii) The medical dominance of referrals is not conducive to initiatives in practice development. All nurses recognise the need for further 'skills' training. This desire to either a) an attempt at fixing an ideological base for practice or b) an attempt to assist client groups who are not getting specialist therapeutic help from existing services.

iii) Nurses have an expressed desire to move towards primary care practices. They recognise a need for a shift in psychiatric services towards a community base and the potential of being focal actors in psychiatric community services.

iv) There is an absence of philosophical framework for the team. Aims and objectives are stated but felt by all to be limited. This "growing up" by the C.P.N. team means that opportunity must be made for nurses to 'restate' their aims and objectives and how best they can achieve them.'

The audit report was completed in November 1982. The bulk of the findings were presented to the team at a unit meeting. References to the management structure, style and organization were not included as it was known that a new A.D.N.O. for psychiatry was to be appointed after Christmas 1983. The nursing officer also left to take up a new appointment and the team was left without a nursing officer for a 5 month period.

Any attempts at 'fixing' a new philosophy were therefore bound to wait for the new appointees to take up post and generate reformation. There was a period of 'limbo' during 1983 when

(quite properly) staff were waiting for reorganization to settle and the new team to take over. The author thought it unwise to inculcate radical change during this period.

6.2.2 AUDIT OF COMMUNITY MENTAL HANDICAP NURSES

The audit of the C.N.M.Hs was carried out in exactly the same way as that for the C.P.Ns. There were titular changes made to various sections of the audit document.

The report is once again a combination of formal and informal methods and is presented in the 'present tense' as formulated at the time frame portrayed (Nov. 1982).

'There are five full-time members of the team. Only two of the team (the nursing officer and the charge nurse) hold the appropriate R.N.M.S qualification. The other team members are a mental nurse and two enrolled nurses (general) all of whom have considerable experience in the mental handicap field. The two enrolled nurses are each attached to either the charge nurse or the sister in a 'team' relationship. The charge nurse and sister are responsible to the nursing officer and he in turn is responsible to a Director of Nursing Services, but this relationship will change when a Director of Nursing Services specifically for mental handicap nursing is appointed to Unit 4. The nursing officer has responsibility towards 4 other areas which takes up 40% of his time. The C.N.M.Hs are zoned to cover the whole of Stockport but are based in one office at Treetops, a purpose built day centre for children. There is no consultant attachment in the mental handicap

services and the C.M.N.Hs regard themselves as members of multi-disciplinary teams. The nurses attend two types of meetings, one which represents the multi-disciplinary teams of social workers, doctors, psychologists and nurses. They also attend unit team meetings of nurses each week where all C.N.M.H. nurses meet as a professional team to discuss case work and administration matters. (quote from nursing officer). The service has a comprehensive record keeping system. They also produce statistical returns about workload and client contact. The data produced gives an account of numerical information but little information on therapies used or face to face time with clients.

Nurses are seconded to various workshops in post-basic education and have contact with the Community Mental Handicap Nurses' Association (the nursing officer is a founder member).

There is an identifiable philosophy to the team characterized in a document entitled 'Role of the community nurse (mental handicap).' The document says "The community nurse can offer special skills as a trainer/teacher of mentally handicapped children and adults especially in relation to the development of self-help skills such as feeding, toileting and dressing; trainers in the use of remnants of vision and hearing and co-therapists with parents in the correction of behaviour problems."

The skills orientation of the team is primarily towards behavioural methods but they also act as advisors.

There is an open referral system, however, the local policies are such that all mentally handicapped children under the age of 5 go to the child developement unit and the C.N.M.Hs are only rarely asked to help. Thus the majority of their referrals are aged 5 and above which the nurses believe severely limits their effectiveness.

The team has very obvious future plans which include a change of location (back to the M. H. Hospital) and, given sufficient staff in the future, the nursing officer plans two teams. One for 0-16 years, the other for 16+. He envisages a member from both teams operating from a base within 4 zones with social workers in a resource centre including a toy library, information desk, walk-in appointment rooms for group work. These ambitious plans are dependent upon finance.

The nursing officer is in the process of developing an operational policy for the community mental handicap team. The policy will include aims and objectives, structure and function of the team and an indication of operational philosophy.

The audit questionnaire has given further detail in the areas as indicated:-

Allocation of Time

No comparative studies exist to show against the Stockport nurses. As this information possibly is unique, the presentation is hard to compare.

(Reported time spent upon various activities per week)
A team average estimate

Client contact	37%
Clerical work	27%
Travelling	25%
In Social Services Departments	5%
Community Mental Handicap team meetings	5%
Other	1%

C.N.M.Hs do not discharge cases from a caseload. They use a system of dormancy. Clients are seen as needing long term help which will fluctuate as time goes on. The principle of dormancy allows cases to be taken up quickly should they need help again.

C.N.M.H. have a multi-disciplinary responsibility for case review. They may be appointed as key workers in certain cases, therefore, they must present that case to other members of the multi-disciplinary team. This ensures a constant review of cases by different disciplines. C.N.M.Hs do not spend time on consultants ward rounds or attending lectures. Only one of the staff gives lectures to other groups.

Staff work a flexible time system and are not expected to 'clock in or out'.

General Administration

Questions demonstrated responses to the 'system and content' of the team's client record system. There was equal division amongst the team as to the adequacy of the present recording system, but all were satisfied with the security of confidentiality. This was felt to be especially important in a multi-disciplinary setting.

The records system used has a 'behavioural flavour' to it and is based upon nursing process principles. The records contain an initial assessment form and continuation sheets. The 'current' documentation scheme is designed to 'keep tabs' on limitations and progressions in behavioural performance. The total package is a reasonable but sketchy records system. The package is currently under review. The C.N.M.Hs also have multi-disciplinary team responsibility and use documents associated with it. There is a 'Report of Service Difficiency' form which indicates why a particular client's needs cannot be met. Secondly, there is a community nursing and social work service sheet which is completed when a joint review is carried out.

Legislation

There is a general familiarity with, and access to various Acts of Parliament. There is universal knowledge of all relevant areas although no specific community mental handicap nursing procedures manual is available.

Problems encountered during visits

C.N.M.Hs use other nurses on the team to discuss problems encountered on visits. They have no established system for working through case problems and the usual way is to discuss cases informally and then, when that difficulty has been dealt with, wait until the next time case discussion is needed. Cases are discussed in the multi-disciplinary teams as they progress but discussions are confined largely to client problems and who is doing what.

Job responsibility and Satisfaction

There is universal satisfaction with the job of C.M.H. Nursing in the team. There are sources of irritation, the most fundamental being an inability to get open access to children under 5 years as these are covertously guarded by the Child Development Team (C.D.T.).

The C.D.T. has all handicapped children in Stockport referred to it. This prevents the C.N.M.Hs becoming involved with children until after the age of 5. C.N.M.Hs see their early intervention as fundamental to the prevention of behavioural disorders in some children and feel they can provide support and re-education for the family. The child development team (which consists of health visitors, psychologists, social workers and teachers are unresponsive to approaches which have been made by the C.N.M.Hs. Nurses feel they are consulted about policy and planning.

Student Supervision

C.N.M.Hs do not take many students out with them on practice. They do take students from the Manchester Polytechnic E.N.B. 805 course but only one is a recognised fieldwork teacher. All would like further experience in this area.

In-Service Training

There is a universal desire for further training. This is seen as particularly important in non-behavioural therapies such as counselling and family therapy. C.N.M.Hs feel well equiped in behavioural methods but realize the interpersonal nature of their work with clients and their families. People also wish to participate more in research and there is an encouraging 'air' to the service in personal development.

Audit Summary

A number of key factors arise from the audit review with C.N.M.Hs:-

i) There is some evidence that the present recording system which the nurses use is less than satisfactory. By their very nature the notes of the team and the system they use is complicated and as yet do not give an accurate reflection of planning and work carried out. Although there is no doubt that this goes on, the notes do not demonstrate it.

ii) Nurses working with the mentally handicapped have considerable experience with behavioural methods. The systematic approach that it demands can often lead to a reductionist approach in casework. Nurses in the team have expressed a wish to experience more psycho-dynamic approaches in order to help in family work and counselling.

iii) Nurses want to see their own active involvement with the under fives.

iv) There is an emergent philosophical framework for the team. The nursing officer has made a start in laying down principles for the team. The service is going through a period of consolidation and orientation towards a more identifiable role.'

The audit report was completed in November 1982. Findings were presented to the team.

6.3

IMPLICATIONS OF THE FIRST AUDIT FOR THE PROJECT

The first audit demonstrated some clear links between the 'needs' expressed by the two services and the proposed project. These can be summarized as follows:-

AUDIT 'PRECIPITANTS'	PROJECT PROPOSALS
1) A wish to improve upon client recording systems and give an ideological base to practice	1) Training in, and establishment of problem orientated approaches
2) A need for further training in psycho-dynamic and other therapeutic approaches	2) In-service training programmes
3) The development of a 'team philosophy', aims and objectives for future development	3) Interactive help with organizational incidents and responses
4) More openess in casework	4) Interactive help with organizational incidents and responses

The 'anticipatory' nature of the project proposal had thus been validated by the findings from the first audit. It was technically possible to link the project proposals with the expressed needs of the teams, and it was equally possible to proceed confidently with the next step in the project - Problem Orientation of Casework.

SUB-SECTION 3B

USING INTERVENTION TECHNOLOGIES

IMPLEMENTATION OF NEW ACTIVITIES

CHAPTER SEVEN

CASE DATA PRESENTATION

7.1

PROBLEM ORIENTATION OF CASEWORK

Teaching Methodology

The philosophical starting point for teaching problem orientated approaches lay in a fundamental belief that problem orientation of casework embraces a 'whole system' rather than a simple adjustment of case records.

This important distinction is made by Hurst[106] and Stratman[75] who both state that the 'whole system' impinges upon casework method rather than being a simple statement of clients problems.

A second important issue was a recognition that C.P.Ns and C.N.M.Hs had an existing records system with carefully developed assessment forms and continuation sheets which nurses had worked hard to develop and found satisfactory to use. A compromise was found whereupon nurses used problem orientated data sheets and had a P.O.A. framework in practice but maintained sections of their existing record system.

There is a vast amount of information available upon the use of P.O.A. but surprisingly little is available upon methods of teaching P.O.A. to practitioners. Such information as there is relates predominantly to doctors and only one reference could be found which relates directly to teaching methods which can be used to educate nurses in P.O.A. which had a U.K.

source.

Wood and his colleagues[107] describe the introduction of a problem orientated logbook. They used no formal re-training of their experimental groups of staff but designed an instruction sheet for use with the new logbook. Ward staff were simply told to "try out a different logbook". This is not expanded upon in the study and implies a less than sophisticated approach to educating staff in appropriate methods. Wood does recognise the commonly reported difficulties in P.O.A. usage and appears to support Spitzers[108] view that "it is far easier to design and 'impose' a records system on clinicians than it is to set up procedures to evaluate the efficiacy of these systems. Equally, it would appear easier to impose a P.O.A. recording system than to re-educate staff in a 'whole system' P.O.A. Weed[74] in his seminal article 'Medical records that guide and teach' spends little time explaining the teaching method implied in the title of his article.

Some studies attest the educational value of P.O.A. (Gilandes[109], Bertucci[110]) and suggest the value of problem centred methods in teaching students. Reynolds and Cormack[62] describe the experience of a nurse teacher using a problem orientated approach to nursing diagnosis and nursing care prescriptions using an in-patient assessment booklet. Nurses were asked to describe the problems of psychiatric patients using subjective and objective evidence. The authors argue that this is a valid progression for psychiatric nurse teaching.

Bashook[111] and his colleagues describe the teaching of case material through P.O.A. in two different ways, i) self-instruction, and ii) workshop systems. They describe a controlled study using second year medical students in order to test the two methods and suggest that a self-instruction format is the choice for teaching students while a workshop is best for instructing practitioners. Bashook has also produced 'self-instruction handbooks'[112] and 'Guidelines for format and forms'[112] however, these publications proved unobtainable at the time of the study.

The author reviewed a selection of audio tapes from Graves Audio Medical Services[113] and found one of particular value as a teaching tool,[114] however, the remainder were not valid in the context of the project. With this one audio/slide package, the researchers added to it a series of case studies, trial data sheets, instruction leaflets and pseudo cases for problem orientation. With this material it was possible to begin teaching nurses in problem orientated approaches.

The teaching took two formats, whole team meetings and individual tutorials. Arrangements were made to meet the C.P.N. team and the C.N.M.H. team on two separate dates. Half days were set aside for the meetings and teams were presented with a P.O.A. introductory workshop.

P.O.A. Introductory Workshops

Workshops centred around a familiarization of P.O.A. and a

skeleton programme of events gave focus to the sessions.

Programme - (1/2 day session)

i) Lecture/seminar given on the philosophy of P.O.A.
ii) Presentation of P.O.A. in psychiatry and mental handicap.
iii) Tape/slide programme.
iv) Case example demonstrations.
v) Open discussion.

The workshops were followed-up by individual tutorial sessions. The first being for a half-day session and then 'as required' following the first meeting.

Individual Tutorials

The tutorials had a 'progressive' structure built into them and took place on a one to one basis on various dates following the workshop.

i) Working through fictitious case examples and 'sample' problem lists, treatment plans, and goals.
ii) Problem orientating 'live' cases from the nurse's own case load. These sessions were shared between the researcher and the nurse.
iii) Follow-up at specified intervals (depending upon need) in order to:-
    - ensure correct P.O.A. processing of cases
    - encourage P.O.A. record keeping over the

full spectrum of cases

- provide nurses with an element of case review or an alternative view of casework employing P.O.A. as a framework for case discussion.

Tutorial Follow-up and Casework

Having achieved an introduction to P.O.A. the staff needed an identifiable contact and information source on P.O.A. such as that described by Meldman.(87) This role was given to the research assistant. He sustained a regular and organised contact with all the C.P.Ns and C.N.M.Hs to:-

i) Maintain the problem orientation of new clients as they were referred to the services.

ii) Provide tutorial support for existing staff.

iii) Introduce new staff to the system.

iv) Assist with complex cases whose problem orientation proved difficult.

Nurses were asked to observe a registration of cases in two formats:-

1) By the inclusion of a P.O.R. data sheet in their normal case records system.

Data Sheets were carbonless paper duplicates. Nurses kept one copy in their case notes and the other was collected by the research assistant. The hand written data sheets collected by the research assistant were transcribed to a typewritten copy by the project secretary. Strict verbatim translation was

observed (See Fig. 7.1 and 7.2)

By this means a duplicate copy of clients problems, goals and treatments was available for the project and the nurses case notes with a minimum of disruption to record keeping.

2) A 'patient coding book' was given to each nurse. By using this book, nurses were able to give each client a code number which in turn was the only means of identifying the P.O.A. data sheet with a named client. This maintained client confidentiality. Nurses had a 'batch' of numbers and as each new client was referred they were given the next code number from their 'batch'. Coding books also allowed a note to be made of the referring consultant, age of patient, sex, reason for referral and medical diagnosis. (See Fig. 7.3)

Nurses were considered to be sufficiently able in P.O.A. when they could problem orientate cases without prompting from the research assistant. There were cases which needed some secondary help because of their complexity.

Because of the different nature of referral to psychiatric and mental handicap services, two different points of principle were made. It was known that the mental handicap nurses had a low referral rate and kept cases for many years even if just in a state of dormancy. It was decided therefore, to problem orientate all their existing clients and all new referrals. Psychiatric nurses had a much higher turnover and so no existing cases were problem orientated, only new referrals were processed through the P.O.R. system.

There was also a 'contaminated' sample in both services which had been 'processed' with the help of the research assistant during the course of teaching nurses in P.O.A. This 'contaminated' group was not used in data analysis.

Fig. 7.1

P.O.R. DATA SHEET

Reasons For Referral As Seen By Referring Agent	Date Of Completion	C.P.N. Code	Client Code
Monitor on discharge from hospital.	Date Of First Referral Sept. '83	SH 85	6017
	Date Of Discharge/Dormancy Aug. '84		

Problem No.	Date Opened	Description Of Problem	Description Of Goals	Treatment Plans	Date Of Prob. Resolution
1	Dec. '83	Patient returning home to live on her own following period of severe depression and period of hospitalization.	For patient to return home and resume her normal activities without adverse effect on mood.	1) Supportive home visits. 2) Encourage patient to resume former social contacts and activity. 3) Monitor patient's affective state.	July '84
2		Patient not yet fully recovered from death of husband.	For patient to complete grieving process.	1) Encourage patient to talk about late husband.	July 84

Fig. 7.2

P.O.R. DATA SHEET

Reasons For Referral As Seen By Referring Agent	Date Of Completion	C.P.N. Code	Client Code
Monitor.	Date Of First Referral 16.8.84	SH 85	6031
	Date Of Discharge/Dormancy		

Problem No.	Date Opened	Description Of Problem	Description Of Goals	Treatment Plans	Date Of Prob. Resolution
1	21.8.84	Low mood and associated somatic symptoms.	For patient's mood to return to normal.	Encourage patient to take medication as prescribed.	
2	21.8.84	Patient's irritability causing distress for other members of the family.	a) To modify pt's behaviour so that he is less threatening to family. b) To alleviate distress to relatives.	a) To counsel patient so that he appreciates the distress his behaviour is causing relatives.	
3	21.8.84	Patient has taken to his bed for the past three days.	For patient to get up during the day.	a) Ask patient to come downstairs to be interviewed. b) Encourage relatives not to reward pt. for staying in bed, e.g. not taking his meals to him.	Sept. '84

Fig. 7.3

NURSE : .....

CODE : .....

PROBLEM ORIENTATED RECORDS

PATIENT CODING LIST

CODE NO.	PATIENTS NAME	CONSULTANT	AGE	SEX	DIAGNOSIS

Data Storage

The P.O.R. data sheets were 'categorized' using the problem list and put into file work space in the mainframe system. Each nurse was given a data code and file space.

The research assistant transferred case data on a weekly or bi-weekly basis using a 'live screen' edit facility and an S.P.S.S. package as the program for data storage.

7.2

THE CASEWORK OF COMMUNITY PSYCHIATRIC NURSES

Introduction

Case data from problem orientated methods allowed an enormous range in possibilities for presentation. The data laid out in this section is in some senses a proclamation of the ability of P.O.A. to give both traditionally familiar data presentations and new departures in information about the casework of C.P.Ns.

A multiplicity of statistical testing is available with the S.P.S.S. system, however, the tests of significance and variance were not used extensively as the data is best used to paint a picture of problem specific casework rather than as an opportunity of testing for significant relationships. This reluctance was further reinforced by a knowledge that the validity of one of the categorization (Delphi) lists had not yet been established.

TABLE 7.1 OVERVIEW OF DATA

TOTAL NUMBER OF ALL PSYCHIATRIC CLIENTS	(N)	=	416
TOTAL NUMBER OF E.S.M.I CLIENTS		=	67
TOTAL NUMBER OF PROBLEMS IDENTIFIED FOR ALL PSYCHIATRIC CLIENTS		=	1,041
TOTAL NUMBER OF PROBLEMS IDENTIFIED FOR ALL E.S.M.I. CLIENTS		=	139
TOTAL NUMBER OF ALL MALE CLIENTS		=	126
TOTAL NUMBER OF ALL FEMALE CLIENTS		=	290

416 clients were processed by the project using a Problem Orientated Approach.

Table 7.1 demonstrates that 1,041 problems were identified for those 416 clients. Individual clients problems ranged from one to twelve in number with a mean of 2.5 identified problems per client. As clients problems are often multifaceted a spread of data is to be expected. Females composed the largest group and, in total, over twice as many females were processed as males. This rate increased in the age range 60-70+ (Table 7.2.1, 7.2.2) and the mean problems per client score rose to 2.8.

TABLE 7.2.1

ALL FEMALE CLIENTS CROSS TABULATED BY AGE GROUP

AGE GROUP	UNDER 20	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70+
NUMBER OF CLIENTS	6	44	32	28	28	59	93

N = 290

TABLE 7.2.2

ALL MALE CLIENTS CROSS TABULATED BY AGE GROUP

AGE GROUP	UNDER 20	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70+
NUMBER OF CLIENTS	4	20	14	12	14	23	39

N = 126

A sample study of 100 clients showed distribution of marital status to be unremarkable with married females forming the largest number of referrals (20%) and 40% of clients shown to be in skilled, professional or managerial occupations. Chi squared testing of the sex distribution of clients showed significance which accords with other work done in psychiatric research where females generally form the greater proportion of psychiatric referrals.

Referral of Clients

Reasons for referring clients were identified and are shown in Table 7.3. Referral reasons were multiple in 15% of cases. Some referrals are made as a consequence of procedural practice (cases followed up from discharge, psycho-geriatric assessment). Other referrals are specific in their requests for help and will identify a particular therapy or task (psychotherapy, support with medication). Other requests are less clear and give no guidance to the community psychiatric nurse (general support, other). Some 'other' requests are so diverse it is difficult to categorize them and include such statements as 'please help this person', 'concerned for her safety', 'living alone' and 'something must be done'.

Referral requests are brief and mostly non-specific in nature. This leaves the community psychiatric nurse with a free hand to interpret the referrals as they see fit. It is not easy to compare this data with other studies apart from the original pilot studies for this project when a similar freedom of choice for action was demonstrated. Sladden[29] does examine

reasons for selecting a C.P.N. service in her study, however, her data shows points of general principle rather than case related data.

It is possible to advance a number of explanations for the non-specific nature of referrals. It is conceivable that the C.P.Ns, doctors and other agents know what is meant by 'general support' and 'follow up'. It is more likely to be a procedural device for asking C.P.Ns to assess the needs of clients living in the community.

It is the contention of this study that C.P.Ns have considerable control in the way they commission their referrals. This position is supported by the non-specific nature of referral requests and (as will be demonstrated further) the way in which C.P.Ns translate these requests into action.

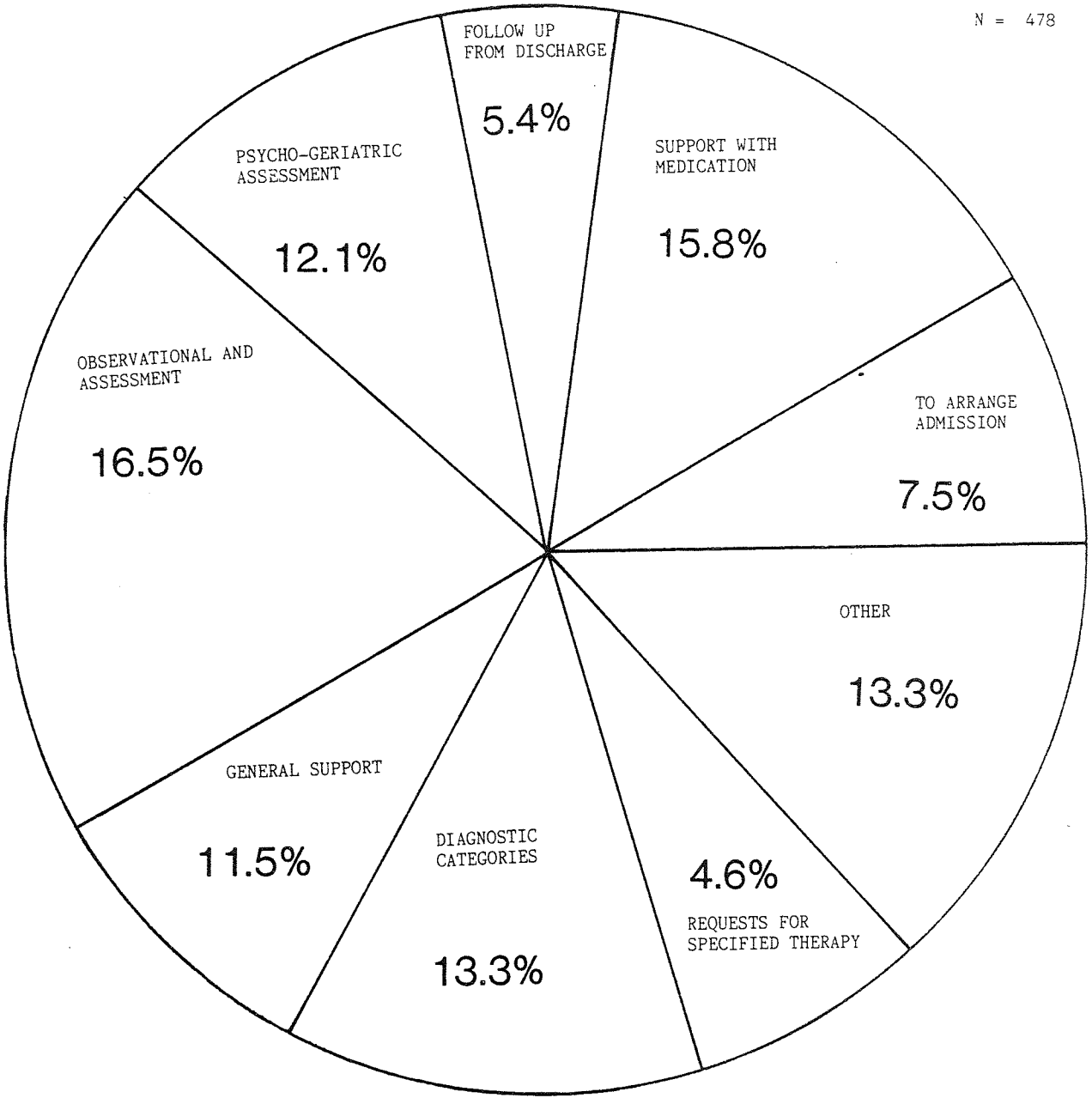
The author would agree with Cormack's observations of psychiatric nurses in other settings[13] that doctors rely heavily upon the clinical judgement of nurses, and that this reliance has transposed itself to the community setting.

TABLE 7.3

REASONS FOR REFERRAL AS SEEN BY REFERRING AGENT

REASON GIVEN	SUB-TOTALS	No. OF OCCASIONS
CASES FOLLOWED UP FROM DISCHARGE		26
PSYCHO GERIATRIC ASSESSMENT		58
OBSERVATION AND ASSESSMENT		79
GENERAL SUPPORT		55
DIAGNOSTIC CATEGORIES		64
DEPRESSION	32	
DEPRESSION AND ANXIETY	5	
ANXIETY	7	
SOCIALLY ISOLATE	2	
OTHER	18	
REQUEST FOR SPECIFIED THERAPY		19
PSYCHOTHERAPY	5	
GRIEF COUNSELLING	6	
HELP ANXIETY	3	
HELP SOCIAL PHOBIA	3	
DESENSITIZATION FOR PHOBIA	2	
SUPPORT WITH MEDICATION		76
TO ARRANGE ADMISSION		36
E.S.M.I. SERVICES	26	
OTHER	10	
OTHER		65
TOTAL REASONS GIVEN TO		478

TABLE 7.4 REASONS FOR REFERRAL AS SEEN BY REFERRING AGENTS SHOWN AS PERCENTAGE



Problems Identified by C.P.Ns and their Clients

The frequency and distribution of problems is shown in Table 7.5.

1,041 problems for the 416 cases were identified and placed into 194 categories generated by the Delphi lists.

A frequency of 0 or 1 was recorded in 57 (29%) of the problem categories. A frequency of 2 to 6 was recorded in 56 (28.8%) of the problem categories. The low frequency of these categories became a focus of debate for the author and the team. Low counts are not only a sign of insignificance but may also be an indication of how the team operates, where they gain their referrals from and what types of problems are to be expected from a consultant attached service.

Following consultation with experts a frequency score of 7 or more was seen to warrant further investigation as a score of 7 or more occured in 90% of all reported problems. This group ranges around scores of 7 to 72 (with a mean of 17, a median of 13.0, and a standard deviation of 16.1).
Table 7.6 shows the distribution of all problem scores of 7 or above and some scores are significantly higher than others. Five problem categories - Intra-family strain, anxiety, depression, non-attendance for depot medication and showing side effects of medication have scores of 32, 35, 42, 72 and 38 respectively. Other high scores can be seen in problems of medication refusal (23), medication administration incorrect (14), family burdened(20), family needs a holiday (25), and

marital relationship (20). The two broad problem groups associated with medication and family dynamics contain a combined total which accounts for 23% of all problems identified by C.P.Ns and their clients.

Sex differences shown in Tables 7.7 and 7.8 demonstrate the exclusivity of some problem groups for one sex type. Problems of unresolved grief, expressed fear of harming children, friendship and loneliness, and prescribed drug dependency are shown to be exclusively female. No single category was shown to be exclusively male. High sex weighting was demonstrated in some problem categories for females, most noteably these were:- anxiety (80% of total score), depression (91% of total score), intra-family strain (78% of total score). Interestingly these three problem categories represent 3 of the 5 highest scoring problem categories. Males did not demonstrate the same extremes in scores, however, certain categories demonstrated high scores for males - refusal/reluctant to take medication (64% of total), social withdrawal (60% of total) non-receipt of benefit (56% of total).

Given the males to females ratio in the study group (greater than 2:1) the scores take on greater significance.

Other research (Goldberg[39], Brown[115]) has observed the high incidence of females in reported cases of depression and anxiety. It is important to note however, that these other studies have used diagnosis verified by consultant psychiatrists. Depression and anxiety categorized in this

study has been identified as such by C.P.Ns and/or their clients. Matters of medication management have also been reported by other researchers (Sladden[29], Parnell[28] and this study demonstrates the continued interest of C.P.Ns in this physical/medical element of casework.

Family centred and interpersonal problems form the second highest collective group. There is no evidence to suggest that the in-service training given to the team directly affected the incidence of reported problems in this group but there is no doubt that C.P.Ns have a sensitivity to problems of this nature and are willing to identify them when they arise.

Problem presentation demonstrates a number of key features about the Stockport team.

i) The shared participation of the problem centred approach gives a more client centred picture of presenting problems.
ii) There is a broad cross section of problems represented which are both scientific/medical and interpersonal in nature.
iii) There is an identifiable sex bias in problem distribution.
iv) Some problems are unique to females only.

TABLE 7.5

PROBLEM DISTRIBUTION CROSS TABULATED BY
a) SEX OF ALL CLIENTS AND b) E.S.M.I.

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I
1	MARITAL RELATIONSHIP	20	4	16	0
2	CARE OF CHILDREN	2	0	2	0
3	REJECTION BY FAMILY	4	2	2	4
4	FAMILY OVERPROTECTIVE	4	2	2	1
5	FAMILY PLANNING	5	0	5	0
6	INTRA FAMILY STRAIN	32	7	25	2
7	EXTENDED FAMILY STRAIN	6	1	5	1
8	FRIENDSHIP - LONELINESS	13	0	13	0
9	SOCIAL ROLE PROBLEMS	1	0	1	0
10	LACK OF SOCIAL CONTACT	25	7	18	8
11	WORK RELATIONSHIPS	3	1	2	0
12	SOCIAL SKILLS	5	2	3	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
13	MOBILITY - TRANSPORT	3	1	2	1
14	GEOGRAPHICAL ACCESS	1	0	1	0
15	NEEDS HELPING SERVICES	10	2	8	5
16	NEEDS SITTING SERVICES	0	0	0	0
17	MISHAND. OTHER AGENT	3	1	2	2
18	OVERINTERV. BY AGENTS	0	0	0	0
19	AT RISK CHILDREN	1	0	1	0
20	NON-RECEIPT BENEFIT	23	10	13	22
21	PROBLEM DRINKING	16	7	9	0
22	UNDEVELOPED MOTHER.SKILLS	4	0	4	0
23	CARE RESTS ONE RELATIV.	9	2	7	3
24	FAM.MISUNDERST. PSYCH.	5	5	0	4

TABLE 7.5 (Cont.)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
25	EXPRESSED FEAR-HARM CHILDREN	7	0	7	0
26	SEXUAL PROBLEMS	3	0	3	0
29	UNDIAG.PHYS. DISORDER	11	4	7	2
30	DIAG.PHYS. DISORDER	15	4	11	5
31	WEIGHT DISTURBANCE	12	2	10	1
32	SLEEP PROBLEMS	23	4	19	3
33	EATING PROBLEMS	22	7	15	4
34	FEEDING DIFFICULTIES	0	0	0	0
35	HEADACHES	1	0	1	0
36	RESPIRATORY PROBLEMS	1	0	1	0
37	CIRCULATORY PROBLEMS	4	0	4	1
38	BLADDER BOWEL PROBS.	11	2	9	5

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
39	DIZZINESS - VERTIGO	5	2	3	0
40	PREGNANCY	1	0	1	0
41	PHYSICAL TENSION	0	0	0	0
42	BLINDNESS	3	0	3	0
43	DEAFNESS	3	0	3	0
44	MOTOR SKILL DIFFICULTIES	4	0	4	2
45	HYPERTONIC PROBLEMS	0	0	0	0
46	TICS - TORTICOLLIS	0	0	0	0
47	UNATTRACTIVENESS	2	0	2	0
48	PRESCRIBED DRUG DEPEND.	9	0	9	0
49	DRUG-ALCOHOL ADDICT.	8	6	2	0
50	NEGLECT OF SELF-CARE	17	9	8	3

TABLE 7.5 (Cont.)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
51	DENTISTRY - ORAL HYGIENE	2	0	2	0
52	CHIROPODY - FOOT HYGIENE	6	3	3	2
53	HYGIENE-PHYS. DECLINE	4	0	4	1
54	DEHYDRATION	1	1	0	0
56	MENT.STATE DETERIORATION	9	3	6	0
57	MENT.STATE FLUCTUATION	12	6	6	0
58	LACKS MOTIVATION	9	2	7	0
59	BOREDOM	1	0	1	0
60	UNRESOLVED GRIEF	12	0	12	0
61	ANXIETY	35	3	32	1
62	AGITATION	10	5	5	1
63	TENSION	11	1	10	1

PROBLEM NUMBER	PROBLEM DESCRIPTION	⌐ L FREQUENCY	MEN	WOMEN	E.S.M.I.
64	EMOTIONAL WITHDRAWAL	0	0	0	0
65	DEPRESSION	43	9	34	1
66	HOSTILITY - ANGER	0	0	0	0
67	MOOD ELEVATION	0	0	0	0
68	GUILT FEELINGS	9	2	7	0
69	FEELINGS OF INFERIORITY	1	0	1	0
70	LACKS CONFIDENCE	16	2	14	0
71	LACKS EMOT. EXPRESSION	0	0	0	0
72	EMOTIONAL LABILITY	1	0	1	0
73	DEPERSONAL-ISATION	0	0	0	0
74	NOTION OF UNREALITY	1	0	1	0
75	MULT.PHYS.-EMOT & MENT. PROBS.	2	1	1	0

TABLE 7.5 (Cont.)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.MI.
76	PSYCH.PROBS-SEASONAL FLUCT.	1	1	0	0
86	MED.ADMIN. INCORRECT	14	5	9	2
87	REFUSE - RELUCT.MED.	25	9	16	2
88	NEED SUPERVISE MED.	15	2	13	0
89	SIDE EFFECT OF MED.	42	10	32	4
90	NON-ATTEND. DEPO.INJ.	72	24	48	1
91	MED. INEFFECTIVE?	3	2	1	0
92	MED. CONFLICT. ADVICE	2	0	2	0
93	OPERATES MACHINES	2	1	1	0
94	SUPERVISE MED. WITHDRAWAL	3	1	2	0
95	DIFFICULTY SWALLOW MED.	1	1	0	0
102	PERSISTENT PHONE CALLS	1	1	0	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
103	REFUSE DOM. AGENCY SUPP.	3	2	1	2
104	LIAISE BETWEEN SUPP. SERVICES	3	1	2	1
105	CPN REFUSED HOME ACCESS	6	2	4	2
106	LACK INFO. RE: CLIENT	8	3	5	4
107	REFUSES HOSP. SERVICES	10	2	8	3
108	MENT.STATE S.T. ASSESS	2	0	2	2
109	FAM.BURDEN - DAY CARE	20	11	9	19
110	FAMILY NEED A HOLIDAY	24	12	12	24
111	WANDERING	11	2	9	6
112	CURRENT TREAT. INEFFECT.	0	0	0	0
113	INABIL.RELUCT. KEEP APPTS.	4	3	1	0
114	FAM.REFUSE TO TAKE CL. HOME	3	2	1	1

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
115	LACK OF AIDS	4	2	2	3
116	CLNT.CONCERNED HOSP.	3	1	2	0
117	CLNT.REFUSES S-S CARE	1	0	1	1
118	CLIENT CPN RELATIONS	6	3	3	1
119	NEED LONG STAY BED	2	1	1	1
120	CARER NEEDS HOSP. TREAT.	4	2	2	2
121	CLIENT PHCT POOR RELATIONS	2	0	2	0
122	LACK OF SOC. SERV.DAY CARE	2	1	1	1
123	PHYS.DECLINE INAPPROP.FAC.	1	0	1	1
124	IMPULSIVE ACTS	2	1	1	0
125	COMPULSIVE ACTS	0	0	0	0
126	MANAGEMENT DIFFICULT.	3	0	3	3

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
127	THREAT. AGGRESSIVE	4	4	0	1
128	SUICIDAL ACTS -D.S.H.	8	1	7	0
129	PHOBIC BEHAVIOUR	7	0	7	0
130	SEXUAL DYSFUNCTION.	0	0	0	0
131	SEXUAL DEVIATION	0	0	0	0
132	COMPULSIVE RITUALS	3	2	1	0
133	COMPULSIVE SLOWNESS	0	0	0	0
134	OBSESSIVE RUMINATIONS	1	1	0	0
135	HYPERACTIVITY	1	0	1	0
136	PSYCHO-MOTOR RETARDATION	0	0	0	0
137	ROCKING	0	0	0	0
138	SELF-MUTILATION	0	0	0	0

TABLE 7.5 (Cont.)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
139	DESTRUCTIVE BEHAVIOUR	0	0	0	0
140	STAMMERING	0	0	0	0
141	POOR MOTIVAT. -INSTITUT.	2	0	2	0
142	SOILING,WETT. PROBLEMS	4	2	2	2
143	PUBLIC BEHAV. EMBARRASSING	2	2	0	0
144	BIZARRE - INEXPLIC.ACTS	1	1	0	0
151	LEGAL	0	0	0	0
152	TENENCY	0	0	0	0
153	ILLITERACY	0	0	0	0
154	INNUMERACY	0	0	0	0
155	FIND-KEEP EMPLOYMENT	2	1	1	0
156	UNEMPLOYMENT REDUNDANCY	5	4	1	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
157	CRIME - DELINQUENCY	2	0	2	0
158	SHOPLIFTING	0	0	0	0
159	FEELING OF HELPLESSNESS	0	0	0	0
160	CLIENT UNABLE TO COPE	6	0	6	0
161	SOCIAL WITHDRAWAL	20	8	12	1
162	VOCATION.ROLE DISSATISFACTION	4	1	3	0
163	DISSATISF.LIV. ENVIRONMENT	13	1	12	1
164	CULTURE SPECIF. PROBLEMS	3	1	2	0
165	LIABLE TO EXPLOITATION	2	0	2	1
166	BEREAVEMENT	8	0	8	0
167	RETIREMENT	1	1	0	0
168	SCHOOL - COLL. ATTENDANCE	1	1	0	0

TABLE 7.5 (Cont.)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
169	HOUSEKEEPING	10	1	9	2
170	DOM.MANAGEMT. BUDGET	13	3	10	0
171	HOUSE UNSUIT. LIVE ALONE	2	1	1	0
172	ADJUST TO INDEP. LIVING	10	5	5	0
173	NEEDS SUITABLE CLOTHES	1	1	0	0
174	LACKS DOMESTIC SKILLS	2	0	2	0
175	COURT PROCEEDS.	1	0	1	0
176	TRANSITION RESID.CARE	1	0	1	0
181	THOUGHT DISORDERS	0	0	0	0
182	HALLUCINATIONS	6	2	4	0
183	DELUSIONS - PARAN. IDEAS	24	7	17	4
184	UNUSUAL THOUGHT CONTENT	2	1	1	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MEN	WOMEN	E.S.M.I.
185	DISORIENTAT-ION	0	0	0	0
186	MEMORY IMPAIRMENT	2	0	2	0
187	OBSESSIVE THOUGHTS	7	1	6	0
188	SUICIDAL THOUGHTS	0	0	0	0
189	REASONING DIFFICULTIES	0	0	0	0
190	CONCENTRATION	0	0	0	0
191	PROBLEM SOLVING	0	0	0	0
193	CONFUSION	9	4	5	5
194	PSYCHOTIC SYMPTOMS	2	2	0	0

TABLE 7.6 PROBLEMS REPORTED ON 7 OR MORE OCCASIONS BY C.P.N'S : ALL CLIENTS

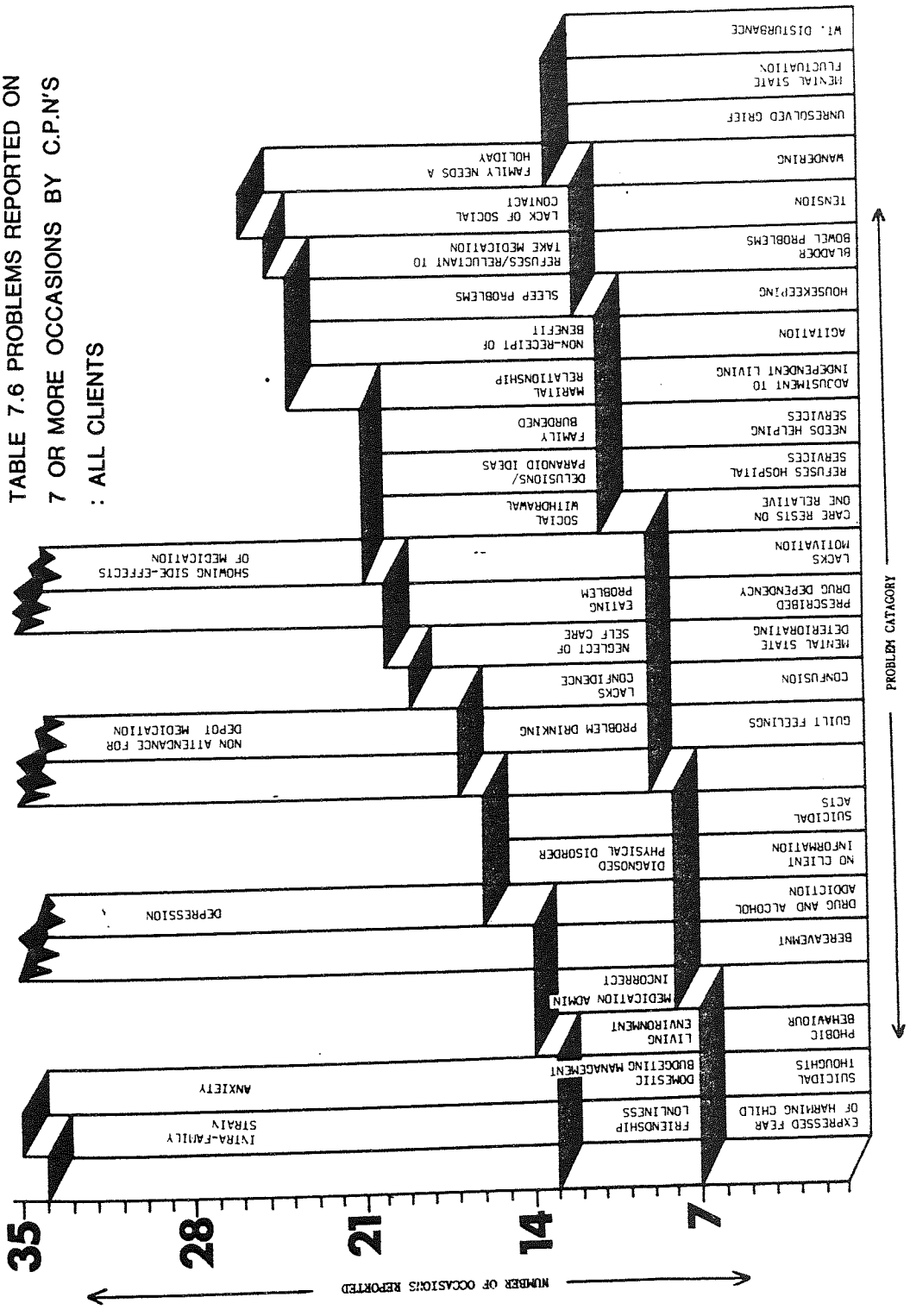


TABLE 7.7 SEX DISTRIBUTION IN 23 PROBLEMS SHOWING HIGH SCORES FOR FEMALES

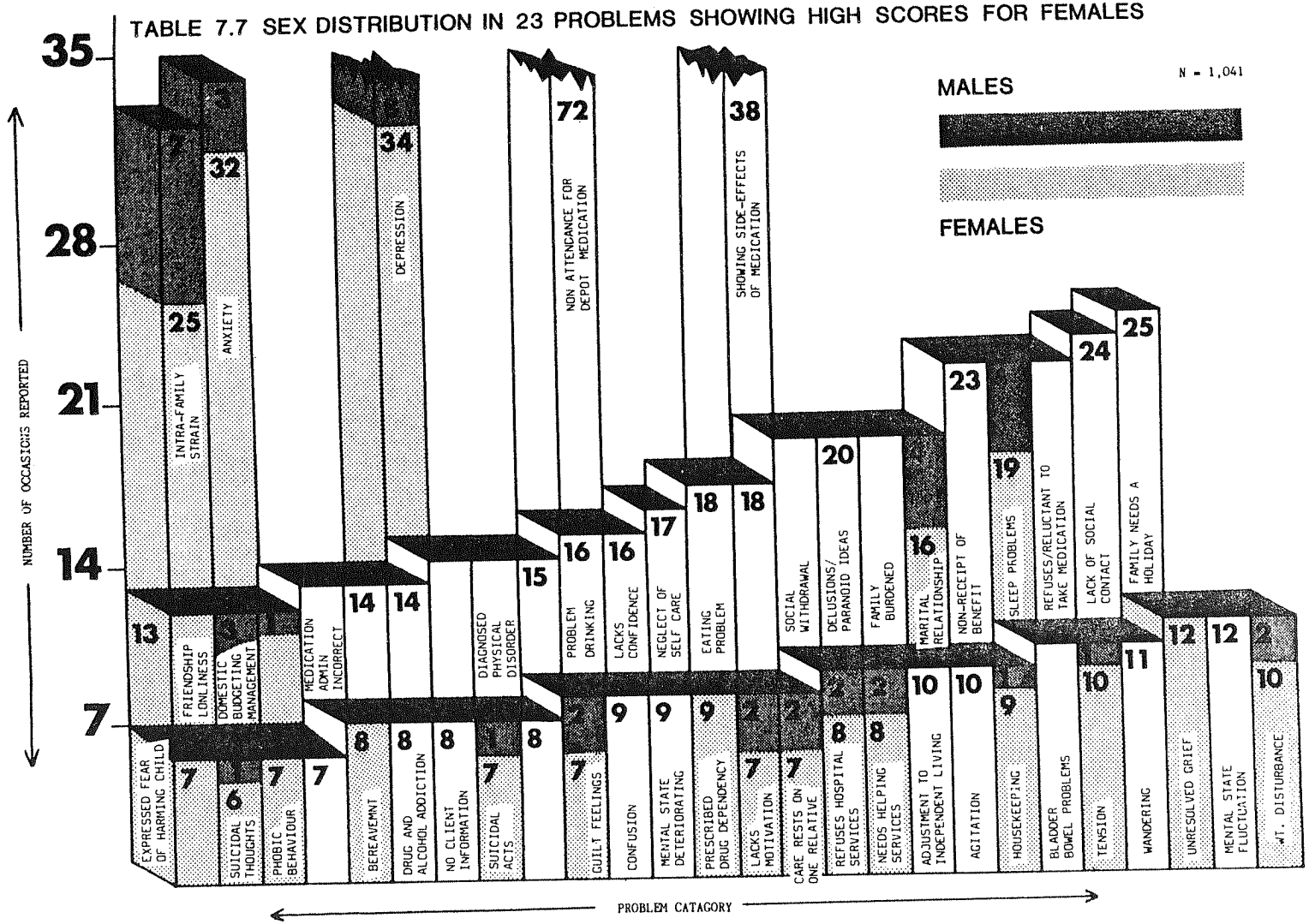
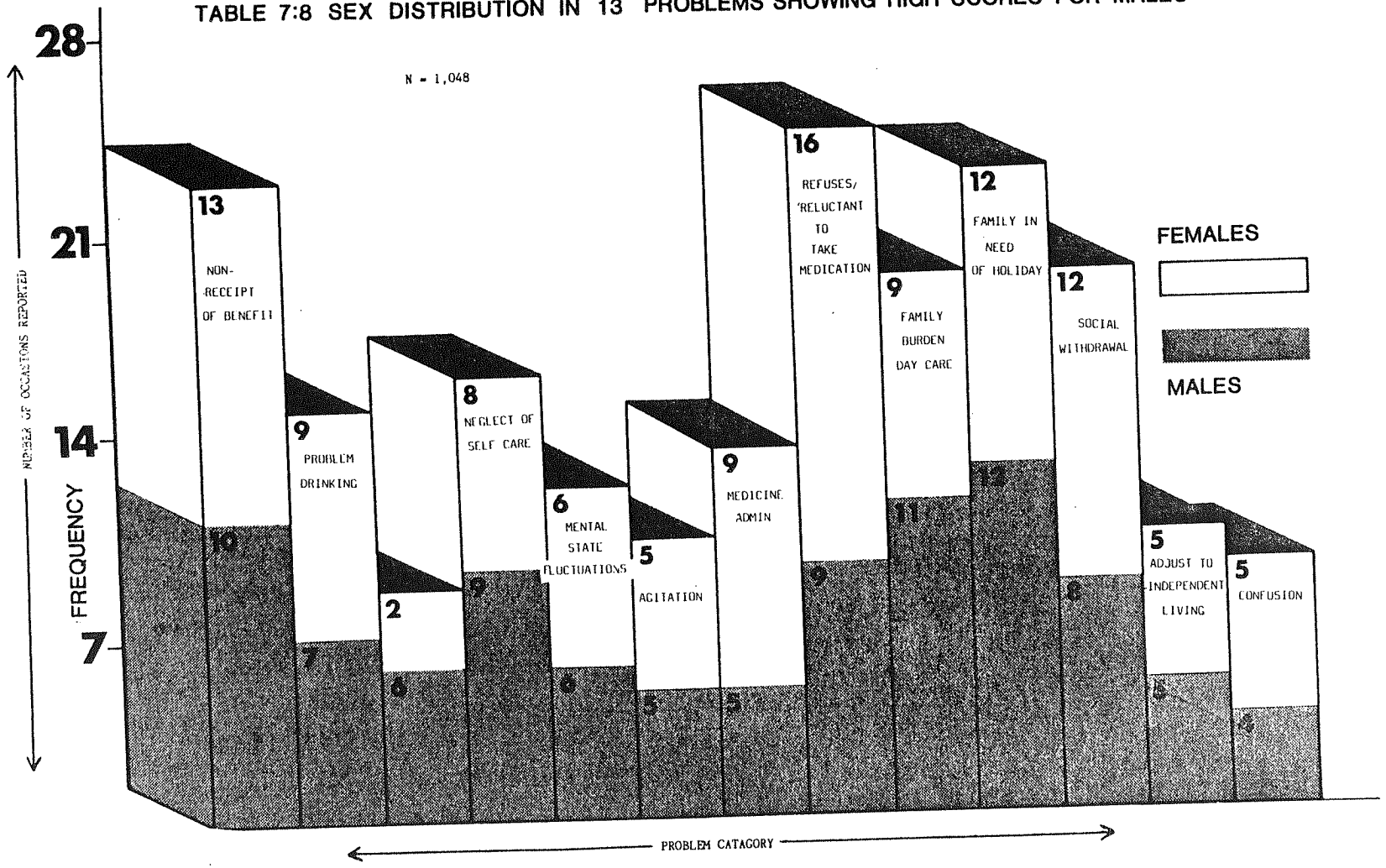


TABLE 7:8 SEX DISTRIBUTION IN 13 PROBLEMS SHOWING HIGH SCORES FOR MALES



Treatments and Therapeutic Interventions

Choice of action with clients by C.P.Ns is shown at Tables 7.9.1 and 7.9.2.

It has already been suggested in this chapter that C.P.Ns are given a free hand in the commissioning of their referrals. A summation of action taken by C.P.Ns shows that this bears no relationship to the action requested by the referring agent.

Most striking in the actions carried out by nurses was that where a specific therapeutic intervention was employed. On these occasions nurses specified particularly the mode of action 'behaviour therapy', 'psychotherapy' and so on. This particular action was carried out on 16.9% of occasions when it had been requested in only 4.6% of referrals. Secondly, a group was identified where some interpersonal activity was carried out by nurses. These were often defined as 'discuss at length', 'advise', 'talk to', 'reassure' and 'encourage'. No generic term comes easily to mind which encapsulates this type of activity although other attempts have been made to do so. Sladden[29] calls this group "psycho-social", Goldberg[39] the "sustaining and nurturing" aspects of social work. Looking at the case data sheets where these activities were mentioned, there was a deliberate intention to their use. Examples serve to make the point:-

"discuss Mrs X's problems with her to try to define further her problems in sleeping"

"reassure Mr L about his anxiety for the next

3 weeks and reassess the situation"

"encourage Mr F to go out more".

This group has eventually been defined in this study as 'sustaining and nurturing' as no other new classification could be agreed upon by experts when consulted, but from case data sheets, the use of sustaining and nurturing appears deliberate and makes up 12.3% of nurse interventions.

Medication continued to play an important part of action by nurses and a general form of activity to do with the stabilization of medication formed 19.7% of C.P.N. activity. This stabilization involved continuing an established regime, reviewing an established regime and reducing or bringing a client off an established regime.

The largest identified group was seen as liaison with other services (25%). This liaison was most commonly with social services, general practitioners, health visitors and district nurses. The liaison was not a means to discharging a client into someone elses care but more to involve another professional in some part of a care plan or to keep them informed of progress. The liaison role of the C.P.N. is already well documented in other studies but a feature of the Stockport service was the liaison function as a means of giving information rather than as a request for help.

Part of the remaining 23% of various categories was confined to gaining new resources, such as day care and holiday relief, obtaining out patient appointments and physical nursing care.

These actions were mostly wholly confined to the E.S.M.I. services (86%) and can be seen as an essential part of working with the elderly. It is also a reflection of how the service operates that it has access to new resources and can obtain out patients appointments with speed. Not all C.P.N. services can offer this facility.

Finally, two named categories, general support and continued assessment and observation, indicate a willingness to 'hold' certain cases without defined intervention. Both these categories exemplify non-intervention and case examples support this:

"Continue to observe and assess Mr B for 2 months and then discharge"

"Offer general support to the family and be available when required".

Non-intervention appears to be a mechanism for getting clients to maintain contact for a period of time when action or therapy is not needed but relapse is a clear possibility.

One minor catergory - 'other' 2.3% - is so diverse as to defy general description and includes some once only intervention unique to particular cases.

"Contact R.S.P.C.A. to find new pet"

"Find local enthusiasts club"

Treatments and therapeutic interventions used by C.P.Ns in

Stockport demonstrate that they:-

i) Use defined therapeutic interventions in casework.

ii) Exercise considerable freedom of choice in their intervention activities.

iii) Employ interpersonal, sustaining and nurturing and medication techniques commonly in their interventions.

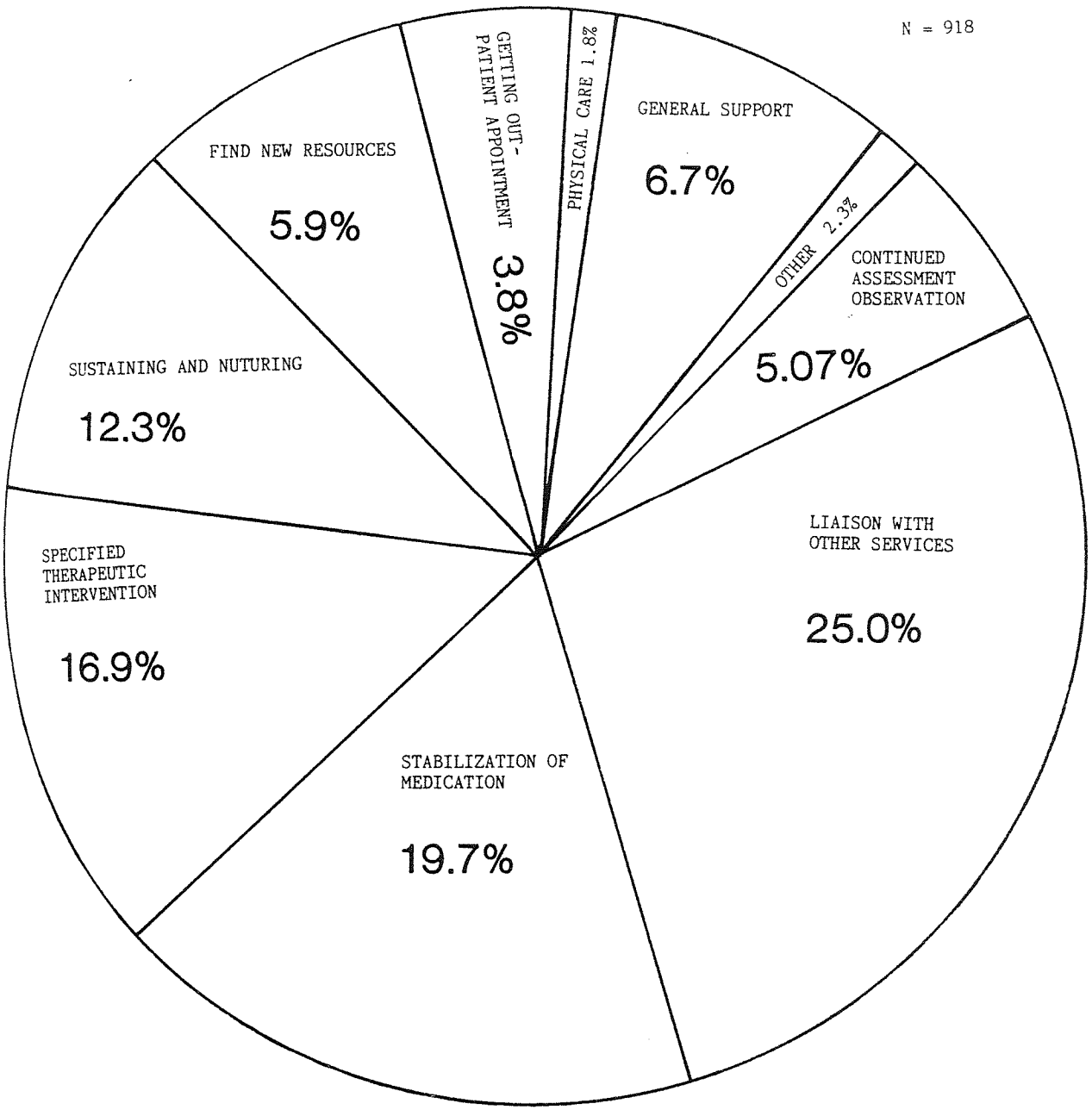
iv) Have a self defined and important 'liaison' function with other disciplines.

TABLE 7.9.1

TREATMENT AND THERAPEUTIC INTERVENTION USED BY ALL NURSES

TREATMENT/THERAPEUTIC INTERVENTION USED	SUB-TOTAL	TOTAL
SPECIFIED THERAPEUTIC INTERVENTION		156
BEHAVIOUR THERAPY	33	
PSYCHOTHERAPY	4	
FAMILY THERAPY	3	
CONTROLLED DRINKING/ABSTINENCE PROGRAMME	14	
COUNSELLING	70	
SOCIAL SKILLS TRAINING	18	
OTHER	14	
SUSTAINING AND NUTURING NON SPECIFIED APPROACHES USING TERMS SUCH AS 'DISCUSS', 'TALK TO', 'INFORM', 'ADVISE', 'ENCOURAGE', EDUCATE', 'REASSURE', 'VENTILATE'		113
GETTING OUT PATIENT APPOINTMENT		36
LIAISON WITH OTHER SERVICES (HEALTH VISITOR) (DISTRICT NURSE) (GP) (SOCIAL SERVICES)		231
STABILIZE MEDICATION		181
CONTINUE REGIME	145	
REVIEW REGIME	31	
BRING OFF/REDUCE	5	
FIND NEW RESOURCES		55
DAY CARE	30	
HOLIDAY BED RELIEF	6	
PSYCHOLOGIST		
OTHER	11	
GENERAL SUPPORT		62
PHYSICAL NURSING CARE		17
CONTINUE OBSERVATION AND ASSESSMENT		46
OTHER		21
TOTAL		918

TABLE 7.9.2 TREATMENTS AND THERAPUTIC INTERVENTIONS USED BY ALL NURSES SEEN AS PERCENTAGE



Introduction to Problem Outcomes

Problems were processed as to outcomes. Four possible outcomes were allowed for:-

i) ACTIVE

- Problems were defined as 'active' when the client was discharged from nursing care by the C.P.N. while still experiencing an on-going definable problem at their time of discharge about which the C.P.N. was unable or unwilling to do anything. Some problems were defined as active by mutual agreement between client and nurse, others were defined by the nurse alone.

ii) RESOLVED

- Problems were defined as 'resolved' where they no longer constituted a 'problematic' label as defined by the nurse and the client. This mutual negotiation is an integral part of P.O.A.

iii) REDEFINED

- Problems often underwent a process of redefinition as more information became available. The label of redefinition implies that certain problems had not been resolved but it had become possible to be more specific about the problem or in the light of new information, change it, thereby making it necessary to call it something else.

iv) CURRENT

- A principle had been made not to problem orientate the

existing caseload of psychiatric nurses at the beginning of the study. A second principle was adopted at the end of the study, namely having a 'cut-off' date beyond which no more data would be collected. As some clients would have problems which were not yet resolved or redefined, their existing problems at the point of cut-off were categorized as 'current'.

These four possible problem outcomes could be cross tabulated in data presentation which is demonstrated in tables 7.10 to 7.15.4.

A series of selective decisions was made in order to present those problem outcomes which demonstrated practice/client/ organizational connections.

a) Total problem outcomes could be presented using the four defined categories.
b) 'Person specific' outcomes could be demonstrated using source of referral, individual C.P.N. involved and age range as parameters in cross tabulation.
c) Problems which had a high resolution rate or a low resolution rate could be picked out and compared with 'average' outcome data.

Problem Outcomes

Tables 7.10 to 17.13.2 demonstrate total outcomes and outcomes cross tabulated by age, sex, nurse and source of referral.

Total outcomes show that 'resolution' is the most likely outcome for indentified problems. Problems were resolved on 62.0% of all cases, 13% of all identified problems were active on discharge and 15% of problems became redefined into other problems categories. Table 17.15.1 demonstrates that when problem outcomes are adjusted to discount redefined and current problems, the scores show 77.7% of problems are resolved and 22.3% of problems remain active. Attempts were made to test for any associations between length of community nurse contact and outcome using linkage and factor analysis techniques but no significant relationship was found. Chi squared testing for problem outcomes related to sex was not significant suggesting that the client group had an equal opportunity of problem outcome regardless of sex.

An examination of outcomes related to age for generic clients suggested that clients in the 40-59 age group were most likely to be discharged with active problems and that the 60-70+ age group had the highest problem resolution group. The E.S.M.I. group had an 81% problem resolution rate. This high rate has much to do with the philosophy of the E.S.M.I. team and the nature of the cases it deals with. Short term case requests and requests for assessment are part of the team's standard response and resolution of these problems is not difficult if there is access to short term care facilities and manpower to carry out assessments. C.P.Ns showed some consistency in their outcomes of casework. Their clients had a range of problem outcome possibilities ranging from 60-82% of problems being resolved and a 17-28% chance of problems staying active upon discharge. No significance was noted between

practitioners (Table 7.15).

Table 7.12.2 shows that individual consultants had an outcome for their referrals of 17-27% of problems being active on discharge and 69-82% of problems being resolved for generic cases. G.P. referrals were differently balanced and outcomes of 42% and 52% were recorded for active and resolved problems respectively. This small sample size will doubtless account in part for the difference in outcome to consultant referrals.

Table 17.15.2 demonstrates 9 problem outcomes and their scores adjusted to discount for redefined and current problems. Problems of medication, day care, sleeping and eating problems and bowel/bladder problems show high outcomes towards resolution (85%, 100%, 85% and 88% respectively). Any suggestions of significance in these findings are tempered by a knowledge that resources are the key to resolving problems of day care. There is evidence to suggest that psycho/social and family problems are not as amenable to intervention as those which involve medication management. This may or may not have to do with the skills of the C.P.Ns but a skills repertoire which allows nurses to deal competently with these problems is an obvious asset given their high incidence. Table 7.15.3. shows the duration of involvement of nurses with their clients. A case contact time was very variable but most cases fell into a range of between 2 and 12 months. This long term contact is a feature of those cases which have been problem orientated, however, as study data points out in Chapter 9 (9.3) short term contacts have not always been processed by problem orientation.

A comparison of the age groups of referrals between G.P's and consultants suggests the G.P's referrals are predominantly younger than those of consultants.

Problem outcomes for clients of community psychiatric nurses demonstrate the following:-

i) C.P.Ns working with clients can expect a high resolution rate of their clients problems.

ii) Certain problems are more amenable to intervention than others particularly those of medication management and finding day care.

iii) Outcomes for male and female clients are not affected by sex group which suggests unbiased attention from C.P.Ns.

iv) No problem area is significantly higher than others in having an 'active' outcome, however, problems of a psycho-social and familial nature are less likely to be resolved.

v) Source of referral has an effect on the likely age group of the clients involved when G.P's and consultants are compared.

TABLE 7.10

IDENTIFIED PROBLEM OUTCOMES CROSS TABULATED BY SEX

OUTCOME CATAGORY	ALL PROBLEMS		E.S.M.I.	
	MALE	FEMALE	MALE	FEMALE
ACTIVE	46	139	5	17
RESOLVED	202	444	72	77
REDEFINED	14	34	4	8
CURRENT	35	127	4	2
TOTAL	297	744	85	104

N= 1,041

TABLE 7.11.1

PROBLEM OUTCOMES FOR ALL GENERIC CLIENTS

OUTCOME CATEGORY	UNDER 20	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70+	TOTAL
ACTIVE	7	26	19	19	29	28	28	156
RESOLVED	15	99	60	14	56	103	111	458
REDEFINED	0	13	3	1	5	10	6	38
CURRENT	1	19	19	22	18	33	42	154
TOTAL PROBLEMS	23	157	101	56	108	174	187	

TABLE 7.11.2

PROBLEM OUTCOMES FOR ALL E.S.M.I. CLIENTS

OUTCOME CATEGORY	50-59 Years	60-69 Years	70+	TOTAL PROBLEMS
ACTIVE	1	0	21	22
RESOLVED	0	20	129	149
REDEFINED	0	0	12	12
CURRENT	0	0	6	
TOTAL PROBLEMS	1	20	168	

N = 189

TABLE 7.12.1

SEX DISTRIBUTION OF 316 COMPLETED CONSULTANT REFERRALS CROSS TABULATED BY AGE

		UNDER 20		20-29 Years		30-39 Years		40-49 Years		50-59 Years		60-69 Years		70+	
CONSULTANT	TOTAL PTS.	M	F	M	F	M	F	M	F	M	F	M	F	M	F
CONSULTANT 'A'	93	1	0	7	18	1	7	1	12	3	5	5	14	8	11
CONSULTANT 'B'	48	2	1	6	1	2	3	1	7	1	2	3	8	3	8
CONSULTANT 'C'	46	0	0	0	1	0	3	1	1	2	6	2	15	0	15
CONSULTANT 'D'	48	0	1	2	8	0	5	1	4	2	2	1	6	2	14
CONSULTANT 'E'	81	2	0	3	7	8	9	6	3	5	9	6	14	0	9
	316	4	2	18	35	11	27	10	26	13	24	17	57	13	51

TABLE 7.12.2

PROBLEM OUTCOMES OF CONSULTANT 'GENERIC' REFERRALS

CONSULTANT	ACTIVE	RESOLVED	REDEFINED	CURRENT	TOTAL
CONSULTANT 'A'	40	136	14	30	220
CONSULTANT 'B'	13	60	3	33	109
CONSULTANT 'C'	19	65	5	29	118
CONSULTANT 'D'	31	80	4	19	134
CONSULTANT 'E'	39	127	10	34	210
	142	468	36	145	

TABLE 7.13.1

PROBLEM OUTCOMES OF G.P. REFERRALS

ACTIVE	RESOLVED	REDEFINED	CURRENT	TOTAL
17	21	2	6	46

TABLE 7.13.2

SEX DISTRIBUTION OF G.P. REFERRALS CROSS TABULATED BY AGE

TOTAL		UNDER 20		20-29		30-39		40-49		50-59		60-69		70+	
M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
5	16	0	1	1	5	0	6	1	1	1	3	2	0	0	0
total 21		1		6		6		2		4		2		0	

TABLE 7.12.1 AND 7.13.2

GP REFERRAL AND CONSULTANT

REFERRALS R = 0.22
(SPEARMANS COEFFICIENT CORRELATION)

TABLE 7.14.

GENERIC CPNs. OUTCOMES OF PROBLEMS CROSS TABULATED BY AGE

OUTCOME	UNDER 20	20-29 Years	30-39 Years	40-49 Years	50-59 Years	60-69 Years	70+	TOTAL
ACTIVE	7	26	19	19	29	28	28	156
RESOLVED	13	97	60	47	56	103	111	487
REDEFINED	0	11	3	1	5	10	6	36
CURRENT	1	19	19	22	18	33	42	154
	21	153	101	89	108	174	187	

TABLE 7.15

INDIVIDUAL C.P.N. CASE OUTCOME PROFILE FOR 8 C.P.Ns WITH CONSISTENT CASE INVOLVEMENT THROUGHOUT THE STUDY

CPN	ACTIVE	RESOLVED	REDEFINED	SUB-TOTAL	CURRENT	TOTAL	No. OF CASES INVOLVED
A	8	33	3	44	9	53	27
B	30	87	4	121	21	142	52
C	9	41	2	52	8	60	28
D	20	46	2	59	18	77	31
E	20	42	2	69	9	73	32
F	16	43	7	66	2	68	39
G	17	53	7	77	18	95	44
H	7	33	0	40	23	63	23

R = 0.8

SPEARMANS COEFFICIENT CORRELATION

TABLE 7.15.1

PROBLEM OUTCOMES AS A PERCENTAGE OF TOTAL (ADJUSTED TO DISCOUNT REDEFINED AND CURRENT PROBLEMS)

OUTCOME	ACTIVE	RESOLVED
PERCENTAGE OF TOTAL	22.3%	77.7

TABLE 7.15.2

PROBLEM OUTCOMES DEMONSTRATING RESOLUTION RATES (ADJUSTED TO DISCOUNT REDEFINED AND CURRENT PROBLEMS)

PROBLEM	ACTIVE	RESOLVED
LACK OF SOCIAL CONTACT	11	15
INTRAFAMILY STRAIN	11	15
SLEEPING AND EATING PROBLEM	3	18
BOWEL AND BLADDER PROBLEMS	1	8
DEPRESSION	8	22
ANXIETY	8	15
MEDICATION	19	111
DAY CARE	0	19
SOCIAL WITHDRAWAL	3	10

TABLE 7.15.

DURATION OF COMMUNITY NURSE CONTACT FOR 316 COMPLETED REFERRALS

LENGTH OF CONTACT	UP TO 1 MONTH	2-3 MONTHS	3-6 MONTHS	6-12 MONTHS	OVER 12 MONTHS
No	21	66	72	102	55
% AGE	6.6%	20.9%	22.8%	32.3%	17.4%

Discussion of Community Psychiatric Nurses and Problem Orientated Casework

Problem orientation of casework must be viewed in the context of the organizational development project.

P.O.A. was chosen to provide detail on casework, a philosophy of action and to give substance to planned client care. Initial audit of the C.P.N. team showed a need to provide these elements and it is the contention of the author that P.O.A. has provided substance and direction to casework. P.O.A. has proved itself as a means to gathering case data and information about the activities of C.P.Ns and their clients. As a consequence a number of characteristics have emerged about the Stockport service which may have general application elsewhere.

1) C.P.Ns exercise considerable freedom of choice in commissioning their referrals. The requested action from referring agent is vague and non-specific giving C.P.Ns an open choice for action.
2) C.P.Ns demonstrate a wide repertoire of action when commissioning referrals. They have started to choose specific therapeutic techniques to meet particular problems and they continue to develop a number of successful methods in medication management and sustaining and nurturing activities.
3) The clients of C.P.Ns demonstrate a full range of presenting problems. By joint negotiation nurses and their clients can identify the most pressing problems

and act upon them.

4) P.O.A. has the potential to pick out area of high and low problem resolution, thus pointing the way to service deficits and needs for further training.

5) The effect of C.P.N. intervention with clients who have problems is largely successful. Clients show a high problem resolution rate upon discharge.

6) C.P.Ns have a high liaison function which will put them into a co-ordinative role on many occasions.

7) It is possible to use a categorization (Delphi) list to process casework which has been problem orientated. The author believes that the categorization (Delphi) list, shown in Chapter 11, is suitable for general use in this purpose.

8) Problem orientated casework presents only a part picture of case related activity. 'One off' interventions and non case related activity are not amenable to P.O.A.

9) The 'dynamic exchange' of casework cannot be fully represented in P.O.A.

The acceptability of P.O.A. to the team is demonstrated in Chapter 10. It is sufficient validation to note that the C.P.N. service has continued to use the system and the data sheets devised by the project even though the support team has left.

Some developments are necessary to produce an easy system of data collection. The method used by the team of processing all case data into a mainframe computer using an S.P.S.S. package is too cumbersome for general use. It would not be

technically difficult to use a prepared software system which was user friendly in order that nurses could put case information into a more accessible system and thereby allow the team a continuous analysis of case data.

7.3

THE CASEWORK OF COMMUNITY MENTAL HANDICAP NURSES

TEACHING METHODOLOGY AND DATA STORAGE

The teaching methods employed for the community mental handicap nurses were a replica of those used for the psychiatric nurses.

The materials were amended and all the sample casework used for teaching was based upon cases involving mentally handicapped people.

Data was collected and stored in the same way as for the psychiatric clients with nurses using a coding list and case data being transferred from data sheets to the computer storage facility.

It was known that the 'case' turnover for the team was much lower than that for psychiatry for a number of reasons.

i) Cases are seldom totally discharged from all care agents, however, they may go through a period of dormancy when little activity is taking place.

ii) Cases often require sustained and intense input to work on behavioural programmes

iii) The nature of casework means that nurses may for a period of time become 'key workers' and when they have discharged their responsibilities, cases may pass to another member of the multidisciplinary team.

Introduction

Information from the community mental handicap nursing team is presented as frequency counts and cross tabulations of various groups of data. Tests of significance and variance are not used extensively and the final picture is used to paint a picture of case content and outcome rather than a standard of significant relationships.

DATA TABLES

TABLE 7.16 OVERVIEW OF DATA

TOTAL NUMBER OF ALL MENTALLY HANDICAPPED CLIENTS	= 104
TOTAL NUMBER OF PROBLEMS IDENTIFIED FOR ALL MENTALLY HANDICAPPED CLIENTS	= 317
TOTAL NUMBER OF MALE MENTALLY HANDICAPPED CLIENTS	= 65
TOTAL NUMBER OF FEMALE MENTALLY HANDICAPPED CLIENTS	= 39

TABLE 7.17.1

ALL FEMALE CLIENTS CROSS TABUL:ATED BY AGE GROUP

AGE GROUP	0-4	5-10	11-15	16-20	21-30	31-40	41-50	51-60
NUMBER OF CLIENTS	2	6	6	8	10	2		3

N = 39

TABLE 7.17.2

ALL MALE CLIENTS CROSS TABULATED BY AGE GROUP

AGE GROUP	0-4	5-10	11-15	16-20	21-30	31-40	41-50	51-60
NUMBER OF CLIENTS	7	15	10	9	10	10	2	2

N = 65

TABLE 7.18

AGE RANGE OF ALL CLIENTS

AGE GROUP	0-4	5-10	11-15	16-20	21-30	31-40	41-50	51-60
NUMBER OF CLIENTS	9	21	16	17	20	12	4	5

N = 104

104 clients were processed by the project using a problem orientated approach.

Table 7.16 demonstrates that these 104 clients had 317 identified problems. Males composed the largest group in a ratio of 1.6 : 1 to females. Age range was widely spread through the sexes with a predominance in 5-30 years groups in both sexes. The low numbers in the 0-4 age group are a reflection of the local policy from the child development unit although as will be seen later some referrals are made from that service.

Chi squared testing of the males/females age range was not significant but indicates an even spread of cases regardless of sex. All clients were unmarried and 4 were in full employment.

Referral of Clients

Reasons for referring clients were identified and are shown in table 7.19. Referrals were from a variety of members of the community mental handicap team including doctors, psychologists, social workers, clients and their families and other nurses. Requests were divided into 3 main groups and 9 minor groups. Case management requests formed 33% of all referrals and these were primarily for short term care, future long term care and carers who were unable to cope because of age and frailty. It became apparent that community nurses were seen as a prime resource for short term care facilities and were recognised as such by the referring agent. Specific

therapies were asked for in some referrals (14%) and these were particularly toileting programmes, social skills training and programmes to encourage independent living. The third most requested activity (21%) was to deal with a behaviour problem most commonly where threatening and aggressive behaviour was causing difficulty. Other referrals (31%) were very varied and ranged from requests for further information to problems with epileptic seizures.

Some observations may be drawn from this data.

1) C.N.M.Hs are identified as the 'gatekeepers' to some resources (i.e. short term care) and are referred to for specific help of this nature.

ii) C.N.M.Hs are seen as suitable agents to which to refer for help with behavioural problems and particular therapies most notable behavioural programmes.

iii) Although not an integral part of the child development services, clients are referred to C.N.M.Hs from this source.

TABLE 7.19

REASONS FOR REFERRAL AS SEEN BY REFERRING AGENT/TEAM

REASON GIVEN	SUB-TOTAL	NO. OF OCCASIONS
CASE MANAGEMENT		66
SHORT TERM DAY CARE PLACEMENT	51	
FUTURE LONG TERM PLACEMENT	3	
CARERS CAN'T CARE (ELDERLY ETC)	12	
REQUESTS FOR SPECIFIC THERAPY		28
TOILETING PROGRAMME	8	
SOCIAL SKILLS TRAINING AND/OR INDEPENDENCE	20	
BEHAVIOUR PROBLEM		43
THREATENTING AND AGGRESSIVE	18	
ATTENTION SEEKING	8	
BOREDOM	8	
DISRUPTIVE BEHAVIOUR	6	
SEXUAL DISINHIBITION	3	
OTHER		6
REFERRALS FROM CDU		10
UNSATISFACTORY HYGIENE		4
NOCTERAL ENURESIS		6
NEED FOR MORE INFORMATION		9
SUPPORT NEEDED		6
ASSESS BEHAVIOUR PROBLEM		9
EPILEPTIC SEIZURES		5
DAY CARE		6
TOTAL		198

Problems Identified by C.M.H.Hs, their Clients and Families

The frequency and distribution of problems are seen in Table 7.20. It will be noted that there are some additions and some deletions from the original Delphi list. Problem data arose in the project which did not fall into any of the named categories. Equally some categories were considered redundant at the end of the study.

169 categores are show in the problem list and 317 problems were identified within these categories. A frequency of 0-2 was recorded in 58 (34%) of all categories and following discussion it was felt that a score of 3 (representing 1.3% of all total problems) was seen as a viable cut off point for further discussion.

This remaining group ranges aroung a score of 3-26 (with a mean of 6.4, a median of 5 and a standard deviation of 7.9). The group demonstrates some high scores for certain categories and these are shown at Table 7.21. Most prominent are need for short term care, soiling and urinating problems, family's coping ability, future welfare of elderly parent and threatening and aggresive behaviour. These show scores of 26, 18, 15, 11 and 10 respectively. Family centred problems account for 19% of problems identified and equally behaviour centred problems account for 19% of total.

Sex difference in 9 problems is shown at Table 7.21.1 with no problem seen as belonging exclusively to one sex but two problems, threatening and aggressive behaviour and family's

coping ability, are most predominantly male. Two problems, screaming and lack of social contact, are seen as predominantly female. Counts shown in the remaining problems are so small as to make their significance minimal.

Table 7.21.2 shows 11 problems cross tabulated with age and sex and although no discernable differences are noted between sex and age for these 11 problems, there are age 'clusters' which show that certain age groups are more likely to present with particular problems. This is most easily observed in family need rest/short term care where case presentation is likely to be between the ages of 0-15 years, and future welfare of an elderly relation (most commonly seen in the 21-50 age group). Similar concentrations can be seen in family's coping ability 6-20 years, and threatening and aggressive behaviour 11-20 years.

Explanations as to data type are tempered by lack of comparable data and the smallness of the sample size. Some general conclusions may however be drawn from the data..

i) There is a broad cross section of problems represented by the clients of community mental handicap nurses.
ii) Community mental handicap nurses are presented with problems which have a high proportion of family work and behavioural problems.
iii) Some problems are more sex specific than others.
iv) Presenting problems show age 'concentrations' in certain categories.

PROBLEM DISTRIBUTION CROSS TABULATED BY SEX

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
1	MARITAL RELATIONSHIP	1	1	0
2	CARE OF CHILDREN	0	0	0
3	REJECTION BY FAMILY	0	0	0
4	FAMILY OVERPROTECTIVE	9	3	6
5	FAMILY PLANNING	1	0	1
6	INTRA FAMILY STRAIN	1	1	0
7	EXTENDED FAMILY STRAIN	1	1	0
8	FRIENDSHIP - LONELINESS	2	2	0
9	SOCIAL ROLE PROBLEMS	0	0	0
10	LACK OF SOCIAL CONTACT	7	2	5
11	WORK RELATIONSHIPS	1	1	0
12	SOCIAL SKILLS	2	1	1

TABLE 7.20 (CONT)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
13	MOBILITY TRANSPORT	4	2	2
14	GEOGRAPHICAL ACCESS	0	0	0
15	NEEDS HELPING SERVICES	1	1	0
16	NEEDS SITTING SERVICES	1	0	1
17	MISHAND. OTHER AGENT	0	0	0
18	OVERINTERV. BY AGENTS	0	0	0
19	AT RISK CHILDREN	1	1	0
20	NON-RECEIPT CHILDREN	0	1	0
21	NEED SHORT TERM CARE FOR FAMILY REST	26	16	10
22	NEEDS SPECIALIST SUPPORT	1	1	0
23	DAY CARE REQUIRED	4	1	3
26	PLAYTIME RESTRICTED	3	3	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
27	LITTLE FAMILY INTERACTION	1	1	0
28	FAMILY UNABLE TO EMPLOY PROGRAMME	5	4	1
29	NO KNOWLEDGE OF BEHAVIOURAL SKILL	2	2	0
30	NO KNOWLEDGE OF SIGN LANGUAGE	1	1	0
31	INAPPROPRIATE PARENTAL HANDLING	5	4	1
32	FAMILY'S COPING ABILITY	15	10	5
34	FAMILY UNABLE TO DO PHYSIOTHERAPY	2	2	0
35	CLIENT CARE ON ONE RELATIVE	3	3	0
36	CARER PHYSICALLY ILL	2	1	1
39	DIAGNOSED PHYSICAL DISABILITY	5	4	1
40	UNDIAGNOSED PHYSICAL DISABILITY	3	0	3
41	WEIGHT DISTURBANCE	3	0	3

TABLE 7.20 (CONT)

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
42	HEADACHES	1	0	1
45	BLADDER/BOWEL PROBLEMS	2	1	1
46	EXERCISE PHYSIO	1	1	0
50	SPEECH DEFICIT	3	3	0
51	DEAFNESS	1	0	1
52	MOTOR SKILL DIFFICULTIES	1	0	1
54	HYPERTONIC PROBLEMS	1	1	0
55	EPILEPTIC SEIZURES	4	2	2
59	NEGLECT OF SELF-CARE	1	0	1
60	LIMB CONTRACTIONS	1	1	0
61	DENTISTRY - ORAL HYGIENE	1	1	0
62	EXCESSIVE SALIVATION	1	1	0

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
72	REASONING DIFFICULTIES	1	1	0
73	CONCENTRATION	2	1	1
78	DEPRESSION	2	1	1
84	LACKS CONFIDENCE	3	1	2
86	LACKS MOTIVATION	1	1	0
87	BOREDOM	2	0	2
94	MAINTAIN DEPOT MED.	2	2	0
95	SIDE EFFECT OF MED.	3	3	0
96	MED. INEFFECTIVE	1	0	1
97	RELUCTANT TO TAKE MEDICATION	1	0	1
100	CNMH - FAMILY RELATIONSHIP	2	0	2
102	LIAISON BETWEEN SERVICE	3	1	2

TABLE 7.20

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
103	CLIENTS SCHOOL HOLIDAYS NEEDS OCCUPATION	3	2	1
104	LACK OF INFORMATION RE CLIENT	7	4	3
105	NO HOSPITAL BEDS AVAILABLE	2	1	1
108	FUTURE WELFARE OF ELDERLY PARENTS	10	8	2
109	LACK OF AIDS	8	6	2
110	INAPPROPRIATE AIDS	2	2	0
111	INABILITY-RELUCTANCE TO KEEP AIDS	2	1	1
112	LOCAL HOSPITAL SERVICE REJECTED	9	5	4
113	POOR KNOWLEDGE OF SERVICE	1	0	1
115	POOR RELATIONSHIP WITH PARENTS	2	2	0
117	NEEDS SUPERVISED ACCOMMODATION	1	1	0
120	SPITTING	4	3	1

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
121	THREATENING AGGRESSIVE	12	10	2
122	PHOBIC BEHAVIOUR	4	3	1
123	SCREAMING	8	3	5
124	SLEEP PROBLEMS	5	4	1
125	EATING PROBLEMS	4	2	2
127	SEXUAL DISINHIBITION	5	4	1
132	HYPERACTIVITY	3	2	1
134	ROCKING	1	1	0
136	GRINDING TEETH	1	0	1
138	SOILING URINATING PROBLEMS	18	11	7
140	DESTRUCTIVE BEHAVIOUR	1	1	0

TABLE 7.20

PROBLEM NUMBER	PROBLEM DESCRIPTION	TOTAL FREQUENCY	MALE	FEMALE
143	DIFFICULTY DRESSING	2	2	0
144	DISRUPTIVE AT PLAY	1	1	0
152	ILLITERACY	1	1	0
159	SOCIAL WITHDRAWN ISOLATION	4	2	2
161	LIFE-ENVIRON-MENT DISSASTISFACTION	4	2	2
162	CULTURE SPECIFIC PROBLEMS	1	1	0
164	BEREAVEMENT	1	1	0
166	SCHOOL ATTENDANCE	2	2	0
167	HOUSEKEEPING	6	5	1
168	DOMESTIC MANAGEMENT	1	0	1
169	TRAVELLING	4	3	1

TABLE 7.21 PROBLEMS REPORTED ON 3 OR MORE OCCASIONS BY C.N.M.H./S : ALL CLIENTS

N=317

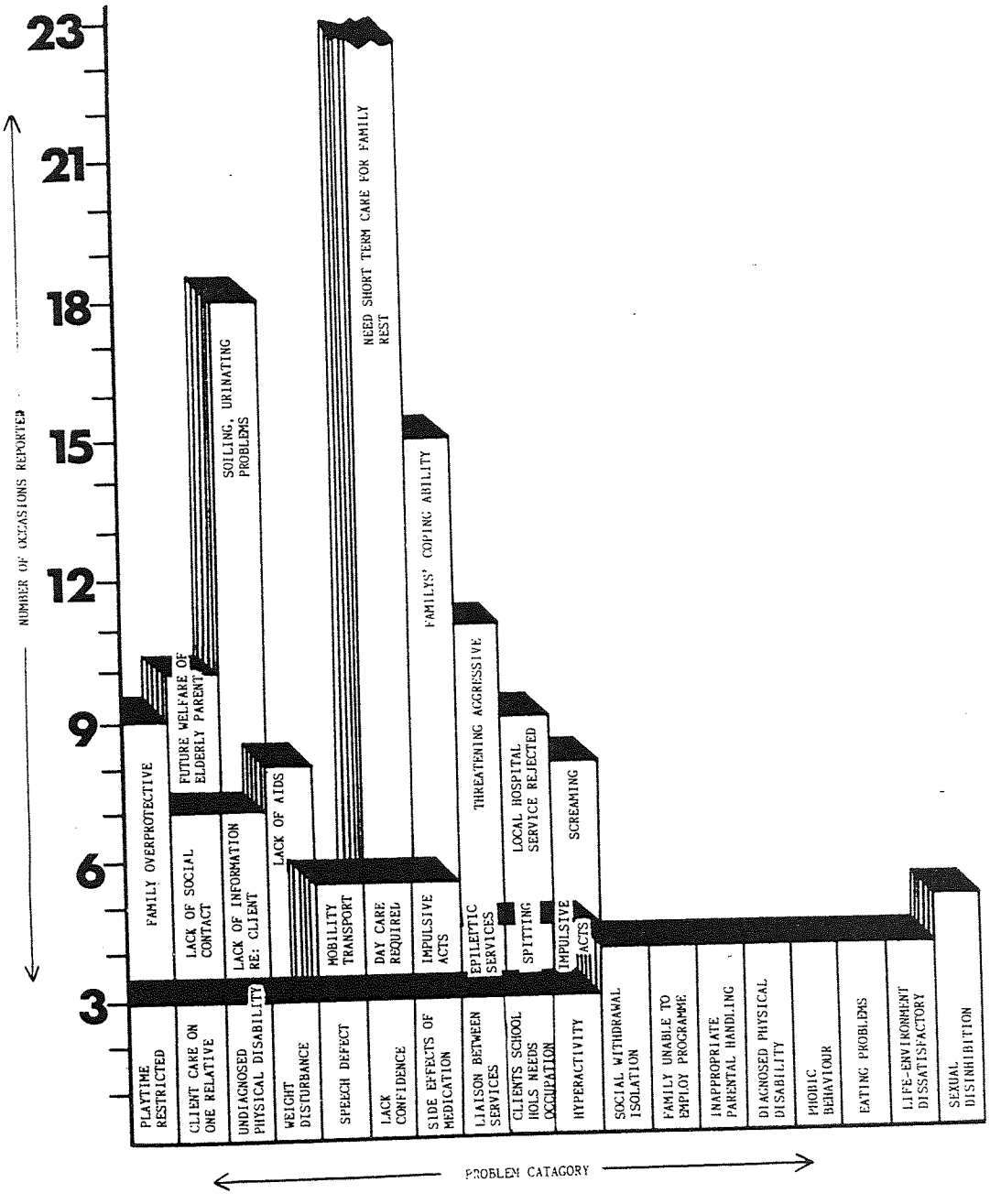


TABLE 7.21.1 SEX DISTRIBUTION FOR 9 PROBLEM CATEGORIES SHOWING HIGH SCORES FOR MALES OR FEMALES

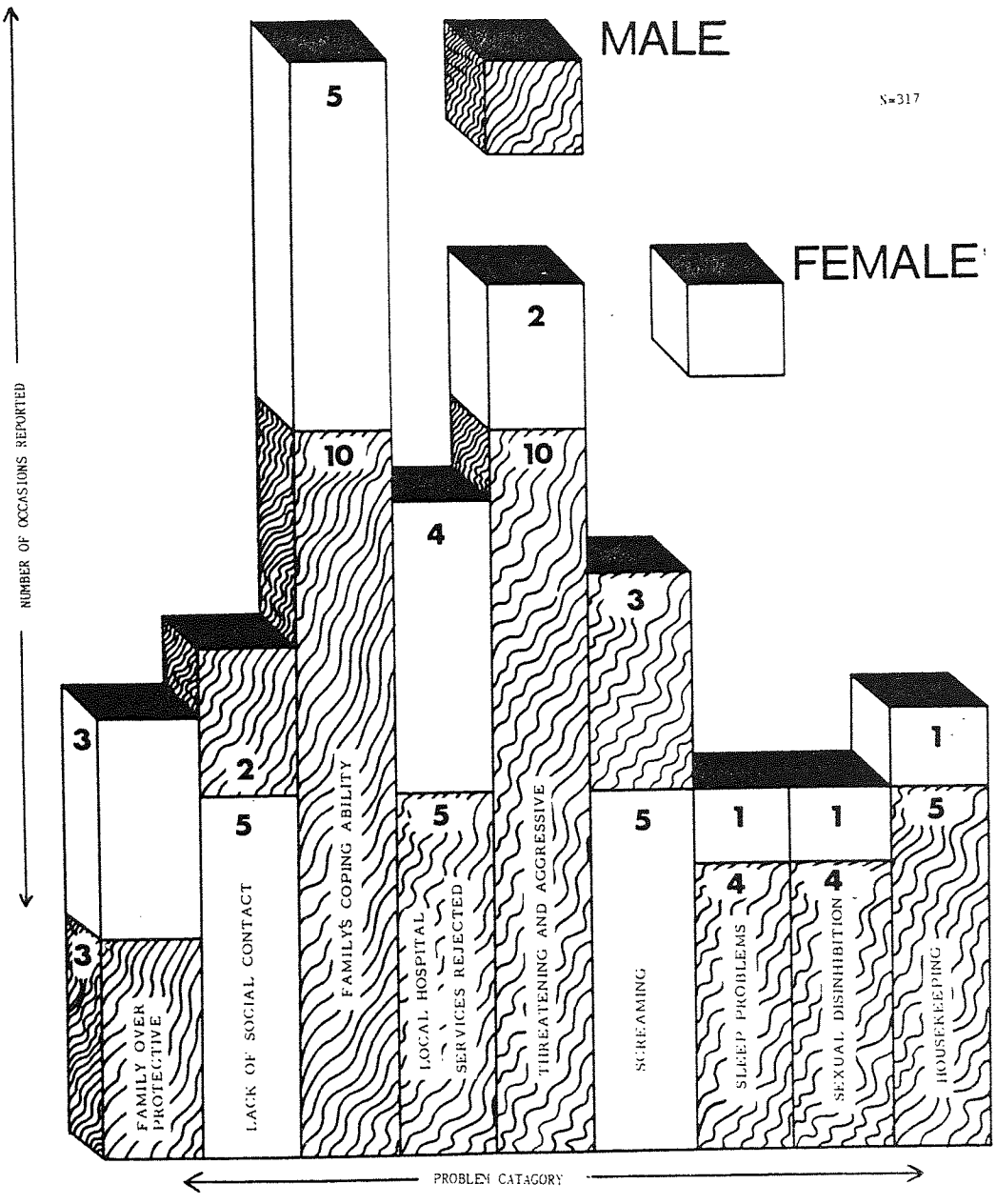


TABLE 2.21.2

11 PROBLEMS CROSS TABULATED WITH AGE AND SEX

PROBLEM CATAGORY	SEX	0-4	5-10	11-15	16-20	21-30	31-40	41-50	51-60
FAMILY OVER PROTECTIVE	M		1	3					
	F			1	1	1	1		
LACK OF SOCIAL CONTACT	M			2					
	F			1	3				
FAMILY'S COPING ABILITY	M	4	3	1	2				
	F		2	1	1				
LOCAL HOSP ITAL SERVICE REJECTED	M	1		1		2			
	F		1		1	2	1		
THREATENING AGGRESSIVE	M		2	3	3		1	1	
	F				1	1			
SCREAMING	M	1		2	1				
	F		2		2				
SLEEP PROBLEMS	M			2	2				
	F			1					
SEXUAL DISINHI- BITION	M	1		2	1				
	F			1					
SOILING AND URINATING	M		5	3	2		1		
	F		2	1	2	2			
FAMILY NEED REST SHORT TERM CARE	M	3	8	2	2		1		
	F	4	3	3	1			1	
FUTURE WELFARE ELDERLY RELATIVE	M				1	2	3	2	
	F					1			1

R =0.1

(SPEARMANS COEFFICIENT CORRELATION)

Treatments and Therapeutic Interventions

Choice of action with clients by C.N.M.Hs is shown at Table 7.22.

Frequency counts show that nurses spent a great deal of time in finding new resources and liaising with other services. These two activities account for 50% of nursing action with clients. This is doubtless to do with their philosophy of action as members of a multidisciplinary team and as agents of short term care facilities.

Specific therapeutic interventions when combined together accounted for 14% of interventions. C.N.M.Hs showed a similar tendency to use a sustaining and nurturing approach described for psychiatric nurses (19.4%). Once again they used terminology in this category such as 'explain', 'discuss', 'gain the confidence of' and 'form a relationship with'.

Nurses also used some non-programmed but most effective interventions which the author chose to call 'common sense' alternatives. An example serves to illustrate the point:

Particular problems had been experienced with a girl who had been seen by a number of other professionals to try and change a behaviour which caused particular annoyance - listening to continuous loud music. Various programmes had been tried and had failed. The C.N.M.H. persuaded the parents to buy some headphones and a portable music machine. The problem resolved. C.N.M.Hs appeared to use such strategies with

success on a number of occasions (4.5%). Interestingly, C.N.M.Hs have little involvement with medication or physical nursing which is not well documented in other studies.

Certain general observations can be drawn for this data.

i) C.N.M.Hs use defined therapeutic programmes in casework.

ii) C.N.M.Hs use interpersonal methods in a number of their contacts.

iii) 'Common sense' alternatives are used in some difficult cases.

iv) Liaison and resource finding are high scoring activities for C.N.M.Hs.

TABLE 7.22

TREATMENTS AND THERAPEUTIC INTERVENTIONS USED BY ALL NURSES

TREATMENT THERAPEUTIC INTERVENTION USED	SUB-TOTAL	TOTAL	PERCENTAGE OF TOTAL
SPECIFIED THERAPEUTIC INTERVENTION			
BEHAVIOUR PROGRAMME			
OWN	21		
FROM PSYCHOLOGISTS	6		
COUNSELLING	4		
FAMILY THERAPY	4	35	11.4
SUSTAINING AND NUTURING NON SPECIFIC APPROACHES USING TERMS AS 'EXPLAIN', 'DISCUSS', 'FORM RELATIONSHIP', 'GAIN CONFIDENCE'		60	19.4
FIND NEW RESOURCES			
BENEFITS	4		
SITTING SERVICE	8		
DAY CARE	15		
SHORT TERM CARE	36		
ADULT TRAINING CENTRE	3		
LONG TERM CARE	5		
AIDS	6		
CLUB	6	83	26.8
MEDICATION (continue regime) (review regime)		15	4.8
CHANGING BEHAVIOURS BY 'COMMON SENSE' ALTERNATIVES		14	4.5
CONTINUE OBSERVATION AND ASSESSMENT		15	4.9
LIAISON WITH OTHER SERVICES (SOCIAL SERVICES) (HEALTH VISITOR) COMMUNITY OCCUPATIONAL THERAPIST		73	23.6
PRESCRIBED PROGRAMMES i.e. A, B, C, CHARTS MEKATON (SOMETIMES WITH OTHERS SUCH AS SPEECH THERAPISTS)		8	2.6
ARRANGE MEDICAL EXAMINATION		6	1.9
TOTAL		309	

INTRODUCTION TO PROBLEM OUTCOMES FOR THE CLIENTS OF COMMUNITY MENTAL HANDICAP NURSES

Following the established methods identified in section 7.2.2 four outcomes were allowed:-

i) Active

ii) Resolved

iii) Redefined

iv) Current

Casework lent itself to cross tabulation with a variety of other variables.

TABLE 7.23.1 PROBLEM OUTCOMES FOR ALL CLIENTS

OUTCOME CATEGORY	NUMBER OF PROBLEMS
ACTIVE	56
RESOLVED	172
REDEFINED	21
CURRENT	68
TOTAL PROBLEMS	317

Problem Outcomes

Tables 7.23.1 and 7.25.2 demonstrate total outcomes, outcomes cross tabulated by age, sex and nurse. Problems using total outcome measures show that resolution is the most likely outcome for all problems (54%). 18% of problems remained active, 7% were redefined into other categories and 21% were on-going when the project discontinued. When problem outcomes are adjusted to discount redefined and current problems, scores show 75.5% of problems are resolved and 24.5% of problems remain active. Chi squared testing for problem outcomes related to sex was not significant suggesting that clients had an equal opportunity of problem outcome regardless of sex.

Problem outcomes related to age showed that clients in the 16-30 age group were approximately 20% less likely to resolve their problems and that the two age extremes (0-4 and 41-60) were most likely to resolve their problems.

Individual C.N.M.Hs showed little variation in client outcomes with scores ranging around 68%-82% of problems being resolved for all C.N.M.Hs when outcomes are discounted for redefined and current problems.

Some problem groups showed a high resolution rate when discounted for current and redefined problems. Short term care 92%, lack of information re: client 100%, rejection of hospital services 83%, and screaming 85% all had high resolution rates. These high scores were not found in many

categories and proved to be the exception rather than the rule.

Finally, 55% of all cases were in contact with the C.N.M.Hs for between 3-12 months (Table 7.26). This length of contact is hard to determine with accuracy as the case dormancy principle described in Chapter Six may have been used before the case was considered closed.

General observations from problem outcomes suggest:

i) C.N.M.Hs working with clients can expect a high problem resolution rate.
ii) Certain problems are more amenable to intervention than others particularly those of short term care.
iii) Outcomes for male and female clients are not affected by sex.
iv) Some problems by virtue of the age of the clients affected, are less likely to be resolved.
v) Duration of active C.N.M.Hs with clients is usually between 3-12 months.

TABLE 7.23.2

PROBLEM OUTCOME CROSS TABULATED BY SEX

OUTCOME CATAGORY	NUMBER OF PROBLEMS	
	MALE	FEMALE
ACTIVE	36	20
RESOLVED	113	59
REDEFINED	16	5
CURRENT	41	27
TOTAL PROBLEMS	206	111

TABLE 7.23.3

PROBLEM OUTCOME CROSS TABULATED BY AGE

OUTCOME CATATORY	AGE GROUP								ROW TOTAL
	0-4	5-10	11-15	16-20	21-30	31-40	41-50	51-60	
ACTIVE	4	11	8	11	10	10	0	2	56
RESOLVED	20	46	33	25	14	10	16	8	172
REDEFINED	1	3	6	7	1	0	2	1	21
CURRENT	4	22	13	15	8	3	1	2	68
COLUMN TOTALS	29	82	60	58	33	23	19	13	317

TABLE 7.24

INDIVIDUAL CASE OUTCOME PROFILE FOR FOUR CNMN's WITH CONSISTENT CASE INVOLVEMENT THROUGHOUT THE STUDY

COMMUNITY NURSE	ACTIVE	RESOLVED	REDEFINED	ROW SUB TOTAL	CURRENT	ROW TOTAL	NUMBER OF CASES
W	8	39	7	54	27	81	27
X	7	20	0	27	3	30	13
Y	9	69	9	87	0	108	25
Z	10	22	0	32	17	49	20

TABLE 7.25.1

ALL PROBLEMS OUTCOMES AS A PERCENTAGE OF TOTAL (ADJUSTED TO DISCOUNT REDEFINED AND CURRENT PROBLEMS)

OUTCOME	ACTIVE	RESOLVED
PERCENTAGE OF TOTAL	24.5%	75.5%

TABLE 7.25.2

PROBLEM OUTCOMES SHOWING HIGH RESOLUTION RATES (ADJUSTED TO DISCOUNT REDEFINED AND CURRENT PROBLEMS)

PROBLEM	ACTIVE	RESOLVED
NEEDS SHORT TERM CARE	2	24
LACK OF INFORMATION RE: CLIENT	0	7
REJECTION OF HOSPITAL SERVICES	1	5
SCREAMING	1	6
SOILING AND URINATING	4	7

TABLE 7.26

DURATION OF COMMUNITY NURSE CONTACT FOR 80 REFERRALS

LENGTH OF CONTACT	UPTO 1 MONTH	2-3 MONTHS	3-6 MONTHS	6-12 MONTHS	OVER 12 MONTHS
NUMBER	5	12	20	32	11
PERCENTAGE OF AGE	6.2	15	25	40	13.8

Discussion of Problem Orientated Casework and Community Mental Handicap Nurses

The problem orientation of casework for community mental handicap nurses has allowed some detailed examination of their work.

It has provided a philosophical paradigm to casework and because of its itemizing approach has fitted in well with the behaviouralist influences currently popular in caring for mentally handicapped people. P.O.A. has allowed data gathering which gives some general pointers as to the involvement of C.N.M.Hs with mentally handicapped clients and their families.

1) C.N.M.Hs are recognised as a valuable resource in the community mental handicap team and act as access to some facilities.
2) C.N.M.Hs demonstrate a width of responses to requests for intervention. These may be in either family centred or psychotherapeutic methods.
3) The clients of C.N.M.Hs demonstrate a full width of problem presentation within the categories defined for the study.
4) The effect of C.N.M.Hs intervention is largely successful. Clients show a high resolution rate upon discharge.
5) It is possible to use a categorization (Delphi) list to process casework which has been problem orientated. The list shown in Chapter 11 is suitable for general use in

this purpose.

The overall acceptability of P.O.A. to the team has been good. The system is being used at the time of writing up the project data and staff believe it is suitable as a framework for action.

Once again (as for the psychiatric nurses) the everyday data collection of problem centred activities on a day to day basis will need the provision of a computer based and user friendly package on a mini system.

CHAPTER EIGHT

CHAPTER EIGHT

IN-SERVICE TRAINING AND EDUCATION

8.1

RATIONALE FOR IN-SERVICE TRAINING AND EDUCATION

In-service training and education was an established element of the study, however, its locus and starting point changed as the study progressed.

In-service training and education was originally designed to be a response to skills deficits which might be highlighted by data collected from the P.O.R. data sheets. This original paradigm had to be abandoned because of a delay in suitable information from the data sheets, but more importantly because information gathered from the audit review indicated that nurses were already aware of skills they had not got and were demonstrably interested in pursuing certain 'skills trainings'. In-service training and education was therefore tailored to the expressed needs of the nurses in the first instance. As training progressed and new casework practice methods were precipitated which required educative attention, they were brought into the programme.

The author recognised a number of constraints in providing education and training programmes. These constraints centred around i) the availability of skilled teachers, ii) provision of the right 'width' of therapeutic skills, iii) an awareness that not all nurses wished to be 'therapists'.

Solutions to these constraints were found which were satisfactory enough to allow this element of the study to proceed. Firstly, the author had access to a number of skilled therapists and trainers through contacts in Higher Education and clinical practice. Secondly, it had been the experience of the author and others[1][114] that there are certain key strands to the therapeutic strategies which those working with the mentally disordered and handicapped can employ. These key strands are seen to revolve around psychodynamic, behavioural and counselling therapies, it was therefore appropriate to give opportunity to use these approaches in the programme as they fitted with the expressed needs of the nurses themselves. Finally, programmes would be designed to act as an incentive to those who wished to develop further skills and not as an imposition of specific ideologies upon practice.

8.2

INTACT TEAM TEACHING

Intact team teaching is a method of bringing education and training to a whole team in a centre of practice rather than teaching individuals away from active practice and expecting them to apply new methods to their work.

Although evidence is slim in support of this in nursing as a methodology, it has been the experience of the author and a number of colleagues that to teach in this way is more successful than trying to change single team members. The

're-entry' phenomenon experienced by nurses going back to unchanged teams is constantly reported by practitioners attending E.N.B. Courses No's 805 and 810. Group dynamics bring an added element in intact team teaching which surfaces as group pressure and a cohesiveness to maintain change. Programmes were constructed around the Psychiatric and Mental Handicap nursing teams and small sub-groups of these teams were used where teams were too large for teaching purposes. Nurses' own casework was seen as a central point for any teaching and their own practice experiences as fundamentally important.

A provisional programme was drawn up with expert advice from practising therapists. Counselling skills were recognised as fundamental to all nurse-client interactions and following a broad introduction to the method, nurses would need to examine self-awareness, personal awareness in interaction and personal space, communication, nurse-client interactions, role play experiences and an introduction to transactional analysis as an example of casework methodology.

Behavioural Psychotherapy was seen as a second cornerstone to practice. The community mental handicap nurses had attended a variety of behavioural based workshops and their practice reflected an expertise in this area. They chose therefore, not to be involved in these sessions. Psychiatric nurses were seen to need inputs on objective measures, goal setting, deep muscle relaxation, role plays of behavioural approaches and client participation through work diaries. One precipitant of sessions on counselling and behavioural psychotherapy was that

the concept of supervision in practice became a subject which required more detailed attention than anticipated. A series of extra sessions was built into the programme and is reported in detail later in this chapter.

The third element was seen to be family therapy. Family work is a known prime activity from other studies[28][29] for community nurses. Family therapy was seen useful as both a therapeutic method and as a vehicle for examining family/therapist interactions. This could be achieved by an introduction to therapy methods, supervision as a live relationship, conjoint therapy, making contacts and first sessions, dealing with impasses, structured family therapy, family cycles, methodologies and access to further training.

Experts were found for the sessions and detailed programmes were worked out between the researchers and experts themselves. Content was left in detail to the presenter but the framework was commonly agreed to be that previously described.

Experts were paid by monies from the project and in total each nurse had 30 hours of expert teaching available to them.

The fine detail of programme content for behavioural psychotherapy, counselling and family therapy is to be found in the appendix as the programme content is extensive and therefore more appropriately moved from the main text. This chapter concentrates upon a central issue which arose from the teaching inputs namely; case supervision.

8.3.

CASE SUPERVISION (EXTRAVISION)

Evaluations from the programmes plus evidence from the research assistant's relationship with practitioners through the P.O.R. data sheets, highlighted a known but undocumented feature of community nurse work.

Nurses lack a system of 'case supervision' between practitioners and reviews of their practice experiences were largely absent. Nurses met on an informal and formal basis but the substance of these sessions was not specifically directed towards casework in a constructive way. Breaktime sessions were cathartic, line management meetings were largely investigative rather than supervisory and team meetings, although sometimes case centred, were often too large for personal discussion and lacked a specific direction or tangible form. This information had also been highlighted by the initial audit of the teams.

These observations began to crystalize at a point in the project where the next sub-programme was to be centred upon family therapy which coincidentally uses the nurses' own case material as a focus. Presentation method of case material became increasingly important and a willingness to be open and examine self practice was central to participation in the family therapy sessions. The two issues of case presentation and supervision were linked and it was considered appropriate to spend time in examining how these elements could be brought

into a training programme, but, more importantly, how the nurses felt about them.

A 'brainstorming' meeting was held in order to provide a starting point and establish some principle ideas.

Prior to this meeting the author looked extensively for material to build upon in order to place case supervision in a theoretical framework. The notion of supervision is well established in such professions as social work and psychology but appears to be largely absent in the nursing profession.

There is considerable confusion in terminology and terms such as clinical supervision, peer review and clinical review are used interchangeably. Clinical review and supervision as used in the U.S.A. and Australia are marked by their connections with work standards and performance levels. This interpretation is nicely summarized by O'Loughlin and Kaubach[116] who describe peer review as "a process by which practitioners of the same work, profession or setting, critically appraise each other's work performance against established standards". Similarly, O'Callaghan[117] describes clinical review as "a mechanism whereby an equal evaluates the work of an equal". The author saw supervision as an enabling relationship not overshadowed by attainable performances or specified standards. This view is one of Pettes who says "supervision is a process by which one practitioner is accountable to another practitioner to help him practise to the best of his ability". Relationships between nurses would therefore, have to be nurturing and helpful in encouraging

them towards a new openness in casework where supervision of practice would develop between practitioners.

A meeting was held and the conceptual framework to case supervision openly discussed with some attempts being made to anchor a common consensus of what case supervision would be. A number of principle points were made by the meeting:-

1) There was general, but not unanimous, agreement that some form of case supervision was needed.

2) The term 'supervision' was not liked by some of the nurses, it was seen to be a somewhat 'sinister' title and implied a supervisor/novitiate relationship. The term 'extravision' was agreed upon in the short term.

3) Nurses agreed to a trial programme which would contain two x two hour sessions during which nurses would present cases to an 'outside' expert supervisor and three of their peers. This programme allowed each nurse to present a case and be helped through their presentation by the 'outsider' and their peers. Criticisms of practice and questions of the practitioner were to be seen as a building exercise towards more conscious practice methods.

4) At the end of these sessions, groups would take over case presentations and the outsider would withdraw.

5) The small groups of four would form the basis for family therapy training sessions which would follow on from supervision sessions.

6) All nurses would meet after the family therapy sessions to discuss the viability of continuing small groups for case supervision.

Given this support by the nurses they were divided into four groups, one for the community mental handicap nurses and three for the community psychiatric nurses. A programme was devised for each group as shown below. As can be seen from the programmes, sessions were designed to run into the family therapy programme. Case sessions are not written up in detail as the presentations were so varied and the direction of discussions took many forms, however, a general rule of thumb was as follows:-

i) Cases were introduced and presented by the responsible practitioner.

ii) Comments were made throughout the presentation if presentations were unclear or confusing.

iii) Nurses were asked to justify choice of interventions and how case analysis was made.

iv) General discussion took place on how the case had been managed and what alternatives might have been used.

v) Credit and criticism was used with equal favour.

It was the experience of the author (and the other supervisors) that some nurses opted for tightly controlled and successful cases which were hard to criticize and comment upon. Other nurses diplayed an immediate openness and brought cases with which they had been stuck or unsuccessful. This in itself generated discussion as to case choice and enabled a series of points to be raised on 'openness' in casework, and the traditional reluctance of nurses to be seen to have 'failed' or lost for direction in casework.

TIMETABLE GROUP 1

EXTRAVISION

SESSION 1	TUESDAY	6-11-84	2 - 4 p.m.
SESSION 2	TUESDAY	13-11-84	2 - 4 p.m.

GROUP MEMBERS

(Please prepare a case study for the session number indicated in brackets.)

Colin McPartland (1)
Glynn Goodchild (2)
Shirley Cobban (2)
Karen Price (1)

GROUP LEADER/SUPERVISOR

Tony Butterworth,
Principal Lecturer,
Project Leader.

FAMILY THERAPY

SESSION 3	WEDNESDAY	21-11-84	2.30 - 4.30 p.m.
SESSION 4	WEDNESDAY	28-11-84	2.30 - 4.30 p.m.
SESSION 5	WEDNESDAY	5-12-84	2.30 - 4.30 p.m.
SESSION 6	WEDNESDAY	12-12-84	2.30 - 4.30 p.m.

GROUP MEMBERS as above.

GROUP LEADER

Jane Harper,
Lecturer,
Manchester Polytechnic.
Therapist, Brindle House,
Hyde.

VENUE:- Conference Room,
Department of Psychiatry,
Stepping Hill Hospital.
Except - SESSION 3 which will be held in the Research Office (David Rushforth's room).

TIMETABLE GROUP 2

EXTRAVISION

SESSION 1	WEDNESDAY	7-11-84	10 a.m. - 12 p.m.
SESSION 2	FRIDAY	16-11-84	10 a.m. - 12 p.m.

GROUP MEMBERS

(Please prepare a case study for session number indicated in brackets.)

Elaine Fitton (2)
Ruth Dube (1)
Linda Lowe (2)
Lindsay Harrop (1)
(Jenny Cross)

GROUP LEADER/SUPERVISOR

Jean Faugier,
Lecturer,
Manchester Polytechnic.

FAMILY THERAPY

SESSION 3	FRIDAY	23-11-84	2.15 - 4.15 p.m.
SESSION 4	FRIDAY	30-11-84	2.15 - 4.15 p.m.
SESSION 5	FRIDAY	7-12-84	2.15 - 4.15 p.m.
SESSION 6	FRIDAY	14-12-84	2.15 - 4.15 p.m.

GROUP MEMBERS as above.

GROUP LEADER

John Archer,
Therapist - CPN,
Brindle House, Hyde.

VENUE:-

Conference Room,
Department of Psychiatry,
Stepping Hill Hospital.

TIMETABLE GROUP 3

EXTRAVISION

SESSION 1	FRIDAY	9-11-84	10 a.m. - 12 p.m.
SESSION 2	FRIDAY	16-11-84	10 a.m. - 12 p.m.

GROUP MEMBERS

(Please prepare a case study for the session indicated in brackets.)

Bob Cousins (2)
Chris Cornwell (1)
Derek Baker (1)
Ruth Dube (2)

GROUP LEADER/SUPERVISOR

David Rushforth,
Research Associate.

FAMILY THERAPY

SESSION 3	FRIDAY	23-11-84	2.15 - 4.15 p.m. (joint session)
SESSION 4	FRIDAY	30-11-84	10 a.m. - 12 p.m.
SESSION 5	FRIDAY	7-12-84	10 a.m. - 12 p.m.
SESSION 6	FRIDAY	14-12-84	10 a.m. - 12 p.m.

GROUP LEADER

Lynn Bradley,
Social Worker/
Family Therapist,
Prestwich Hospital.

VENUE:-

Conference Room,
Department of Psychiatry,
Stepping Hill Hospital.

TIMETABLE GROUP 4

EXTRAVISION

SESSION 1	FRIDAY	9-11-84	2.30 - 4.30 p.m.
SESSION 2	FRIDAY	16-11-84	2.30 - 4.30 p.m.

GROUP MEMBERS

(Please prepare a case study for the session number indicated in brackets.)

Deryn Diamond (1)
Doreen Gilmour (2)
Andrew Myers (2)
Maureen Graver (1)

GROUP LEADER/SUPERVISOR

Brian Hodges,
Lecturer,
Manchester Polytechnic.

FAMILY THERAPY

SESSION 3	TUESDAY	20-11-84	10 a.m. - 12 p.m.
SESSION 4	THURSDAY	29-11-84	2.30 p.m. - 4.30 p.m.
SESSION 5	FRIDAY	7-12-84	2.30 p.m. - 4.30 p.m.
SESSION 6	FRIDAY	14-12-84	2.30 p.m. - 4.30 p.m.

GROUP MEMBERS as above.

GROUP LEADER

Tom Tomlinson,
Lecturer,
Manchester Polytechnic.

VENUE:-

Treetops,
Dale Road,
Marple,
Stockport.

8.4

Evaluation of and precipitants from case supervision

Case supervision was evaluated at the end of the family therapy programme. The principle and practice of case supervision was found to be extremely useful by all but one participant.

A general decision was made to continue with the sessions, the impetus for which would come from the group members themselves. The E.S.M.I. nurses felt that their existing team meetings fulfilled this purpose and that they did not require any extra meeting time. Other nurses decided to afford specific time towards case supervision which is discussed further in a more detailed evaluation of case supervision, and took on board responsibility for organizing and maintaining regular meetings.

In a short programme of experience such as this, any significant observations are tinged with the knowledge that only a longitudinal exposure to a system of case supervision can produce meaningful information. Nonetheless, it is possible to tie in some of the usefulness of case supervision for these teams with observations from previous research and changes in the role of community nursing.

1) Provision of Security -

Chapters 2 and 3 of this thesis have pointed out some characteristics of nurses moving to community work. Their exposure to new practice, challenge of establishing good practices, debasement of medical practice and the search for an ideological framework all provide the nurse with feelings of insecurity.

Case supervision provides nurses with a method of examining their own practice and provides a platform upon which good practice can be validated. By this constant process nurses become increasingly confident in their practice ability, but equally less afraid to seek help and critical comment from their peers.

2) Establishing New Principles -

New practice requires new principles. The traditional training of psychiatric nurses does not encourage nurse initiatives in case presentation. Community work has placed nurses in a position where they become key workers and, temporarily at least, assume responsibility for casework. This responsibility means that nurses will have to present cases in an articulate and comprehensive manner to multidisciplinary groups who may wish to challenge nursing actions. Case supervision allows nurses to establish confidence and competence in case presentation from which they can then generalize for future occasions.

There is also a felt need to establish 'case law' for community nurses. As time progresses, certain principles of casework become established, such as the management of medication or the handing back of cases following discharge from active care. These principles are seldom documented or reviewed but it appears that case supervision allows embryonic case law to surface and then become established. Equally established case law which has become unsatisfactory, such as transporting patients or consultant only referrals, become exposed to repeated scrutiny and therefore progressively change.

3) Training and Supervision -

With two new basic nurse training curricula in psychiatric and mental handicap nursing, renewed pressure is being brought to bear on community nursing teams to provide training and education. The content of both curricula has a hearty community bias which will have to be met in part by community nursing teams. Case presentation and supervision brings new life to old practices and the traditional apprenticeship scheme of nurse education takes on a different emphasis. Modeling expert tuition observation and criticism of practice are all part of case supervision and there is no doubt that students as well as practitioners benefit from case supervision sessions.

4) Stress Reduction -

Working as a lone practitioner brings additional stress to nurses when they are involved in community work. A number of reviews in the nursing press point to two current issues in relation to stress. Firstly the possibility of 'staff burnout' and secondly, the pressure of unremitting stressful environments community psychiatric and mental handicap nurses are exposed to both these difficulties and case supervision appears to affect how they are perceived.

It is the experience of the author, both in this project and from case material on course work (such as that seen in the pilot studies), that nurses become 'stuck' with cases and feel overburdened by some of the emotional content of others.

Community nurses hear distressing and emotionally disturbing cases every working day and need to relieve themselves of this emotional burden by 'talking out' the traumatic content. They also become involved in cases which are just not ammenable to change or fail despite that nurse's intervention. 'Stuckness' and failure both require a means of resolution and case presentation can provide a vehicle for this.

The Nightingale tradition of being 'all things to all men' does not allow nurses to accept failure (See Menzies[105]) and impasse with ease, and to change case law to allow stress relief and emotional discharge will take time. Signs from the project indicated that nurses would need prolonged opportunity to allow this but they had nontheless made the first steps through case supervision and review.

CHAPTER NINE

9.0 ORGANIZATIONAL INCIDENTS AND RESPONSES

9.1 CHANGES IN TEAM PHILOSOPHIES

9.1.1 THE C.P.N. SERVICE

9.1.2 THE C.N.M.H. SERVICE

9.2 THE CAPTURE OF ONE-OFF VISITS

9.3 ANALYSIS OF MONTHLY STATISTICAL RETURNS

9.0

ORGANIZATIONAL INCIDENTS AND RESPONSES

The deliberate intention of the study to be a resource for the nursing teams has been described in the methodology section (4.4.8)

Within this intention it was important to strike a balance between being intrusive and diffident towards the growth and change process going on within the teams. Intrusiveness would interfere with the normal manager/staff relationship. Equally, too much time devoted to matters outside the inner core of the study would distract efforts from the central purpose of the O.D. programme. Matters for attention were therefore selected carefully for the attention they should be given.

The study team contributed in many minor ways to the provision of documentation, utilization of District resources and establishing contacts with outside bodies. This chapter describes 3 major 'incidents' which had a fundamental effect on the change process of the teams involved. It is difficult to quantify the impact of the study upon these events. Two would have occured naturally without the presence of the study team, the third was precipitated by the study itself.

9.1

CHANGES IN TEAM PHILOSOPHIES

9.1.1

THE C.P.N. SERVICE

Section 6.2.1 states in a summary of the initial audit of the community psychiatric nursing team "There is an absence of philosophical framework for the team" and goes on to suggest that C.P.Ns feel the need to restate aims and objectives for their service.

Management of the C.P.N. team went through a number of changes throughout the life span of the study. The nursing officer left to take up a new post one year into the study period. His successor was not appointed until 8 months later. This was a consequence of the appoinment of a new Assistant Director of Nursing Services who had himself to be appointed and then employ a new nursing officer for the service. The completion of these new appointments took some time and during the 8 months hiatus, the charge nurses and sisters took turns in 'acting up' as the nursing officer.

Not surprisingly little attempt was made to set up new policies and operational philosophies. With the appointment of a new nursing officer (himself a practising and experienced C.P.N.) new attention was given to developing an operational philosophy and developmental plan for the service.

The District Authority was experiencing locally; the national phenomena of a rapid growth in community care for the mentally disordered and an equal growth in the number of funded posts for C.P.Ns. (See TABLE 2.4.) Bids for posts were being encouraged by the N. W. Regional Health Authority and Districts were guaranteed posts (within specified growth limits) if a properly agreed case was put forward. This made the production of a statement of aims and objectives for the services all the more vital as the newly funded posts would need to be sited within a developmental framework.

The District Nursing Officer, Director of Nursing Services and the Assistant Director of Nursing Services all made clear their support for the development of a dynamic and more responsive C.P.N. Service. This was made public at a meeting coincidently organized by the study team to present an update on project information. All service managers were present and the nursing officer took the opportunity to present an initial case for changing the future of the C.P.N. team development. The focus of his agreement was a need to open up the team to a geographical location and an open referral system (such as that described in Chapter 3 [3.2.3].

His ideas were given the support of senior managers and he was asked to produce an operational philosophy to mobilize the change process.

The study team had a series of meetings with the nursing officer and discussions took place about the production of a suitable document. Guidelines for producing an operational philosophy were requested from and given by the author. The guidelines are reproduced below, and although less than complete as an instructional guide, provide an introduction to the notion of building up and committing to paper an operational philosophy.

Within this basic framework the nursing officer wrote a provisional document and worked towards producing a comprehensive statement of team activity. His attempts were not helped by the piecemeal development of the team and an absence of previous aims and objectives. As a consequence, his first document was a very full statement of past, present and proposed activities for the C.P.N. Service.

The aims and objectives are reproduced in this chapter. The document was produced in partnership with nurses in the team and represents a benchmark in describing a service framework. It was initially presented to senior managers 4 1/2 months after the initial meeting and a final 'action' version produced at the end of the study period.

Although the document has flaws and does not state precisely how future efforts are to be attained, there is no denying its impact which can be summarized as follows:-

i) It crystallizes the purpose and intentions of the C.P.N. team.

ii) Its acceptance by senior managers validated what had previously been covert attempts to bring in an open referral system.

iii) It clarified the status of the G.P. attachment scheme which had become an open-ended trial without completion and was in danger of losing its value.

iv) It allowed senior managers to plan more specifically for future manpower demands for C.P.Ns.

OPERATIONAL PHILOSOPHY

SOME GUIDELINES

1. INTODUCTION

An operational philosophy should provide a statement of intention as to the purpose and direction of a CPN Team. It may demonstrate one, or include all of the following patterns :-

1.1 Fixed It may describe what the team is doing her and now, whether or not it is the diesired state of affairs.

1.2 Developmental It may describe the processes which the team has gone through to arrive at its present state and the directions it wishes to go in.

1.3 Determinal The proposed objectives of he team may well determine the direction in which it wishes to go. In this instance the ultimate objectives which the team wishes to pursue will force decisions and policies upon the team which at this point in time may appear unreasonable.

2. ORGANISATIONAL STRUCTURE

Any statement of operational philosophy should include statements about

2.1 Team base and mechanics of operations :- i.e.

i. source of referrals

ii. methods of commissioning referrals

iii. procedure for discharge and passing on of information

2.2 Division of labour (Who will do what and how). Such matters as professional discipline, accountability and intra professional supervision will be observed.

2.3 Distribution of labour Where the team fits in terms of servicing, multidisciplinary team structure etc.

3. Review of skills on offer and how the service is providing a needed facility.

4. Presentation of a developmental plan to give information upon the in-service training needs, personal development needs and changes in operational philosophy which can at that point in time be anticipated.

CAR/CMB

'AIMS AND OBJECTIVES FOR THE STOCKPORT C.P.N. SERVICE'

An abstract from 'BUILDING TOWARDS THE FUTURE' a document of operational philosophy for the Stockport C.P.N. Service.

AIMS AND OBJECTIVES FOR THE C.P.N. SERVICE

The following aims and objectives must be considered if the department can fulfil its function in dealing with the mental health of people in the community.

The C.P.N. Department is the subject to growth and development which up until this point in time has been incremental with the Consultant Psychiatrists.

Taking into account the present situation where nurses travel long distances between visits and bearing in mind the amount of nurses who may become available to the Community Psychiatric Department, firm plans must be made to accommodate the growth.

If we plan to just keep adding C.P.Ns to the Consultant teams then the cost will come prohibitive. A new plan for the department must be provided and this plan must take growth into account.

Geographical Sectorization of C.P.Ns

An acceptable alternative to the present organization and structure of the C.P.N. Department would be to geographically sectorize the team so instead of each C.P.N. working with paticular Consultants, the C.P.Ns would work within basic geographical locations. This sectorization should be the first of two stages in the reorganization of the C.P.N. Department.

STAGE 1

C.P.Ns should become responsible for providing psychiatric nursing care for patients who live in defined area. This change in philosophy would effect the department as follows:-

Referrals

The method of referral should remain the same, i.e. the C.P.Ns should only receive referrals from Consultants and referrals should be made on the existing referral forms. These should then be handed to a central point (the Nursing Officer), who then allocates referrals to appropriate C.P.N Teams. Referrals should be accepted on merit.

Injection Clinics

Patients who can attend clinics for injections should be gradually encouraged to do so; this would relieve C.P.Ns from time consuming work. Patients who attend psychiatric out-patient clinics could also be transferred to local Health Centre Clinics.

Local Resources and Services

C.P.Ns should familiarize themselves with local services and resources, this could partly be achieved by an induction programme which places emphasis on community rather than hospital as is the present procedure.

C.P.N. Base

The C.P.N. base should remain the same for the time being, although office space is extremely cramped. If the C.P.N. Department develops to anything like the regional estimates consideration must be given to changing the C.P.N. base into the community, perhaps into Local Health Centres. I feel it is important to keep the department together and avoid creating separate teams, e.g. for Consultant base at the Psychiatric Unit and a team working in the primary care situation based in Local Health Centres.

A large drawback to the present system is the lack of access to the department, this lack of access must make the department less effective. Future basing of the C.P.N. team within the local community would make the service more accessible and therefore more effective.

Education

Hospital wards and departments should be kept informed of the changes and the reasons why the changes should take place. C.P.Ns should also keep local Community Services informed about the change in role of the C.P.N. Eventually C.P.Ns should become involved in meetings of other disciplines, i.e. Social Service Teams and the Primary Care Teams. This will help ease the department into its new community role.

STAGE 2

Eventually the role of the C.P.N. in the Stockport District Health Authority must change from one of dependence on Consultants to one of independence (in the sense of Practitioner) and interdependence (in the sense of the teamwork approach reference: Carr, Butterworth and Hodges - 'Community Psychiatric Nursing'.

The department should also establish a selective open referral system.

N.B. By 'selective' I mean that the department should be allowed to choose whether or not to accept a refferal or not.

The base must become accessible to the consumer and referring agencies, so it must be sited at a convenient place in the community, in easy reach of its users.

AIMS AND OBJECTIVES OF C.P.N. DEPARTMENT

Aims and objectives for the Community Psychiatric Nursing Department.

AIMS

1. To geographically locate nurses.
2. To implement an open referral system.
3. To fully utilize post basic training available to community staff.
4. To plan growth within the department.
5. To provide incentives to work/enhance work within the department.
6. To provide injection clinics in the community with medications prescribed by general practitioners.
7. To minimise the use of community services for transport of patients to therapeutic locations.
8. To extend the E.S.M.I. C.P.N. Team and create a management structure for this speciality.
9. To educate all relevant parties in the functions of the C.P.N. Team.
10. To provide comprehensive statistical information.

OBJECTIVES

1. To provide a more comprehensive service community staff more orientated to a specific geographical area.
2. To enable a community staff to be available to all agencies for advice and referral.
3. To provide all community staff with the appropriate skills to carry out duties.
4. To allow all staff concerned with the department the opportunity to be involved in the future planning and needs of the deparment.
5. To ensure that staff working in the department and wishing to work in the department have a clearly defined development programme.
6. To remove the need for staff to provide injections within the hospital setting and minimise the need for injections to be administered at patients' homes - and to help spread the cost of medication to the community.
7. To use the C.P.N. appropriately and not first as an 'errand' service.
8. To accept the differing needs of the elderly mentally infirm in the community and look carefully at the structure of the team giving this care.
9. To remove the 'mystique' surrounding the community team by ignorance or other parties.
10. To evaluate the needs of the patients in the community and the need for our department to adapt to changing circumstances.

9.1.2

THE C.N.M.H. SERVICE

The community mental handicap nursing service had already devised an identifiable philosophical framework based upon the concept of a 'District Handicap Team' model, encouraged throughout the North West Regional Health Authority.

The C.N.M.Hs are absorbed to some extent within this multi-disciplinary framework and although nurses are mentioned specifically within the document, many of the aims and objectives are multi-disciplinary.

The document was issued in December 1983. The study team played no part in its writing but it is reproduced here for the sake of completeness and as a record of a statement of organizational development within the study timetable.

STOCKPORT HEALTH AUTHORITY

COMMUNITY MENTAL HANDICAP SERVICE (ADOLESCENT/ADULT)

OPERATIONAL POLICY

1. INTRODUCTION

1.1 The Community Mental Handicap Service comprises a group of professional workers in a number of disciplines and is an essential pre-requisite to effective community care for people with a mental handicap. Those caring for such people should have easy access as appropriate, to advice and support on a wide range of clinical and social issues.

1.2 The Community Mental Handicap Service will be involved with people with a mental handicap from school leaving age onwards and those concerned with their care, within the boundaries of Stockport Health Authority.

2. AIMS AND OBJECTIVES OF THE COMMUNITY MENTAL HANDICAP SERVICE

2.1 To co-ordinate the services required for each individual and his family and to act as a local point of contact.

2.2 To provide the necessary specialised aid and support needed by people with a mentl handicap, at home or in residential accommodation. Through co-operation with residential services, day services and primary care

services, appropriate programmes of education, training, treatment and recreation will be provided.

2.3 To offer either direct services to the person with a mental handicap or to provide additional support to existing primary care services as required.

2.4 To assess and monitor each person with a mental handicap by means of an individual programme plan drawn up by members of the Community Mental Handicap Service and/or by the appropriate staff in residential or day placement establishments. Each person with a handicap will be offered a regular routine health screening programme. In addition to routine medical assessment, dental screening programmes are also operative.

2.5 To liaise with the Residential Services Group at Offerton House and to support those people recently discharged from N.H.S. accommodation.

2.6 In addition to intervention as and when problems arise, the Service will also aim to prevent wherever possible, problems occurring in the future by helping to co-ordinate programmes of short-term and respite care and by offering education and training in client management techniques to all those who care for people with a mental handicap, whether professionally or as parents.

2.7 It is proposed that the first contact with people with a mental handicap will take place at the school leaver conference, where the initial individual programme plan will be devised. The Child Health Service will,

however, remain responsible up to school leaving age.

2.3 To assist, through the Senior Clinical Medical Officer, in the reduction of genetically determined handicap in the future, by advising people with a mental handicap and/or their relatives of the appropriate genetic counselling services available.

2.9 To formulate and maintain close links with voluntary organizations.

2.10 To be subject to continuous evaluation from both internal and external sources, and to be responsive to changing needs and demands.

3. ORGANIZATION OF THE COMMUNITY MENTAL HANDICAP SERVICE

3.1 The Community Mental Handicap Service as a whole is available to provide advice to other professionals working in mental handicap in day and residential accommodation and will co-ordinate the services for people with a mental handicap as required. The service provided will be mainly domiciliary and will complement but will not replace, primary care services provided by either the Health Authority or by the Social Services Division.

3.2 The disciplines comprising the Community Mental Handicap Service are as follows:-

Nursing

Medicine

Social Work

Psychology

Occupational Therapy

Physiotherapy

Chiropody

Speech Therapy

Dentistry

Careers

Each discipline retains an independent professional role in addition to having a role within the Community Mental Handicap Service. Voluntary organizations and parents representatives are encouraged to contribute and participate in the Community Mental Handicap Service.

3.3 Disciplines within the Community Mental Handicap Service will maintain close links with statutory and voluntary agencies and will have joint and individual professional links with other health and local authority services. Members of the Service will meet periodically as a Steering Group. Their responsibility will be to initiate, co-ordinate and monitor developments in community services to mentally handicapped people, to create a context in which the front-line staff can work effectively; and to maintain effective liaison between the agencies represented and with other relevant agencies. The group will produce objectives and plans for implementation for consideration by the Unit Management Team and other relevant managers.

3.4 Community Mental Handicap Team
(including decentralized sub-teams)

Within the Community Mental Handicap Service the disciplines of nursing, medicine, social work and psychology will meet together regularly and will be described as the Community Mental Handicap Team. Other disciplines within the Service will contribute to Team meetings as necessary. As the strength of community nursing and social work within the team develops, it is planned to form a number of sub-teams comprising these two disciplines. These will each serve a particular area of Stockport and have their main base within that area, whilst coming together regularly with other members of the Team.

3.5 Membership of Community Mental Handicap Team

Community Nursing Officer and Community Nurses
Senior Clinical Medical Officer
Social Worker(s)
Community Psychologist

The team will act a partners to those caring for people with a mental handicap and can provide specialist advice and practical help with difficulties such as adverse behaviour, financial and emotional stress, learning and development problems. Short-term care or day care with appropriate agencies may be arranged as necessary.

Although there will be a certain overlap of roles within the Team, each member will have specific skills as follows:-

(a) The Community Nurses will offer special skills as trainer/teacher of adults with a mental handicap, especially in relation to the development of self-help skills such as feeding, toileting and dressing and as co-therapists with parents or carers in the correction of behaviour problems with the co-operation of the Psychologist. These services may be provided for children by arrangement with the Child Development Unit.

(b) The Senior Clincal Medical Officer or other nominated community health doctor will be responsible for the assessment of the medical needs of adults with mental handicap and will be involved in routine medical screening and specialist sensory screening as necessary. The Medical Officers will maintain contact with the family doctor.

(c) The Psychologist will be responsible for all adults with mental handicap and provide specialist advice and expertise in dealing with behavioural problems, the assessment of learning deficits, the evaluation of intervention procedures and the assessment of differing psychological therapies and their contribution in meeting the needs of people with mental handicap.

(d) The Social Worker will support the whole family in their changing attitudes towards the member with a mental handicap and help them face problems in a positive way. The Social Worker will take into account attitudes of siblings and neighbours, and will be concerned with community activities and with the possibility of involving other individuals and groups in the provision of alternative ways of supporting families to enable the person with a mental handicap to develop their potential and lead as normal a life as possible.

(e) Secretarial support will be provided by the secretaries of the respective members of the Team, who will maintain files, receive telephone calls and may attend case conferences as appropriate.

3.6 Not withstanding the particular roles described above, the team members share the responsibility for providing a reliable and flexible service to mentally handicapped people and their families. They will ensure by the way they work together that the service does not become fragmented.

9.2

THE CAPTURE OF 'ONE OFF' VISITS IN THE COMMUNITY PSYCHIATRIC NURSING TEAM

As the study became established and nurses were presenting problem Orientated casework for data collection, it became apparent that case numbers did not include visits to clients which were classified as 'one offs'. A summation of casework showed the following:-

ANALYSIS OF CASEWORK

TOTAL 'ONE OFF' REFERRALS PER MONTH	167
CASES WHERE APPROPRIATE NURSING CARE WAS GIVEN ON A ONCE ONLY BASIS	95
MISSING CASES	72

'One off' cases were those which nurses categorized as situations where longitudinal casework was not needed. They did not become problem orientated in the usual way and were escaping the attention of the study. Although such cases appeared in the statistical returns to nurse managers, it became apparent upon closer examination that some very definite casework activity was taking place. Further analysis of 'one offs' demonstrated that they could be categorized into two distinct groups as follows:-

GROUP A - visits which were part of interdisciplinary goodwill -

Casework of this nature included holiday cover for CPN colleagues and other disciplines and was carried out to ensure client safety and will being rather than to engage in specific therapeutic action. These situations were largely temporary

and very necessary to maintain effective nursing cover.

Other casework in this group was to clients defaulting for an out-patient appointment or day hospital session. In some instances client were already on the nurse's caseload but in some others it is certain that nurses were 'policing' clients on behalf of other professional and not engaging in therapeutic activity. Finally in this group were clients transported by CPNs to appointments or home from wards. These trips were sometimes carried out for clients not on the CPNs own caseload. There was a definite split amongst nurses who would not 'taxi' clients as a matter of principle and those who saw it as an integral part of CPN work.

GROUP B - referrals where only one visit was required - These visits were undertaken where nurses went to see clients with specific short term action in mind. The following serve as examples:-

- to give instruction on a medication taking regime and advise on the possible consequences of side effects.
- to assess the home environment/climate following a client's discharge from hospital.
- to handle a crisis situation which was resolved on the spot or before the nurse had arrived.

Such was the nature of these cases that they were seldom problem orientated as the P.O.A. procedure outweighed the short term nature of the contact. However, in a number of

cases it was discovered that some clients were becoming repeatedly 'short term' thus presenting an impression of short contact for what was in fact long term casework. This was not always realized by the nurses themselves or their managers. Within this group were two elements of casework which were being overlooked and, unintentionally undervalued as therapeutic activity. Firstly, there were short term but valuable 'one offs' which required no further action and secondly, there were short term contacts which built up into longitudinal casework. Steps were taken to analyse this data more completely and a return sheet for 'one offs' was devised and is shown below.

The study recognised that not all 'one offs' needed to be problem orientated, equally there were a number that could be. A brief discussion paper was produced and following a meeting of the team nurses agreed to the following:-

i) all major casework would be problem orientated as before

ii) referrals where repeated short term action became a longer term commitment would be problem orientated

iii) short term action which was easily problem orientated would be processed like i) and ii)

iv) nurses would complete a monthly return sheet as shown above in order to look more closely at the 'one off' phenomena.

ANALYSIS OF MONTHLY STATISTICAL RETURNS

TABLE 9.1 'ONE OFF' RETURNS FOR OCTOBER 1984

ITEM	TOTAL
A. HOLIDAY COVER VISIT	30
B. DEFAULT FOLLOW-UP	3
C. TAXI-ING CLIENTS (of pts. not on caseload)	9
D. NO CPN FOLLOW-UP REQUIRED FOLLOWING INITIAL VISIT	7
E. SPECIFIC ACTION REQUIRED FROM REFERRING AGENT	11
TOTAL =	60

Reasons given under item E. were very varied but on four occasions were to 'deliver' items, i.e. medication or items left on wards. Three visits were pre-appointment visits where nurses visited patients waiting for admission to hospital or

an out-patient appointment.

Other studies have not identified casework in this way and little comparable data from other studies is available. Sladden[29] suggests that nurses in her study visited on a once only basis but she does not quantify this in any detail. Parnell[28] does not demonstrate any detailed presentation of once only visiting.

The usefulness of 'one off' casework is debatable. The cost effectiveness of nurses acting as deliverers of medicine is hotly contested by some C.P.Ns and the use of C.P.Ns as an alternative ambulance service is generally recognised to be a wasted resource. Present nurse managers were keen to see both these practices discontinued.

In addition to these obvious non-nursing activities some other less clear demarcation activities go on.
Skidmore[104] suggests that nurses spend a great deal of time re-interpreting the information which doctors have already told patients and casework analysis shows that some of this activity does go on in Stockport. The 1983 Mental Health Act has also placed some responsibility on psychiatric nurses to police patients upon the so called 'long leash' arrangements (frowned upon by the Mental Health Act Commission). Equally clients known to be participants in the 'revolving door' syndrome of repeated short term admissions are often seen by C.P.Ns to prevent readmission during a short term crisis situation. Stockport C.P.Ns were not involved in the former but did participate in the later 'policing' activity.

Following an awareness of 'one offs' the tendency to lump them into this ill described assortment became less as figures for the following months showed.

October 1984	60
Examination of one off visits	
December 1984	26
January 1985	31
February 1985	28

'One off' activity is a considerable element in the C.P.N. working week and takes upon average an estimated 10% of case related activity. Prior to its examination by the project, it was running at 13-14% of case related activity. The reduction can be attributed to a more realistic appraisal of this activity and redefinition of repeated one off contact with some cases.

ANALYSIS OF MONTHLY STATISTICAL RETURNS FOR THE CPN TEAM

As part of the preparation for changing the team philosophy for the community psychiatric nursing team, data was needed about the consequences of the existing team structure and its management.

One possible change under active consideration was a geographical 'sectorization' of nurses. Geographical sectorization is a system whereby nurses take responsibility for a defined geographical area within a District Health Authority. Community psychiatric nurses in Stockport were in

effect offering a personal service to each consultant psychiatrist who were themselves not geographically attached, thereby, obliging nurses to travel across the whole District catchment area.

In order to demonstrate the existing situation and possible alternatives, the study team undertook a review of statistical returns and a comparative analysis with other similar services. The following paper is a product of that analysis and was eventually built into the document 'Building towards the Future' eventually produced by the nursing officer and used as a case for future team development.

ANALYSIS OF THE MONTHLY STATISTICAL RETURNS IN STOCKPORT, WITH SPECIAL REFERENCE TO VISITS AND MILEAGE

TABLE 9.2 VISITS AND MILEAGE FIGURES FOR CPN SERVICE 1983/84 SAMPLE OF 5 CPNs/5MONTHS

	CPN 1	CPN 2	CPN 3	CPN 4	CPN 5	TOTAL - 5
A * VISITS CATEGORIES 3, 7.	268	212	406	224	224	266.80
5 MONTH MILEAGE	2145	1957	2808	1956	2443	2261.80
MILES PER VISIT	8.00	9.23	6.92	8.73	10.91	8.48
B * VISITS CATEGORIES 3,4,7,12,13,17,18,19	338	243	482	312	296	334.2
5 MONTH MILEAGE	2145	1957	2808	1956	2443	2261.80
MILES PER VISIT	6.35	8.05	5.83	6.27	8.25	6.77

Average No. of visits/month/CPN = 66.84 visits (range 26-111)
Average Mileage/month/CPN = 452.00 miles (range 175-623)
Average Mileage/visits/CPN = 6.77 miles per visit

*Visiting categories include:-

3 one-off visits
4 domiciliary visits with consultant psychiatrists
7 regular visits
12 visits to General Practitioner
13 injections given
17 visits to health centres
18 visits to clinics
19 visits to other hospitals

THE C.P.NS

The figures which appear in Table (9.2) relate to five of the Community Psychiatric Nurses working in Stockport Health Authority. The common factor in all cases is their district-wide catchment area. Other CPNs who have a joint primary health care commitment plus attachment to consultant psychiatrists have been excluded.

The figures therefore, reflect the number of visits, mileage and miles per visit of CPNs who have no geographical or organizational restraint on their visiting pattern.

Visiting Categories

Visiting categories are sub-divided into rather specific forms of contact. The CPNs are required to return statistical information on a monthly basis.

Miles per Visit

The monthly statistical analysis allows the calculation of visits in a number of ways. For example, regular visits and one-off visits together form a substantial part of a CPN's client contact. However, this does not accurately reflect the variety of contact CPNs have with clients and other professional groups during their daily travels away from base. It is recommended that the data in Section B. of Table 9.1 illustrates the mileage, visits and average miles per visit more accurately. All further references are to visit

categorized in Section B.

As the numbr of miles clocked up by CPNs increases with the number of visits, the most useful indicator of geographical spread is the number of miles covered between visits. The average mileage covered per visit (for all CPNs in the 5 month sample) is 6.77 miles per visit.

Comparison with North West Sectorized Service

Figures given by a geographically sectorized CPN team elsewhere in the R.H.A. provide useful comparison. A direct comparison of the number of miles covered between visits shows a wide discrepancy. The Stockport figure of 6.77 miles is substantially higher than 'Anytown' with 4.64 miles covered per visit. Given there are a number of differences between the two Health Districts, it is impossible to be sure that the net gain of 2.13 miles per visit in 'Anytown' is attributable to a single variable, namely sectorization. The difference between average mileage/month/CPN shows little difference, 452 miles in Stockport compared with 432 miles in 'Anytown'. However, there is significant increase in the CPN visiting pattern. CPNs in 'Anytown' visit 40% more clients per month than Stockport. One explanation for this higher visiting rate in 'Anytown' can be explained by the injection visits, which tend to be a short term task orientated activity. Client contact on these visits may consume less time. They total some 21.2% of the number of visits per month compared with 13.7% in Stockport.

Permision has been obtained to use the data but not the name of the Health Authority. Hence the use of the label 'Anytown'.

Sectorization

Nevertheless, sectorization would appear to be an influential factor in reducing the number of miles travelled between visits and consequently increasing the time available for visits. It also appears to have had a positive effect on the total amount of face-to-face client contact and partly explains the maintenance of high average monthly mileage figures of 432 miles in 'Anytown' Health Authority. Communication with the Nursing Officer of the Anytown Service has revealed a second factor. During the sample period, some cross-sector visits took place. This travelling has been reduced by 80%, however, the recent figures were unavailable but a forecast would predict a further drop in the number of miles covered between visits.

Comparison with Macclesfield CPN Service

Macclesfield yields some interesting data on miles per visit. During the period 1978/79 and 1979/80 the 8 CPNs recorded an average of 7.3 miles/visit and 6.7 miles/visit respectively. This was prior to sectorization and confirms that the high mileage in Stockport is mirrored elsewhere.

Differences between individual CPNs in Stockport

The differences between individual CPNs are reflected in the average number of miles each CPN covered during the 5 month sample period. The range varying from 1,956 miles (CPN 4) to 2,808 (CPN 3). The monthly average mileage for the CPNs was 452 miles. The differences between individual CPNs are marked and show a range of 175 miles against 623 miles. There is

little surprise in a corresponding wide range in the number of visits completed by CPNs each month, 26 visits as against 111 visits. The mean number of visits reaching 66.84 per month.

The average number of miles per visit during these five months and taking all 5 CPNs into the equation is 6.77 miles per visit. The range is 5.83 miles per visit against a top figure of 8.25 miles per visit. As the relationship between visits and mileage correlate highly, the more visits which are completed the greater the mileage involved. It is intended to explain the differences between CPN visits and mileage without separate reference to these variables. The lower figures, i.e. 26 visits/month are due to holiday leave. The sickness rate is very low and appears to have had a negligible effect during this period.

The higher figures for example, 623 miles per month and 111 visits were recorded by CPN 3. Incidently, these maximums did not appear in the same month. When interviewed it became apparent that the high level of activity was partly in response to a large number of referrals from the consultant psychiatrist. The CPN had only recently taken up the post, and was working well over 40 hours per week.

The high mileage may be of great concern to those responsible for the budget, however, it is noticeable that this same CPN returned the lowest number of miles per visit during this period, 5.83 miles per visit. The consistently high mileage and lower visiting rate reported by CPN 5 is in keeping with the wide, geographical area he covers. This particular CPN

has a high proportion of his clients in the Buxton area, this is attributed to his attachment to a consultant with clinics at Devonshire Hospital. Consequently, he receives large numbers of local referrals.

Lower Mileage

Although a drop in the overall CPN mileage is likely, a substantial fall is not predicted. If Stockport CPNs achieve parity in the number of miles covered per month with 'Anytown' figures, a saving of 2,400 miles per annum could be achieved. This would be a net saving of 4.4% on the total team mileage. This modest figure is a conservative estimate, given that the Elderly Severely Mentally Ill Service provided by CPNs continue to offer a district-wide service under proposals being formulated by the Nursing Officer.

Conclusions

The move to sectorization would appear to have a number of advantages. These include:-

1) The real possibility of a substantial increase in client-CPN contact which would be measured by the average number of visits completed each month by a CPN.

2) Less driving between appointments and consequently this

will free more time to be spent on other CPN activities.

3) A modest fall in overall mileage. Careful selection of health centres/clinics based on present service demands, i.e. research of where current clients live may reduce CPN mileage still further.

CHAPTER TEN

CHARACTERISTICS OF THE OBSERVED ORGANIZATION (1985)

CHAPTER TEN

CHARACTERISTICS OF THE OBSERVED ORGANIZATION (1985)

10.1

GENERAL INTRODUCTION TO ORGANIZATIONAL CHANGE

The second audit of the organization took place starting in March 1985.

Using the same procedures as those described in Chapter Six, both community psychiatric and community mental handicap nurses were interviewed and with a combination of this data, and the project teams familiarity with the organization, a profile of the services was produced.

Many influential appointments had been made during the time span of the project, some of which directly affected the study itself and others which changed the organizational climate from the top down. A new Assistant District Nursing Officer was appointed in 1983 for Unit 5 which includes the community psychiatric nursing services. A new Assistant District Nursing Officer was appointed at a similar time for Unit 4 which includes the community mental handicap nurses.

When producing the first audit report it was known that the nursing officer for the community psychiatric nurses was to leave for another post. Unfortunately, the service was left without a nursing officer for a 5 month period during which

time the charge nurses and sisters took turns to 'act up' on a rotational basis which depleted the service of manpower on occasions. The new Nursing Officer took up post in 1984 and that meant that a new Nursing Officer and a new Assistant District Nursing Officer were managing the community psychiatric nursing service.

Finally, a substantial change was made in the appointment of a District General Manager in 1985. This appointment was the first step in a series of projected appointments of Unit Managers and Assistant District General Manager posts which will further change in the organizational climate of the services under scrutiny. The anticipating nature of waiting for these appointments and the design of a management structure for Stockport Health District contributed very much to a generalized 'instability' in the organizational climate. There was a constant feeling of future decisions being put off and lack of control over the destiny of the various posts in question. This uncertainty was transmitted to the 'grass roots' workforce who form the basis of this study.

At the time of writing, Stockport has not had its structure approved by the North West Regional Health Authority, the future of the Senior Nurse Managers was still in doubt and the general air of uncertainty continued.

The District Nursing Officer was anxious to promote and develop both services and devoted a considerable amount of time to preparing a case for future developments regardless of senior management changes.

This need was further reinforced by a report from the North West Regional Health Authority which gave projected manpower figures up to 1999. The report showed a dramatic growth in manpower for both services. (32.9 W.T.E. for the C.P.N. service and 128 W.T.E. for the C.N.M.H. service.) These projections have already been described in Chapter 2. To meet the growth in manpower, detailed projections were needed from both services on deployment, distribution and training for manpower in both services. This activity was still underway when the project ended, but there is no doubt that the exercise was forcing both services to look closely at their present activities and future organization.

10.2

DEFINITION OF EXISTING SERVICES (1985)

10.2.1

AUDIT OF COMMUNITY PSYCHIATRIC NURSES

All community psychiatric nurses were once again interviewed using the 'audit' questionnaire shown in the appendix. The data generated from the interviews was combined with observations gained from informal discussions with service staff and their managers. The researchers had now gained considerable insight into the teams by their longitudinal involvement with them over the project period.

The C.P.N. Service is still divided into 2 main groups of generic and E.S.M.I. C.P.Ns. Manpower has grown during the course of the project. There are 13 C.P.Ns and two posts available, one a newly founded post and the other a vacancy.

The service is divided so that there are now 4 nurses working with the E.S.M.I. service and 11 with the generic service. The teams are administratively responsible through the Nursing Officer, who still retains responsibility for the O.P.D. and E.C.T. services, to the Assistant District Nursing Officer for Unit 5.

Generic C.P.Ns are still nominally responsible to consultant psychiatrists although at the time of the final audit nurses had devised a plan for geographical 'patching' and were establishing themselves in geographical areas, consequently detaching themselves from consultant psychiatrists. There are three pilot attachments to Health Centres and extensive contact being made with Primary Health Care Services. The generic service is in fact metamorphosising into that described in Chapter 3 (3.2.3) as a "specialist and community attachment service".

E.S.M.I. C.P.Ns maintain a different approach by offering a district wide service to a specific client group - the elderly. In this way they appear to best utilize the particular facilities of that group and although there is some discussion that the service should provide a 'patching' service this had not yet been fully developed.

The whole C.P.N. Service has now quite clearly got a philosophy of care which is defined extensively in Chapter 9 (9.2.1) of this thesis. In generating and writing about the team philosophy, it is noticeable that nurses have a clearer picture of what the service is there to do, what direction it will take in the future and how it is to be managed.

The team meet in a number of ways to satisfy clinical and administrative needs. There are monthly meetings to discuss administration matters and future developments.

Peer review and case supervision sessions are held by the generic team to air matters relating to casework and develop skills in case management. The Nursing Officer is seen as having some clinical expertise and gets heavily involved in matters relating to casework activity. He is available in a consultative capacity and will jointly visit clients and families with the team. There is still some dissatisfaction about his having responsibility for the O.P.D. and E.C.T. services, and although it is noticeable that the C.P.N. Service receives the greater part of his attention, there is still no 'goodness of fit' between his expected responsibilites.

Case notes are based upon the P.O.R. system as a consequence of the project, and nurses have a sophisticated case records system which provides comprehensive coverage.

Statistical data is still generated on caseload size, numbers of patients seen and time spent, the system has been orientated during the course of the project and the finer points of the system have been detailed in Chapter 9 (9.4).

The 'lack of trust' suggested in the first audit between the team and the managers has now gone. The appointment of the A.D.N.S. and the Nursing Officer has introduced an air of trust which encourages flexible working and less 'clock watching'. This is not to say that managers are now less concerned about supervision of staff but the two way trust has enabled more flexible working methods better suited to community work. The proposed patching system is further validation of this.

Allocation of Time

On a further subjective estimate of time spent per week on various activities there is little suggestion that allocation of time has changed dramatically but some change is evident. Once again evidence from similar studies is used to demonstrate outcomes.

Travelling Time

STOCKPORT (1982)	STOCKPORT (1985)	PARNELL (1978)	SLADDEN (1979)
23%	21%	22.5%	20%

The patching system when fully established will no doubt alter the travelling time and the prognostications of

Chapter 9 (9.9.2) will take time to effect change.

Ward Round Time

STOCKPORT (1982)	STOCKPORT (1985)	PARNELL (1978)	SLADDEN (1979)
9.8%	9.1%	16.6%	14%

Ward rounds are felt more particularly important by the E.S.M.I. team who generate referrals and case discussions in this arena. The generic service appear to be spending slightly less time in ward round activity.

Client Contact Time

Client contact time is estimated higher in this second audit that in the first.

STOCKPORT (1982)	STOCKPORT (1985)	PARNELL	SLADDEN	SKIDMORE AND FRIEND
40%	48%	33%	18%	18% - 60%

There is a noticeable degree of change which is evidenced from case data sheets where more particular plans and therapeutic methods are being employed as the project progresses (1982-1985).

Clerical Work Time

STOCKPORT (1982)	STOCKPORT (1985)	PARNELL (1978)	SLADDEN (1979)
20%	21%	9%	22%

Clerical work remains a heavy commitment of the nurses' working time. Interestingly the use of a Problem Orientated Approach to casework has not added significantly to the

nurses' perceived involvement in clerical work and was not highlighted as a contributory cause by any of the nurses. The 'general satisfaction' with time allocation reported at the first audit continues and the nurses report a strong expression of their ability to manage casework. Work standards are not checked in a structural way but it is noticeable that the Nursing Officer now spends time visiting with members of the team and carrying his own small caseload.

General Administration and Records

The team appear to have complete confidence in their recording system. They are able to say that patients' problems and goals are identified from the records and this is supported when looking randomly at records on file. There is a concommitant clarity about the therapeutic strategies that nurses wish to persue.

Nurses at the first audit suggested room for improvement with inter-professional communication and this is still an area which concerns 50% of the team at the second audit.

Legislation and Policy Formation

All nurses are familiar with Legislative Acts which impinge upon their practice, and have access to the necessary information.

Problems encountered during visits

Nurses encountered problems of an emotional or threatening nature whilst in the community and equally reported cases where they became 'stuck'. Half of the generic nurses quoted the case supervision sessions as being a suitable avenue for resolving problems of this nature, the rest appeared to be still using their informal networks as a sole means of support.

Joint Responsibility/Supervision

There is still universal satisfaction with the job of community psychiatric nursing. The move to Primary Health Care is eagerly awaited by the generic team.

Student Supervision

The School of Nursing at Stockport Health District has been investigating a post registration training course for Registered General Nurses wishing to become Registered Mental Nurses. This has generated a lot of interest in student supervision and the C.P.N. team have been involved in developing learning objectives for students on placement. This has further stimulated interest in all team members for student supervision. The team continue to take students attending E.N.B. Course No. 810 from Manchester Polytechnic and 70% of team members expressed a wish for further training in teaching methods related to student supervision.

In-Service Training

A close interest exists in developing skills based expertise. The In-service training programme given to the team and described in Chapter 8 has not satisfied this demand and paradoxically has stimulated further demand for training.

Nurses have been sent on further training workshops around the country and a healthy attitude to further training is evidenced by all team members without exception. Selection of which therapeutic methods to persue further has been carefully considered by 70% of team members.

Audit Summary

Key issues arise from the audit review, which is summarized and compared with the first audit at the end of this chapter. Issues which arise from the first audit have been modified or resolved. The management style is now appropriate to the flexible demands of community work. A philosophical framework exists which, although not complete, gives a sense of direction and development to the team. The impending patching system will do much to alter the narrow referral system to the C.P.N. service but will bring its own difficulties as the team fragments further and the referrals become less specific and borderline (Goldberg[41]). The good start made on in-service training has not been lost and enthusiasm for training amongst team members needs further cultivation. Given the present financial restrictions the interest and initiative shown may not survive.

10.2.2

AUDIT OF COMMUNITY MENTAL HANDICAP NURSES

The second audit of the community mental handicap nurses was carried out in the same way as that done for the community psychiatric nurses.

Little major change apart from personnel changes had occured to the team during the course of this study. Two new registered nurses joined the team, one left before the end of the study. Her short stay was said to be due to unhappiness at the persistent unwillingness on the part of the Child Development Unit to allow nurses to be involved with children under 5 years of age. This frustration was also pointed out in the first audit. It became all the more difficult to reconcile when an examination of the C.N.M.H. team case data for the study period showed they were in fact involved with 10 separate cases of children in this age group. Upon discussion, it would appear that these cases are often those where the Child Development Unit is 'stuck' or the cases are particularly intractable. This would appear to be a policy of selective convenience on the part of "someone"! The sensitive 'political' nature was such that no efforts were made to persue the problem further. The managers do however continue to attempt a change of policy.

The team returned to office accommodation at the mental handicap hospital at the end of the project and one member of staff, due to physical placement with the social services

department, established some good contacts with the local authority agents.

Allocation of Time

Some change from the first audit can be noted from the questionnaire and is shown thus:

	STOCKPORT 1982	STOCKPORT 1985
Client Contact	37%	41%
Clerical Work	27%	23%
Travelling	25%	20%
In Social Services Departments	5%	8%
Community Mental Handicap Team Meetings	5%	7%
Other	1%	1%

The principle of multidisciplinary working, is still central to action and staff continue to work a flexible time system.

General Administration

The recording method used by the team is based upon the P.O.A. system. It demonstrates all the requirements of a comprehensive recording system. The team also use supplementary data and information sheets which indicate service deficiency and a sheet for joint reviews between differnt disciplines. There appears to be general happiness with the present system.

Legislation

Familiarity with, and access to various Acts of Parliament is apparent from the audit questionnaires. There is still no specific community mental handicp nursing procedures manual.

Problems encountered during visits

All nurses reported occasion when they had been subject to emotionally disturbing consequences of casework. They did not always have the opportunity to unburden themselves of these emotional consequences as at the time they were usually working alone and not likely to see a colleague until the next day. 2 nurses reported that it was now "easier to talk about such things" but did not credit case supervision as the precipitant of this change.

Job Responsibility and Satisfaction

Community Mental Handical Nursing maintains a source of universal job satisfaction. The policies of other groups working with mentally handicapped are a source of some frustration.

In-Service Training

There is a felt need for further training in a number of areas. Counselling and family therapy were mentioned by 60% of the staff but a feeling exists that further training in any of these is only a faint possibility.

Student Supervision

The team still takes students from Manchester Polytechnic and see the need for further training in fieldwork supervision. The attention of all nurses has been drawn to the fact that they themselves have been depleted by sending members of their team on E.N.B. Course No. 805.

Audit Summary

Issues arise form the audit review. The continuing frustration of working policies with the Child Development Unit continue to reduce the source of referral to the tea,. The gatekeeping effect of the C.D.T. affects the team's practice. No easy answer lends itself at this point in time.

Nurses would like to persue further training and see the usefulness of a family/systems based approach to care. The P.O.A. and the project may have encouraged a broadening of perspectives away from a behaviouralist ideology.

The First and Second Audit compared

The first and second audit have some clear links and the project has interveened in some of these areas.

First Audit Precipitants	Project Actions	Second Audit Precipitants
1) A wish to improve upon client recording systems and give an ideological base to practice	Training in and establishment of problem orientated approaches	General satisfaction with client recording system. No stated problems with an ideological base
2) A need for further training in psychodynamic and other therapeutic approaches	In-service training programmes in family therapy, counselling and behavioural methods	Further demands for more extensive training or more depth in a chosen therapeutic method
3) The development of a 'team philosophy', aims and objectives for future developments	Interactive help with organizational incidents and responses	Both teams with operational policies and clear plans for future actions
4) More openess in casework	Case supervision and peer review	Some mention of the usefulness and continued initiative for case supervision

The audits have demonstrated some pathways between expressed need, project action and stated outcomes. As with the outcome criteria for the P.O.A. system, some problems resolve other become redefined and others still continue.

CHAPTER ELEVEN

EVALUATION, OF INSTRUMENTS AND TECHNOLOGIES

METHODOLOGY

The complex nature of organizational research means that to work effectively in changing organizational methods a system of closing in the boundaries for operational reasons must be devised.

The project has sought to do this through an O.D. programme and as a consequence has addressed only a proportion of the inter-related elements of the organization under review. The finer dynamic qualities of the organization have not been studied in any great depth but an evaluation of the study methods gives some indication of the effectiveness of the intervention technology chosen.

Using action research and an O.D. programme for the project foundation has given substance to a complex area. By using the sequential form of these methodologies it has been possible to 'unpick' some of the organizational elements and examine their presentation and possibilities for change.

The choice of technologies has allowed i) a review of the existing structure, ii) a medium for change, and iii) a review of the effects of change. On a larger scale the author would argue that the presentation of material in Section 3 provides an examination of system performance and the effects of specific intervention.

It has become apparent to the author during this project that an O.D. programme is not fixed and inflexible. The way in

which the programme has run has been one of partnership, negotiation and flexibility. One of the more difficult aspects in a study of this nature is the fine art of finding agreement amongst participants without compromising the main thrust of the study programme.

11.1

AUDIT AS A MEASURE OF ORGANIZATIONAL CLIMATE

An O.D. programme must have a statement of organizational climate and an agency profile at the beginning and end of its programme.

Audit was chosen to provide this information and certain observations can be made about its usefulness for this purpose.

The nature of presentation meant that nurses had to sit down with an interviewer and provide answers to pre-set questions. This information was supplemented by observations from daily contact with the team (the ethno-methodological element of the study). There is no doubt that audit methods provide a definition of the existing organization as Chapter Six and Chapter Nine demonstrate. The wholesale usefulness of audit as a regular procedural devise is questionable however. Some 36 hours of interview contact time were recorded with the C.P.N. team and a further 12 hours with the C.N.M.H. team. This expenditure of time must be measured against the purpose of auditing a team. In a project of this nature where time

and expertise are available, and the detail required extensive, then the use of audit can be justified. In a nursing team which needs to review its own performance and aspirations on a yearly basis, then a modified version of audit could be used. The sections of the audit interview schedule which were most informative proved to be:- general administration and records, problems encountered during visits, job responsibility and supervision, in-service training and allocation of time. A more succinct version for general management purposes could be based around these categories providing a good picture of organizational climate on a yearly or two yearly basis. Two claims were made for audit from the literature review, it would provide a statement of organizational health and had usefulness as an agency profile. The author would argue that organizational health can only be measured using a series of reviews (as in this study). The progressive nature of these reviews would provide baseline data from which changes in health can be measured. The author would support audit as a useful provider of agency profile.

11.2

VALIDITY OF PROBLEM ORIENTATED APPROACHES

In reviewing problem orientated approaches in Chapter Five (5.5) a number of attributes were given to P.O.A. i) as an educational tool, ii) as a total approach in the clinical setting, iii) as an audit procedure to correct deficiencies in provider performance. Other important questions were raised

two of which were of central interest to the author, a) is P.O.A. a less substantial approach than nomothetic diagnostic methods? b) is P.O.A. negativistic by subjecting clients to problem based hurdles? c) is P.O.A. intrusive upon established psycho-dynamic or behavioural methods?

Chapter Seven provides an extensive picture of problem based data and in part answers questions posed in the literature review. It is necessary however to add experiential observations having been a P.O.A. 'user'. The educational value of P.O.A. has shown itself manifestly useful. In teaching the team in P.O.A. methods the system was used as an educational tool in order to examine casework. P.O.A. allows the teacher to break down casework and examine elements which go to make up casework activity. So useful has the approach proved to the author (himself an educationalist) that the system has been built into a number of post qualifying courses.

In Chapters Two and Three, the author notes several studies which suggest the ideological neutrality of psychiatric nursing. P.O.A. as a total clinical approach has sought to fill the ideological vacuum. P.O.A. is now a common language for the Stockport teams. It is possible to go to the recording system or discuss casework with nurses and have a common understanding. P.O.A. has not replaced or excluded the particular therapeutic ideologies of psycho-dynamic or behavioural methods but provides them with a framework for action which is commonly understood by all. P.O.A. has deficiencies in some areas. It cannot for example, pick up

nursing action which is of a short term 'one off' nature. The effort of processing such cases through the P.O.A. approach outweighs its value and a less sophisticated system, such as that described for processing 'one offs' in Chapter Nine (9.2), needs to work in tandem with a P.O.A. system.

P.O.A. as an audit procedure has something to recommend it. Data displayed in Chapter Seven shows that certain problem areas predominate and in some instances (i.e. family centred work) nurses do not have the necessary skills to meet the demands of casework. In this way it is possible to take a positive stance towards provider performance and build in in-service training programmes to counter these observed deficiences.

The author would agree that P.O.A. is as substantive in its approach to casework as diagnostic methods. By excluding any reference to diagnostic categories in this study, it has still been possible to paint a full picture of casework and the implicit partnership between clients and nurses in defining problems makes the method as acceptable as any other.

Finally, the problem centred approach in this study has been supplemented by goal directed activity in case records (See Figure 7.2). No attempt has been made to measure goals against problems, rather the negativistic element has been tempered by mutual agreement between nurses and clients about problem resolution and goal achievement.

Problem categorization has formed a substantial part of the

study and the production of two final problems lists which have generalized usefulness has been one aim of the project. At the end of the project period the two problem lists (by now considerably amended from the originals) were retested for inter-rater reliability using those methods described in Chapter Five (5.4.2).

Using randomly selected practitioner raters, two further sets of data sheets were processed by these raters using the amended Delphi lists. 'Kappa' analysis was once again used to test for inter-rater reliability. The results were as follows:

'Kappa' score for Community Mental Handicap Nurses

Kappa = 0.65

'Kappa' score for Community Psychiatric Nurses

Kappa = 0.61

These scores were well within acceptable limits of confidence and suggest commonality of purpose amongst practitioners. The final Delphi lists for both groups are shown below. It should be noted that some problem categories make reference to others of a similar nature for example, 008 - Friendship - loneliness makes reference to two other similar categories - 010 - Lack of social contact and 161 - Social withdrawal. This has proved necessary in order that the raters can consider a wider range of problem types rather than go for the first problem shown on the category list.

The author proposes that these lists represent a validated method of problem categorization for C.P.N. and C.N.M.H. teams.

FIGURE 11.1 FINAL DELPHI LIST COMMUNITY PSYCHIATRIC NURSING

FAMILY SOCIAL PROBLEMS

001 Marital relationships - divorce proceedings, fights/rows between couple, separation, (See No. 026)

002 Care of children (?latch-key, neglected, poorly clothed/fed, (See No. 022, 023 (079)

004 Overprotectiveness by family (including dependency on relatives)

005 Family planning (contraception, vasectomy)

006 'Intra' family strain (between son/daughter, parents, husband /wife)

007 'Extended' family strain (grandparents, cousins, in-laws etc living outside client's home)

008 Friendship - loneliness (See No. 010, 161)

009 Dissatisfaction with social role (e.g husband no longer breadwinner (See No. 022)

010 Lack of social contact - restricted by environment (house-bound, lives-alone, tied to ageing parents/wife/husband - See No's 008,014,023,129,161)

011 Work relationships (See No. 162)

012 Social skills

013 Mobility/transport

014 Geographic accessibility

015 Needs 'helping' services (appropriate voluntary groups, meals-on-wheels, domestic help, overburdened by elderly See No's 103, 107, 110, 117)

017 Mishandling by other agents (See No's 092, 104)

019 At risk children - non-accidental injury, sexual abuse (See No. 165) (072)

020 Not in receipt of appropriate benefit (attendance allowance etc)

021 Problem drinking (See No. 049)

022 Undeveloped mothering skills (associated with post-natal mental problems, inadequacy See No's 002,)

023 Burden of care rests on one relative (See No's 002,010, 015,022)

024 Family do not understand client's psychiatric condition

025 Expressed fear of harming child (resentment towards children)

026 Sexual relationships (See No. 001)

PHYSICAL CRITERIA

029 Undiagnosed physical disorder/disability

030 Diagnosed physical disorder/disability (excluding below)

031 Weight disturbance

032 Sleep problems

033 Eating problems (poor appetite, diet, not eating - overeating)

035 Headaches

036 Respiratory problems

037 Circulatory problems (ischaemia, raised B.P., heart disease, etc)

038 Bladder/bowel problems, (prostrate, constipation, urinary overflow, frequency, - See No. 142)

039 Dizziness/vertigo (falling, postural hypotension etc)

040 Pregnancy

042 Blindness (partial blindness - eyesight problems)

043 Deafness (or partial)

044 Motor skills difficulties - impaired mobility)

047 Unattractiveness - disinterest in personal appearance (See No. 50)

048 Prescribed drug dependency (See 049, 088, 089)

049 Drug/alcohol abuse (See No's 021, 048)

050 Neglect of self-care related to mental condition (See No's 033, 047, 169, 173)

051 Dentistry - oral hygiene (See No. 113)

052 Chiropody - foot hygiene)See No. 113)

053 Hygiene problems due to physical decline/restriction (See No's 050, 169, 173)

054 Dehydrated (See No's 033)

EMOTIONAL-MENTAL STATE PROBLEMS

056 Mental state deterioration (at risk of - See No. 075)

057 Mental state fluctuation (mood swings, See No's 072,075)

058 Lacks motivation (related to psychiatric condition

059 Boredom (e.g. too much spare time)

060 Unresolved grief, guilty feelings (See No's 068, 166)

061 Anxiety - including panic attacks (See No. 063, 193)

062 Agitation - irritable

063 Tension plus anxiety symptoms (See No. 061)

065 Depression (See No's 069, 070, 159, 160, 188)

067 Mood elevation

068 Guilt feelings (not associated with grief)

069 Feelings of inferiority, inadequacy, worthlessness (related to poor social skills, See No's 065, 070, 159, 160, 188)

070 Lacking in confidence

072 Emotional lability (See No's 057, 065, 067)

074 Notions of unreality

075 Multiple physical and emotional/mental state problems (See No's 056, 057)

076 Psychological problems / SEASONAL CHANGE

MANAGEMENT OF MEDICATION PROBLEMS

086 Medicine administered incorrectly (by patient and/ or family) (see 94)

087 Refuses/reluctant to take medication

088 Needs supervision of medication (See No. 094)

089 Side effects of medication (oversedated, - See No's 048, 049)

090 Maintenance of depot injection (reluctant/unable to attend depot clinic

091 Current medication appears ineffective

092 Conflicting advice re: medication (See No. 017)

093 Taking medication and operating machinery (See No's 087, 089)

094 Supervision of withdrawal/reduction of medicines (See No. 086)

095 Difficulty swallowing medication

CASE MANAGEMENT PROBLEMS

102 Persistent phone calls (from client or relative)

103 Refuses domiciliary agency support (other than CPN, - See No's 015, 107, 117)

104 Ensuring liason between support services See No's 017,092)

105 CPN refused access to client's home (See No. 118)

106 Lack of information about the client (See No. 118)

107 Refuses hospital care/services offered (See No's 103, 113,114,117)

108 Present mental state requiring short-term assessment (in hospital)

109 Family unable to manage day care of the client

110 Family (of client) need a holiday/respite/rotational care (See No.015)

111 Wandering problems of containment (runs off ward, - See No. 193)

113 Inability/reluctance to keep appointments with other services. e.g. escort required (See No's 017, 090, 104, 107, 118)

114 Family refuse/reluctant to take client home from hospital (See No.107)

115 Lack of aids - to alleviate physical handicap (See No. 01

116 Client concerned about hospitalization (See No. 107)

117 Client refused social services care offered (See No's 015 103, 107)

118 Relationship between CPN and client (lack of trust, poor relations, distrust of authority - See No's 087, 105 107, 113)

119 Availability/suitability of long-term bed (in hospital or social services - See No's 107, 116, 117)

120 Carer requires hospital treatment/unwell physically or mentally (See No. 023)

121 Poor relations between client and PHCT (e.g. NO G.P)

122 No social service day care facilities (See No's 103, 107, 117, 119)

123 Physical decline - present facilities inappropriate

FIGURE 11.1 (cont)

BEHAVIOURAL CRITERIA

124 Impulsive acts

126 Verbally aggressive, arguementative (See No 127)

127 Threatening or aggressive behaviour (in posture or act - violent towards others,

128 Suicidal act/deliberate self-harm (See No 188)

129 Phobic behaviour (See No's 010, 161)

132 Compulsive rituals

134 Obsessive ruminations

135 Hyperactivity

141 Institutionalism/poorly motivated (See No. 058)

142 Soiling, wetting problems (See No. 038)

143 Public behaviour likely to cause embarrassment/anger

144 Bizzare or inexplicable acts

'LIFE-TASK' PROBLEMS

155 Finding/keeping employment

156 Unemployment/redundancy (See No. 167)

157 Crime/delinquency/conflict with authority (See No. 175)

160 Client unable to cope (See No's 023, 069, 070,172)

161 Social withdrawal (e.g. takes to bed, refuses to go out of home, See No's 008, 010, 129)

162 Vocational role dissatisfaction (See No. 011)

163 Dissatisfaction with living environment (e.g. moving house, lacks facilities, unhappy at home, unhappy in area living, See No's 169, 171, 176)

164 Culture specific problems

165 Liability to exploitation (See No. 019)

166 Bereavement, adjusting to relative's terminal illness (See No's 060, 068)

167 Retirement (See No. 156)

169 Housekeeping (e.g. domestic problems, refusing to clean, wash, cook, upkeep of the house fabric, See No's 163, 171)

170 Domestic management/budgeting (e.g. paying bills, enough food at home, financial difficulties, shopping)

171 Housing unsuitable for client to live in alone (See No's 163, 169)

172 Adjust to independent living (difficulty coping alone, leaving parents, See No's 004, 006, 160, 163, 170)

173 Clothing - client requires clothes, shoes etc (See No's 050, 053)

174 Lacks domestic skills (preparing food, cooking, shopping, See No's 169, 170)

175 Court proceedings (See No. 157)

176 Transition to residential care (See No. 163)

COGNITIVE PROBLEMS

182 Hallucinations

183 Delusional ideas - paranoid ideas

184 Unusual thought content

186 Memory impairment

188 Suicidal thoughts (See No's 065, 128,

193 Confusion (See No's 111,

194 Psychotic symptoms (See No 184)

FIGURE 11.2 FINAL DELPHI LIST - COMMUNITY MENTAL HANDICAP NURSING

FAMILY SOCIAL PROBLEMS

001 Marital relationship (divorce proceedings, fights/rows between couple, separation)

004 Over-protectiveness by family

005 Family planning (contraception, vasectomy, genetic counselling)

006 'Intra' family strain (between son-daughter and parents etc, other than the client, See No. 032)

008 Friendship

010 Lack of social contact - involuntary isolation (housebound, tied to handicapped client, See No's 159, 162)

011 Work relationships

012 Social skills

013 Mobility/transport (See No. 169)

014 Geographical accessibility (See No. 169)

015 Lack of helping services (appropriate voluntary groups, meals-on-wheels, domestic help, See No's 021, 109)

016 Lack of sitting services (See No. 021)

017 Mishandling by other agents (See No. 102)

018 'Over' intervention from caring agents

019 At risk children - non-accidental injury, See No. 165)

020 Not in receipt of appropriate benefit

021 ? Need for short term care (family need rest, holiday, See No. 103)

022 Need for specialist support (physiotherapists, speech therapists, psychologists etc)

023 Day care provision required (See No's 021, 103)

024 Sexual relationships (See No's 001)

025

PARENTING SKILLS

026 Play opportunities restricted (e.g. few toys, no playtime with parents

027 Limited opportunity for family interaction (e.g. both parents at work, tied to baby etc)

028 Family unable to employ behavioural techniques (e.g. reluctant, resistive, overburdened, See No's 034, 108, 112)

029 Family lack of knowledge of behavioural skills/management (See No's 118,

030 Family lack of knowledge of sign language - speech training (See No's 022, 050, 051)

031 Inappropriate/inconsistant parental handling

032 Parent(s) have difficulty coping with impaired son/daughter's behaviour (attention seeking - See No. 006)

034 Family unable to carry out physiotherapy (e.g. reluctant, resistive, overburdened, See No's 028,112)

035 Child care rests on one parent (See No's 026 - 034)

036 Carer/parent physically unwell (See No. 035)

037

038

PHYSICAL CRITERIA (RELATING TO THE CLIENT)

039 Diagnosed physical disorder/disability

040 Undiagnosed physical disorder/disability

041 Weight disturbance

042 Headaches

045 Bladder/bowel problems (See No's 062, 138)

046 Exercise/physiotherapy

050 Speech deficit/impairment (See No's 030)

051 Deafness

052 Motor skills difficulty (e.g. mechanical, neurological)

054 Hypertonic problems (rigidity, See No. 060)

055 Epileptic seizures

059 Neglect of self-care (poor, neglecting self, See No's 045, 078, 086, 159)

060 Limb contractions (See No. 054)

061 Dentistry (oral hygiene, See No. 111)

062 Excess salivation

063 Bathing difficulties

COGNITIVE PROBLEMS (OF THE CLIENT)

072 Reasoning difficulties

073 Concentration

EMOTIONAL AND MENTAL STATE PROBLEMS (OF THE CLIENT)

078 Depression

084 Lacking in confidence

086 Lacks motivation

090 Hypochondriasis

091 Boredom

MANAGEMENT OF MEDICATION

094 Maintenance of depot injections (e.g. reluctant to attend clinic)

095 Side effects of medication

096 Ineffective medication ?(requires medical review)

097 Reluctance to take medication

CASE MANAGEMENT PROBLEMS

100 Relationship between CMHN and client/family (e.g. poor rapport, not yet established)

102 Ensuring liason between the services (See No's 017, 022)

103 School holidays, daytime 'occupation' for the client - (See No's 021, 023)

104 Lack of information about the client (e.g. diagnosis, family or client history)

105 No hospital beds available

107 Placement of client - education/occupation placement in the future

108 Ageing parents - client's future welfare (either/or/both)

109 Lack of aids (nappies, chair, wheelchair etc. See No. 015)

110 Inappropriate aids (to client's requirements, See No. 109)

111 Inability/reluctance to keep appointments with others e.g. escort required (See No's 017, 061, 102)

112 Parents reject local hospital/social services (See No's 004, 028)

113 Poor knowledge of local services

114 Current placement is inappropriate (at work, rehabilitaton unit, group home etc. as perceived by the nurse, See No. 166)

115 Poor relations between parents and school (See No's 107, 111, 112)

116 Poor relations between parents and specialist services (psychologists, social workers and physiotherapists)

117 Need for sheltered supervised accommodation (See No. 161)

BEHAVIOURAL CRITERIA (AS PRESENTED BY THE CLIENT)

118 Impulsive acts

120 Spitting

121 Threatening and/or aggressive behaviour

122 Phobic behaviour

123 Screaming (tantrums)

124 Sleep problems

125 Eating problems (overeating, neglecting diet, selective eating, poor table manners)

127 Sexual disinhibition

132 Hyperactivity

134 Rocking

135 Self-mutilation (See No. 140)

136 Grinding teeth

138 Soiling, urinating problems (See No. 045)

140 Destructive behaviour (See No. 135)

143 Dressing (difficulty in dressing, See No. 170)

144 Interfering/disruptive at play (See No. 026)

'LIFE TASK' PROBLEMS (OF THE CLIENT AND FAMILY MEMBERS)

152 Illiteracy

159 Social withdrawal/isolation (e.g. refuses to get out of bed or go out of home, See No's 010, 086)

161 Dissatisfaction with living environment (e.g. poor housing unhappy with house area, overcrowding, See No. 117)

162 Culture specific problems

164 Bereavement

166 School/college attendance (reluctance/refusal of client, - See No. 114)

167 Housekeeping (e.g. cleaning, washing, upkeep of house)

168 Domestic management (e.g. budgeting, financial problems)

169 Travelling (See No's 013, 014)

170 Inappropriate dress (See No. 143)

171 Independent living skills (See No's 167, 168)

11.3

IN-SERVICE TRAINING FOR COMMUNITY NURSES

The original intention of the study was to link in-service training with observed skills deficits from P.O.A. data. This intention had to be modified easily in the study when it became apparent that the delay in data production did not permit the link to be made until the end of the study.

A compromise was reached by tying in skills training to nurses perceived needs from the first audit. Coincidentally, it appears that one of the areas addressed, namely family work, was that which required attention. From the P.O.A. data, it is apparent that family related work forms a considerable part of nurses' work in both mental handicap and psychiatry. No attempt has been made to assess the impact of this training upon the nurses' work and it must now be seen in a different light. The author would contend that in-service training became the reward system for participating in the O.D. programme. Although the intention was not that it should be, so it became clear that this was the way in which it was reviewed by both managers and nurses alike.

One of the remarkable precipitants from in-service training was the element of casework supervision. It has emerged as a new technology in helping to support nurses in developing a way of working in the new environment of the community. Arguably, training programmes offered to the teams contained the key elements which underpin therapeutic approaches, namely

psycho-dynamic, behavioural, family and counselling work, but the central theme which emerged from this input was the need for supervision.

11.4

ORGANIZATIONAL INCIDENTS AND RESPONSES

The study made particular allowance for those unknown events which are likely to arise in a study of this nature. By being a resource to both teams, the study was able to help out if needed in any activities where developmental progress was being made. This could not be quantified at the beginning of the study but as a point of principle was made public which declared a willingness on the part of the researchers to act as a resource.

In the event it turned out that the team became used by the C.P.N. team but not by the C.N.M.H. team other than for P.O.A. The incidents were largely to do with taking the team forward from a hospital orientated consultant attached service to a community based open referral system. (Types described in 3.2.1 and 3.2.3 in Chapter Three.) This necessitated producing an operational philosophy for the C.P.N. team and an analysis of data to support documents being prepared for geographical attachment of the C.P.Ns around the Stockport Health District. Availability of the researchers allowed help to be given and it is proposed by the author that this flexibility be built into any programme of this nature.

A balance must be struck between intrusiveness and diffidence but to help out in this way within an O.D. programme needs particular time allocation in order that it does not interfere with other constructed elements of the programme.

SECTION FOUR

SUMMARY, CONCLUSIONS, RECOMMENDATIONS & THEORETICAL IMPLICATIONS

CHAPTER TWELVE

SUMMARY, CONCLUSIONS, RECOMMENDATIONS

12.1

SUMMARY AND CONCLUSIONS

The principal aims of this study were:-

i) To use an organizational development model in an action research programme to assist in and enable the transition of a C.P.N. team from traditional methods to more open and appropriate approaches.

ii) To give support and training to counter observed skill deficiencies and organizational difficulties.

iii) To assess the patency and usefulness of 'technologies' as a means of reporting the transition of C.P.N. services within a specific time scale.

4) To apply 'technologies' in order to demonstrate:

   a) The presenting problems which are referred to C.P.Ns.

   b) The goals and methods of intervention employed by C.P.Ns.

   c) Skill deficits shown from the casework methods of C.P.N.s.

   d) Information on the commissioning and disposal of cases.

This chapter provides a summary account of the study from Chapter 1 onwards. It also gives an indication as to the meeting of these original aims and the contribution each

chapter makes to additions in the representative bodies of knowledge in nursing and organizational development.

SECTION 1

CHAPTER 1 (Development in Psychiatric Nursing)

Chapter 1 traces the development of psychiatric nursing. It posits a view that there is a relationship between ideology, theory and practice. Because mental nursing has operated without clear therapeutic purpose and because of the shifing nature of psychiatric nursing, no current central purpose exists other than the general enthusiasm for community care. Interpretations of mental nursing in its modern context is only meaningful when viewed from its grounding in history. The general conclusion is that psychiatric nursing operates in an ideology free environment but as a consequence the prevalent (often medical) ideology holds sway.

CHAPTER 2 (Describing the Community Psychiatric Nurse)

Chapter 2 looks at the community psychiatric nurse through four different but interrelated perspectives; research, manpower and service distribution, projected manpower estimates and education. A review of research shows some variety with general consensus that the role of the C.P.N. is ill-defined. Manpower is shown to be growing in an almost exponential manner with varied approaches to team structure. Training is seen to be inequitably available with debates on mandatory training raising intra-professional concern. This chapter represents a commentary on the changing nature of psychiatric nursing and provides a reaffirmation of previous knowledge about psychiatric nursing but provides new knowledge

on the roles and organizational responses to service growth.

CHAPTER 3 (The Dilemmas of Psychiatric Nursing in the Community)

Chapter 3 examines three methods of organizational structure for C.P.N. teams and concludes that an open referral service with links to specialist psychiatric facilities is one which best serves the needs of an identified community. The shifting allegiancies of C.P.Ns are also noted and consequential inter-professional strain that is produced by these shifts.

This chapter exposes a lack of structure which some teams have and an absence of operational philosophies which makes positive direction difficult. Finally, the chapter suggests that C.P.Ns are in a state of paradox for a number of reasons:

i) because they have no ideological anchor
ii) there is no consensus as to the techniques and work methods of C.P.Ns
iii) operational philosophies are unadventurous, do not allow new developments and attempt to maintain the status quo
iv) the old medical model which postulates linear causality is inadequate and it is necessary to live with uncertainty in the community setting.

This chapter provides a new model for examining the difficulties of community psychiatric nursing and offers paradox as a definition for inertia. Paradox provides an

addition to conceptual frameworks for considering practice problems.

SECTION 2

CHAPTER 4 (Generation of Hypothesis and Establishment of the study)

This chapter describes pilot studies carried out in two alternative settings. One is an analysis of casework using a problem centred approach, the other is a national survey and examination of a sample of casework from 2 C.P.N. services. Precipitants from these studies were:

i) That C.P.Ns do not have an articulate means in describing casework.

ii) That a problem centred approach has usefulness in describing casework activity.

iii) C.P.Ns are in a transition state and obliged to use methods often unsuitable for their activities.

This is an addition to existing knowledge about C.P.Ns in this area and the pilot studies bolster up notions gained from literature reviews of similar studies. It is demonstrated that problem centred approaches can be used to examine casework.

CHAPTER 5 (Methodology)

This chapter provides an account of the design, data collection methods and development of data collection tools used in the study.

The chapter sets the study firmly in an action research/organizational developmemt framework. It extensively reviews the usefulness of a problem orientated method as a tool for data collection and offers three potential uses of P.O.A., i) as an educational tool, ii) as a total approach in a clinical setting, iii) as an audit procedure, and finally recommends P.O.A. as an instrument to provide all three elements. The chapter documents the development of a data check list (Delphi list) and provides a list for data storage validated by inter-rater reliability testing to a reasonable degree of confidence. Audit review is recommended as a means of measuring organizational climate and two final elements of in-service training and the responsiveness of the study are reviewed.

This is the first time that these extensive reviews of P.O.A., Delphi testing and data collection methods have been linked to community psychiatric and community mental handicap nursing and as such represent additions to the body of knowledge of nursing and organizational developments.

SECTION 3

SUB-SECTION 3A (Definition and Diagnosis of the Present System, Identifying the Transition State)

CHAPTER 6 (Characteristics of the Observed Organization)

This chapter using an audit data collection method and ethnomethodological observations details the characteristics of the C.P.N. and C.N.M.H. teams, and defines implications of this information for the project, the teams and their organizations.

Four main precipitants were identified, i) a wish to improve upon client recording systems and have an ideological base for practice, ii) a need for training, iii) a need to develop team philosophies with aims and objectives for future action, iv) a wish for more openness in casework. This information is an addition to the body of knowledge that is psychiatric nursing in that a perceived and expressed wish for an action plan has been identified using audit procedures. It is also a unique insight into community mental handicap services provided by nurses.

SUB-SECTION 3B (Using Intervention Technologies, Implementation of New Activities)

CHAPTER 7 (Case Data Presentation)

This chapter describes the way in which staff were taught and then began to use problem orientated methods. Case related data is presented using a system of categorization not based

upon the medical model but upon problem specific categories. Casework is analysed and presented as a series of events, i) the referring agents requested action, ii) the identification of problems, iii) the choice of action by nurses, iv) the outcome of the problem category. Observations are made about the age/sex distribution of cases and the outcomes are cross tabulated against a number of alternative variables. Certain general observations are made in this chapter and conclusions are made from the casework presented, a) nurses exercise considerable freedom of choice in how they commission their referrals, b) specific therapeutic techniques are being commonly used by nurses on a regular basis, c) nurses act as liaison agents, d) nurses have a tendency to provide a sustaining and nurturing role.

The chapter argues for the case that P.O.A. has the potential to pick out areas of high and low problem resolution which may point the way to service deficits and further training. The chapter supports the argument the P.O.A. is generally acceptable as an ideology upon which to base action.

This information, not previously gathered, represents an addition to the knowledge bases to be found in psychiatric nursing, problem centred approaches and organizational development.

CHAPTER 8 (In-service Training)

This chapter documents the provision of an in-service training programme for the participating teams. Core skills are identified in psycho-dynamic, behavioural, family and counselling therapies and detailed programmes have been put in an appendix. Supervision is identified in this chapter as a key factor in casework and there are general observations made about supervision which tie in with community nursing and organizational development. Supervision is offered as a means to obtaining i) provision of security, ii) establishing new principles, iii) stress reduction, iv) training and supervision. These findings are offered as a system of counterbalance to the unease encountered in community work and to a traditional reluctance of nurses to accept nothing but 'cure' as an outcome.

CHAPTER 9 (Organizational Incidents and Responses)

This chapter gives an account of three items which are central to the organizational effort, i) changes in team philosophies, ii) the capture of one-off visits, iii) analysis of monthly statistics. These activities are related to C.P.Ns only although a statement upon the operational philosophy of C.N.M.Hs is documented as a complementary item. The chapter gives an account of these items and gives recognition to their importance in the growth and change of the C.P.N. team. Some consideration is given to the role of an O.D. programme in matters not specifically itemized in its detailed programme. The chapter elaborates the notion of flexibility and

responsiveness in an O.D. programme. This information is an addition to the knowledge base of organizational development.

SUB-SECTION 3C (Monitoring Evaluation and Change)

CHAPTER 10 (Characteristics of the Observed Organization (1985)

This chapter once again details the product of an audit data collection method and ethnomethodological observations. The information is used to highlight the ways in which nurses feel about their services, themselves and the organization. The data demonstrates i) a general satisfaction with the client recording system, ii) demands for more extensive training in therapeutic methods, iii) a clarity of purpose in operational philosophies, iv) the usefulness of case supervision as a support system.

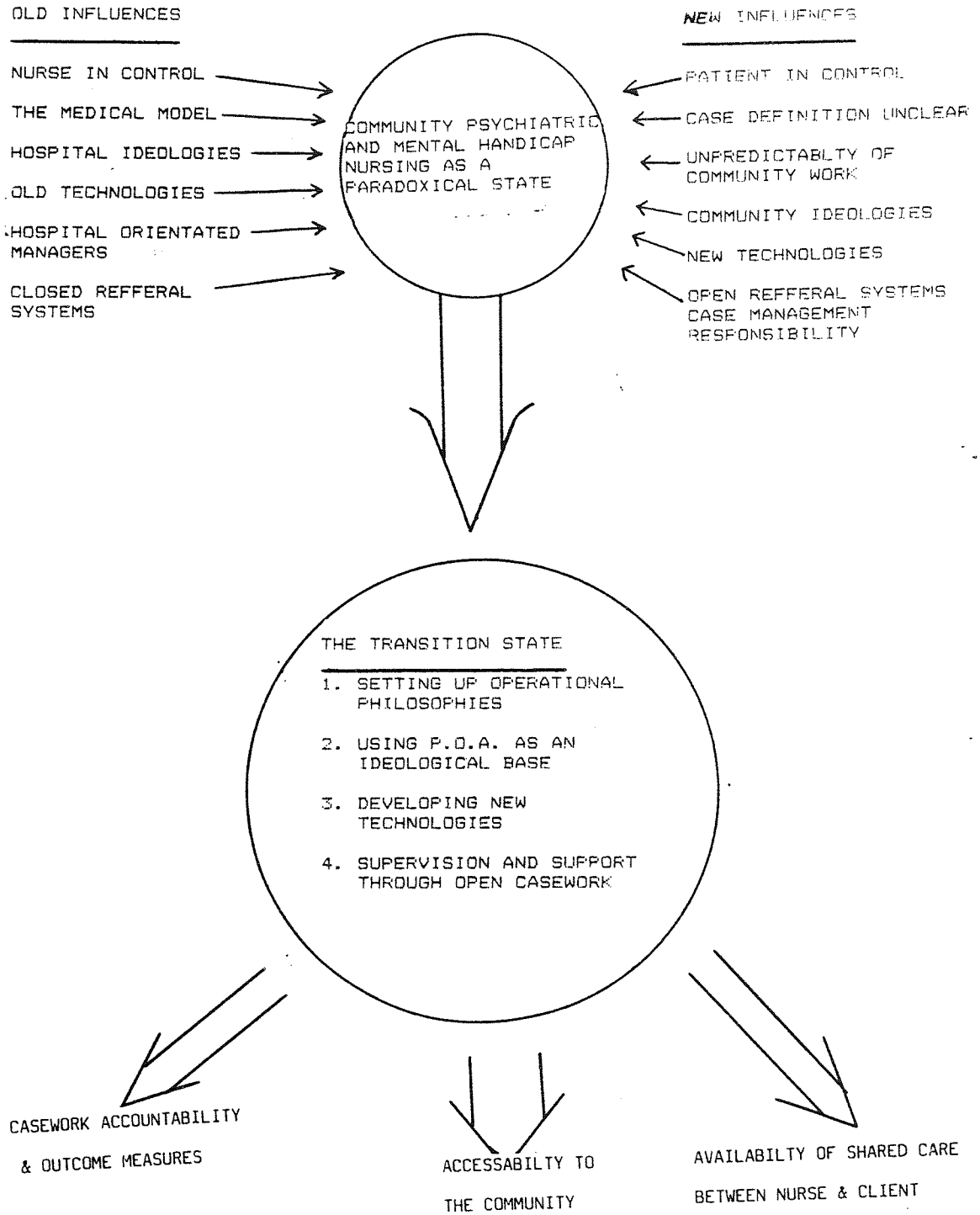
This information is an addition to the body of knowledge that is psychiatric nursing.

RECOMMENDATIONS; THEORETICAL IMPLICATIONS

To paraphrase Cleveland[113] "The care problem in a complex organization is to make the best choices around, in whom to bring together and what to make happen in some interpretation of public interest.". Any change process is based upon a complex set of interdependent sub-systems; people, structures, technology and tasks all of which are embedded in a dynamic environment.

To take a theoretical proposition such as organizational development and transition management to a system which is already in a state of disequilibrium may be considered foolhardy or courageous depending upon proximity. This study has taken a system in disequilibrium (community psychiatric nursing) and attempted to enable its transition to a new perspective. To resolve its disequilibrium, new technologies have been offered and accepted. This has necessitated identifying unsuitable methods being used, pointing out their shortcomings and providing alternatives. Some unsuitable methods have been offered by the system itself, others have been identified by the study. The theory practice divide is no more apparent than in a study of this nature and to talk of community nurses being in a state of disequilibrium has an uncomfortable translation to the practice setting. The theoretical structure has to be translated into a usefulness which can be situation specific and this is shown in Figure 12.1.

FIG. 12.1 THE ORGANISATIONAL TRANSITION OF COMMUNITY NURSES



The new perspective is one which is more directly related to consumer demands, and accessible to those it purports to serve. At Figure 12.1 the perspective is more at one with the 'raison d'être' of community nursing. Within the transitional model shown at Figure 12.1 there exists a number of sub-systems which go to make up the dymanic whole.

The central pivot is a sub-system which has at its core problem orientated approaches. In the light of this study P.O.A. can be recommended as an ideological base for practice, a method of highlighting clinical issues, a system of accountability in casework, a means of working in a partnership arrangement in practice and an effective recording system.

To make these claims for one methodology in practice may appear a little extravagant, however, the author would argue that this study has demonstrated its ability to encompass all these recommendations within varying degrees of success. This is not to suggest that it superceeds other ideological approaches. There is equal distinction to be found in psycho-dynamic, behavioural, humanistic and even medical models. The contention of this study is that P.O.A. provides an approach which suits the type of casework likely to be found by community nurses, is wide enough to encompass all case typology and is not intrusive to particular clinical methodologies.

It is necessary to translate this sub-system to a practice specific model which can demonstrate its usefulness in an

everyday setting, a possible model is shown at Figure 12.2.

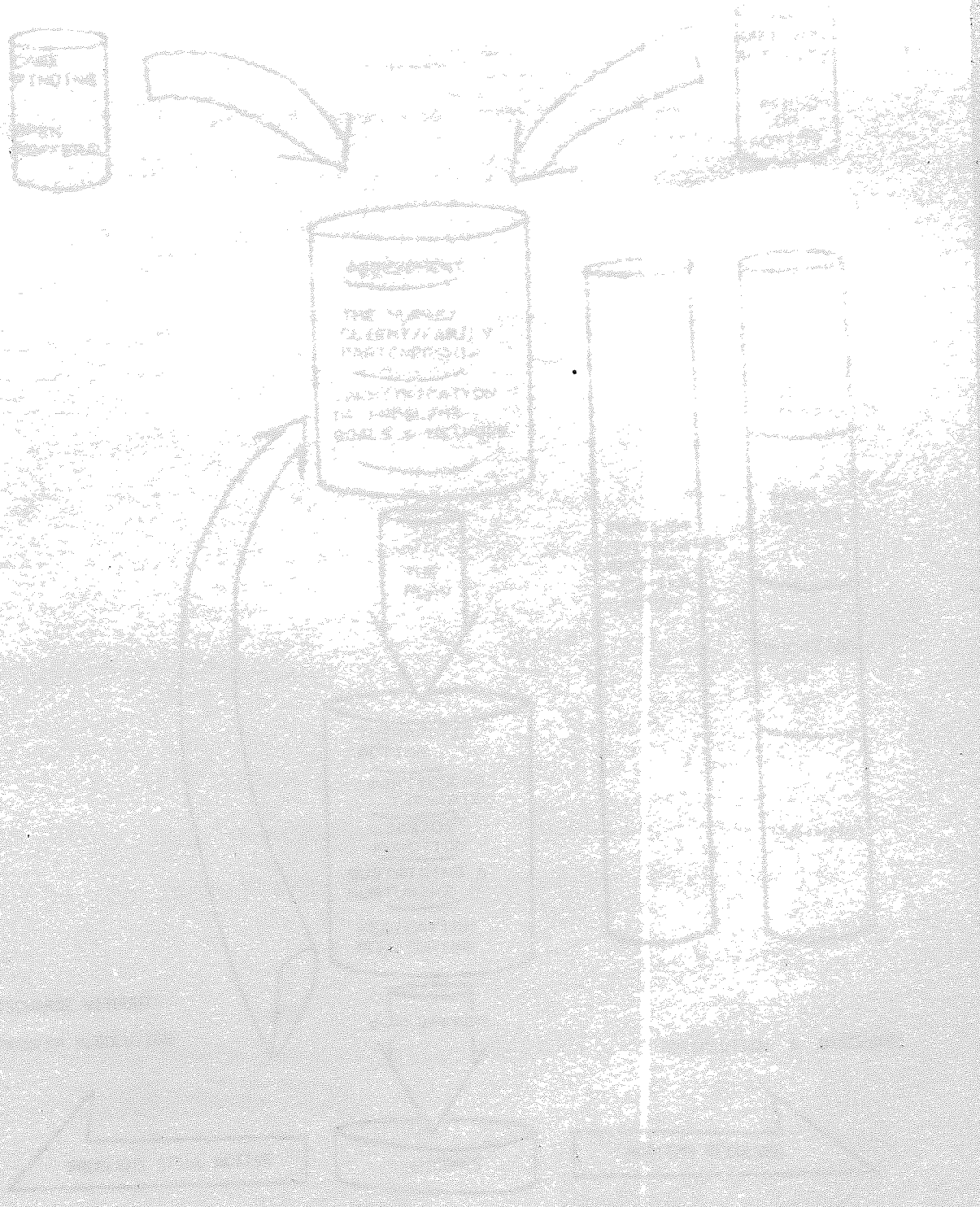
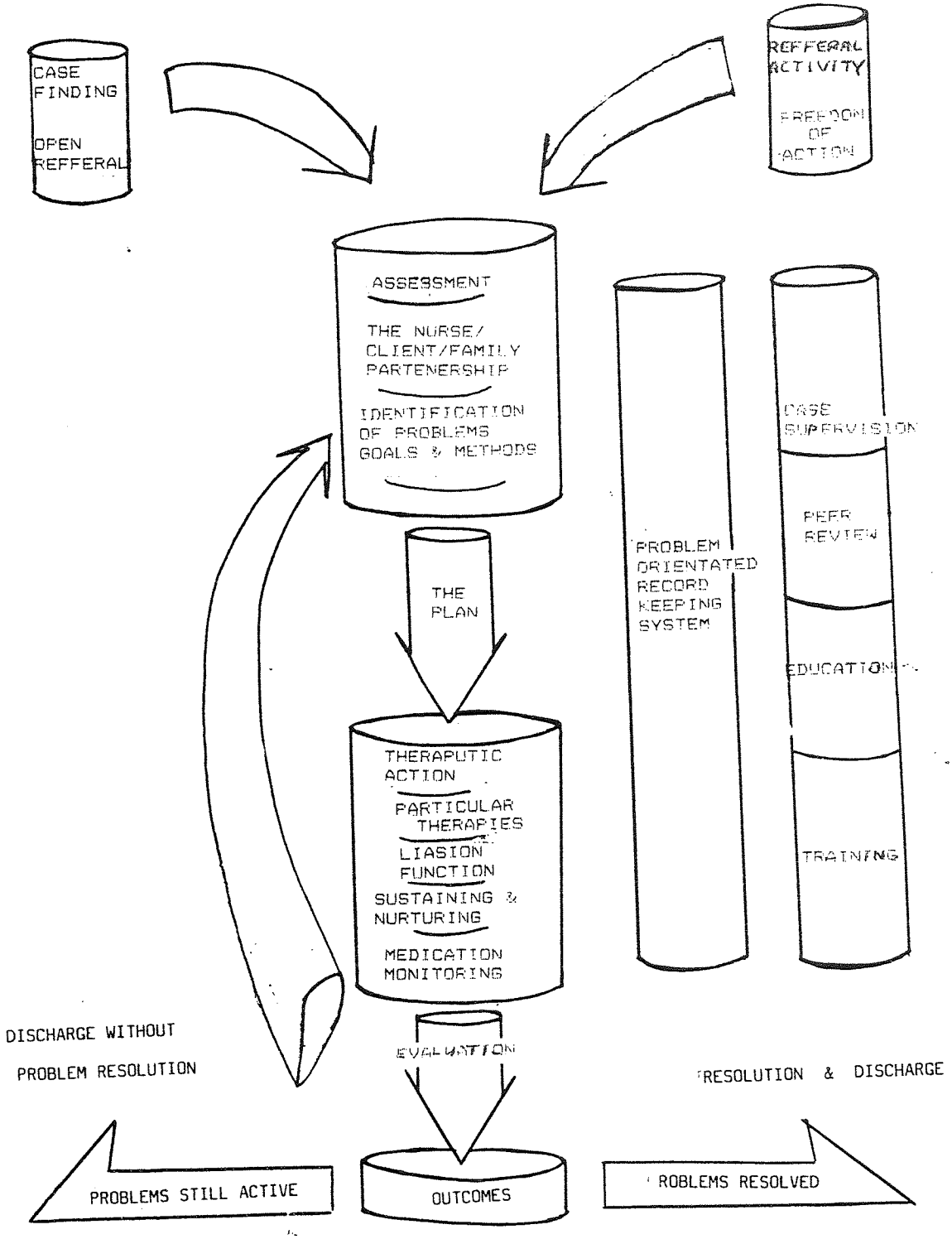


FIG 12.2 A PROBLEM ORIENTATED MODEL
FOR COMMUNITY PSYCHIATRIC &
COMMUNITY MENTAL HANDICAP NURSES



Goldberg[39] quoting Hutton says of her major indictments of social work in the 1950's, she attacked the social workers conviction that she can understand other people better than they understand themselves and the social workers 'duty' to penetrate below what is called the presenting problem - we pass out of the frying pan of charitable condescension into the no-less condescending fire of superior psychological insight. The author would argue that the shared approach of a problem orientated method may prevent the community nurse from treading a similarly dangerous path, and give more equal measure to a sustaining and nurturing role as well as more particularly sophisticated intervention methods.

RECOMMENDATIONS OF THE STUDY

The principal limitation of this study is that it has described only one District Health Authority, which must question the representativeness and predictive validity of the findings.

The author would argue that these teams are representative for a number of reasons.

i) Evidence from the C.P.N.A. survey in 1985 bears witness to the comparability of the structure of Stockport to other psychiatric services.

ii) The C.N.M.H. team is similar in many instances to other teams known to the author. The only exception would appear to be that of the lack of referrals of the under 5 age group.

iii) P.O.A. does not discriminate in specialist orientation and can accommodate a wide range of service types.

iv) The action research/O.D. framework is going to be the same in principle but different in detail on each occasion it is used and it is only the principles which are offered here.

The main recommendations arising from the study are:

i) Community psychiatric and mental handicap nursing needs to be considered in a different light than hospital based care. Training is essential to either the production of new community orientated basic nurse education and/or suitable post-basic training to de-institutionalize and de-medicalize hospital nurses. It is fundamental to those staff wishing to work in the community and who have experienced a hospial based training.

ii) Community nurses need an ideological paradigm to replace their more traditional roles. This must be consciously considered and deliberately chosen.

iii) New coping mechanisms need to be developed for community work as old securities disappear. Supervision, case review and clear operational philosophies are suggested as supportive mechanisms which may help the changes in operation.

iv) Community psychiatric and more particularly community mental handicap nursing should be developed and further explored. There is no doubt that it is presently practiced in a variety of contexts under differing regimes by different

groups of practitioners. This makes the identification of a particular body of knowledge difficult. This study has shown and the author recommends further detailed examination of the nurse as a therapeutic agent. There is no doubt that the nurses featured in this study have a valuable part to play in a role which encompasses liaison and sustaining and nurturing. However, there is evidence that training in more particular therapeutic approaches would enhance practice.

v) During the course of this study a whole career structure for nurses in management has disappeared under new 'Griffiths' style management. The author recommends the creation of a clinical career structure for psychiatric and mental handicap nurses. Three levels might be considered, i) a provider of the right therapeutic mileau or the sustainer and nurturer, ii) the nurse therapist who can offer skilled therapeutic intervention, iii) the nurse consultant who is a specialist in one or a number of therapeutic methods. Each could provide a systematic approach to casework and supervision of another level of nurse.

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APPENDIX

APPENDIX ONE

AUDIT FOR ORGANIZATIONAL CLIMATE: SAMPLE FORM.

DATE OF APPOINTMENT	
IS THIS THE FIRST AUDIT PROCEDURE UNDERTAKEN	

AUDIT FOR 'ORGANISATIONAL CLIMATE'

SECTION A ALLOCATION OF TIME

1. Please state time :

a) Duties commence	
b) Duties terminate	

2. Please state approximately how much time you spend on the following.

Is it :-

	Daily	Hours per week	Weekly	Days per week	Monthly
a) Visiting Patients					
b) Clerical Work					
c) Attending Case Conferences					
d) Ward Rounds					
e) Travelling					
f) Attending G.P. Surgeries					
g) Attending O.P.D.					
h) Attending O.P.D. elsewhere					
i) Social Work Departments					
j) Attending Lectures					
k) Giving Lectures					
l) Community Psychiatric Meetings					

3. In preparing your timetable are you able to take into account the patients' needs in terms of :

	YES	NO	Comments if required
a) Treatment ?			
b) Frequency of treatment ?			
c) Medication ?			
d) Social problems ?			

	YES	NO	COMMENTS IF REQUIRED
4. In preparation of the duty rota :			
a) do you discuss with other Nursing staff ?			
b) can off-duty be mutually agreed ?			
5. Is the duty rota prepared so that advanced notice is given to :			
a) staff ?			
b) Unit Nursing Officer ?			
Do your team participate in late calls			
Are you satisfied that you are able to carry out your domiciliary visits in conjunction with your attendance at Clinics/Health Centres/Surgeries?			
6. Do you systematically check :			
a) Work standards ?			
b) Procedures ?			
c) How ?			
7. Do you give reports of patient progress to the Nursing Officer:			
a) Verbally ?			
b) In writing ?			
8. Are there procedures for arranging any necessary continuity or commencement of care from other agencies after discharge from community nursing care ?			

	YES	NO	COMMENTS IF REQUIRED
9. If the patient requires 'physical care' outside your normal role as a CPN do you arrange this by contacting :			
a) Hospital Liaison District Nurse?			
b) District Nurse?			
c) Attending to it yourself?			
d) Delegating it to another member of your staff?			
e) Are these arrangements made by: i) phone ?			
ii) letter ?			
iii) personal contact ?			
10. On the discharge of a patient from your care is there a satisfactory procedure for conveying such information to:			
a) General Practitioner ?			
b) Psychiatric hospital medical staff ?			
c) Other agencies ?			
11. Do you feel the information it contains is satisfactory ? If no please comment.			

SECTION B GENERAL ADMINISTRATION - RECORDS

	YES	NO	COMMENTS IF REQUIRED
1. Do you think that the present recording systems provides sufficient material for the maintenance of essential patient/client information ?			
2. Are you satisfied that the present recording systems ensures the observation of patient/client confidentiality to the full ?			
3. Do the record systems ensure the co-ordination and continuity of patient/client care is maintained for :			
a) yourself ?			
b) within the Unit ?			
c) between Community/Hospital departments ?			
d) between Community/Social services Departments ?			
4. Do you think that the record-keeping you are doing is :			
a) Time well spent ?			
b) Waste of professional training ?			
c) Could be done by a clerical assistant?			
5. Does maintenance of records prevent your attending to patients/clients adequately ?			
6. Do you have a satisfactory filing system with your record cards, so that patient/cleints' records are easily traced :			
a) by yourself ?			
b) by others ?			

	YES	NO	COMMENTS IF REQUIRED
7. Does your record filing assist you with knowledge of patients/clients requiring :			
a) routine visiting ?			
b) selective visiting ?			
8. Do you attend to the filing and tracing of your patient/client record cards :			
a) by yourself ?			
b) with clerical assistance ?			
9. Are you satisfied that communications are well co-ordinated between the hospital and community health field so that patient /client continuity is maintained ?			
10. Are you satisfied that communications are well co-ordinated between the Social Services Dept., and the community health field, so that patient/client continuity is maintained ?			
11. Which of the following can be identified from your records :			
Patients problems			
a) as seen by nurse			
b) as seen by patient			
Goals to be achieved by client			
Therapies to be used by the nurse			

12. Do you think that it is necessary to know the catagories of information in Q.11.	NECESSARY	NOT NECESSARY
Patients problems		
a) as seen by nurse		
b) as seen by patient		
Goals to be achieved by client		
Therapies to be used by the nurse		

13. Who else other than the Nursing Officer and the CPN team sees the records you keep ? Please specify.

14. Do you use any specially designed assessment procedures i.e. Graylingwell checklist of daily living skills, Becks inventory, Stockton rating scale ?

Please specify

SECTION C. LEGISLATION/POLICIES

	YES	NO	COMMENTS IF REQUIRED
1. Are there facilities to obtain information about the following Acts :-			
a) Children and Young Persons Act, 1969			
b) Chronically Sick & Disabled Persons Act, 1970			
c) Contracts of Employment Act, 1972			
d) Health & Safety at Work Act, 1974			
e) Legal Aid and Advice Act, 1949 - 1972			
f) Medicines Act, 1968			
g) Mental Health Act, 1959			
h) Misuse of Drugs Act, 1971			
i) Motor Vehicle (Passenger Insurance) Act, 1971			
j) N.H.S. (Injury Benefits) Regulations , 1974			
k) N.H.S. (Industrial Injuries) Act, 1965			
l) Prescription Charges			
2. Do you have access to :			
a) Personnel policies ?			
b) Whitley Council Handbooks ?			
c) Psychiatric Unit Policy Manual?			
3. Is there a General Nursing Procedures Manual in your Department ?			
4. Is there a Psychiatric Nursing Procedures Manual in your Department ?			

	YES	NO	COMMENTS IF REQUIRED
5.			
6.			

SECTION D PROBLEMS ENCOUNTERED DURING VISITS

	YES	NO	COMMENTS IF REQUIRED
1. During the course of a visit, have you ever had to deal with the following situations :			
a) Attempted suicide ?			
b) Aggressive patients ?			
c) Violent Patient ?			
d) Intoxicated patients ?			
e) Severely disturbed psychiatric patients ?			
f) Ill treatment of children ?			
g) Do you know the procedure in cases of suspected non-accidental injury to children ?			
h) Other (please specify)			
If so, did you manage to cope with the situation ?			
2. Did the situation affect you :			
a) physically ?			
b) emotionally ?			
3. Did you get the opportunity to discuss such episodes with other colleagues ?			
4. Do you feel that such discussions help you to deal with further situations like this?			
5. Do you know the procedure to follow in cases where patients make allegations about you or other members of staff ?			

Please add any detailed comments you may have on the above question.

SECTION E

	YES	NO	COMMENTS IF REQUIRED
1. Do you feel that the responsibility you get in the community is commensurate with your level of training ?			
2. Are you encouraged to develop your role in the community ?			
3. If yes, who encourages you :			
a) Nursing Officer ?			
b) Sister/Charge Nurse ?			
c) Others (please specify)			
4. Do you consider your patient case-load provid provides you with appropriate level of job satisfaction ?			
5. Do you discuss with other personnel the patients you have on your case-load ?			
6. Is there an adequate procedure for discharging patients from your case-load ?			
7. Are the majority of patients you visit:			
a) elderly ?			
b) patients on injections ?			
c) others (please specify)			
8. Do you have opportunity to participate as a full member of the Community Psychiatric Nursing team ?			

9. Does your post give you 'job satisfaction'

YES	NO	COMMENTS IF REQUIRED

10. Please state here how you see your role developing in the community and indicate what other areas of work you would like to become involved with.

SECTION F PRACTICAL/FIELDWORK SUPERVISON

	YES	NO	COMMENTS IF REQUIRED
1a. Are you an approved Practical Work Teacher of Community Nursing Sisters ?			
b. Are you a qualified Fieldwork Instructor?			
2. If so: Do you feel involved in the design of the training which is relevant to you ?			
3. Do you feel that there is room for improvement in the experience which is available to the Nurses for whose training you are in part responsible ?			
4. Do you have the opportunity to suggest new ideas which may improve their training experience to: a) Community Nursing Officers ?			
b) The appropriate Training Centre?			

SECTION G IN-SERVICE TRAINING

	YES	NO	COMMENTS IF REQUIRED
1. To improve techniques of community patient care, would field staff benefit from further In-Service Training ?			
2. Do the follwoing staff receive In-Service Training :			
a) Yourself ?			
b) Enrolled Nurses ?			
c) Clerical Assistants ?			
3. Do you feel your present level of training is adequate for the work you are doing ?			
4. Do you want to attend the CPN Course (JBCNS 810) ?			
5. Do you use specialist therapies :			
a) Behaviour therapy			
b) Psycho-analysis			
c) Advanced psychiatry			
d) Psycho-sexual counselling (two year course)			
e) Care of the Elderly			
f) Alcoholism			
g) Drug addiction			
h) Other (please specify)			

SECTION E

	YES	NO	COMMENTS IF REQUIRED
1. Are you involved in any research projects			
2. Do you want to be involved in any research projects ?			
3. Do you feel that trained nurses get enough encouragement to attend courses ?			
4. Are you given sufficient information before attending courses?			
5. Have you ever attended a course that you felt was inappropriate ?			
If yes, please give name of course			
6. Are you given the opportunity to use the knowledge you gained from the course ?			
7. Are any books relative to community psychiatric nursing available to you in the department (exclude privately owned books)			
8. Do you keep up-to-day with changes in psychiatric nursing ? Please state examples.			
9. Are there facilities for futher training for yourself, which maintains your knowledge in keeping with changing community needs ?			

	YES	NO	COMMENTS IF REQUIRED
10a. Do you receive Management Training ?			
b. Is it adequate ?			
11. Are you given the opportunity to suf suggest new ideas which may improve the Community Health Service ?			
12. Are you encouraged to visit :			
a) Community Services within the District ?			
b) Community Services in other Districts ?			
c) Hospitals ?			

APPENDIX TWO

AGENCIES & INDIVIDUALS GIVEN INFORMATION ON THEO.D. PROJECT.

INDIVIDUALS & AGENCIES GIVEN INFORMATION ON THE O.D. PROJECT

1. CALDERSTONES HOSPITAL BURNLEY LANCASHIRE
2. LEIGH INFIRMARY LANCASHIRE
3. SANDWELL HEALTH DISTRICT BIRMINGHAM
4. CHEADLE ROYAL HOSPITAL CHESHIRE
5. AIRDALE DISTRICT HANDICAP SERVICE YORKSHIRE
6. ROYAL CARSWOOD HOSPITAL SURREY
7. CLAYBURY HOSPITAL ESSEX
8. ABERDEEN HEALTH BOARD
9. SOUTHMEAD HOSPITAL BRISTOL
10. PARKSIDE HOSPITAL MACCLESFIELD CHESHIRE
11. EXMINSTER HOSPITAL
12. NORTHAMPTON HEALTH DISTRICT
13. Mr K. KELLAHER, SYDNEY AUSTRALIA
14. BARBRO GUSTAFFSON NAKKA PROJECT STOKHOLM SWEDEN
15. BARNSLEY DISTRICT HEALTH AUTHORITY
16. GREAT YARMOUTH & WAVENY HEALTH AUTHORITY
17. P.S.S.U. UNIVERSITY OF KENT
18. P.N.A. DUBLIN EIRE
19. St LUKES HOSPITAL ARMAGH N. IRELAND
20. MAPPERLY HOSPITAL NOTTINGHAM
21. WALTON HOSPITAL CHESTERFIELD
22. BROADGATE HOSPITAL HUMBERSIDE
23. DARLINGTON HOSPITAL DURHAM
24. St BERNARDS HOSPITAL MIDDLESEX

APPENDIX THREE

PAPERS, WORKSHOPS AND LECTURES ARISING FROM THE O.D. PROJECT

PAPERS WORKSHOPS AND LECTURES ARISING FROM THIS PROJECT

1983 'Problem Orientated Approaches to Care '
International Conference on Contemporary Issues in Mental Health, April, Imperial College London.

1984 'Development in Community Psychiatry'
Psychiatric Nursing Annual Conference, April, Dumfries

1983/84 'Theory to Practice - Implementing the Nursing Process'
to Burnley Health District staff. A longitudinal series of workshops to implement new care methods.

1985 The Clinical Career of the Psychiatric Nurse Paper
given to the Annual General Meeting of the Psychiatric Nurses Association : York University

1982 'Mental Health' an overview - in Readings in
Community Health, ed Clarke J. Churchill Livingstone

1983 'Who Attend JBCNS Courses ?', March, CPNA Journal

1984 'The Future Training of Psychiatric and General Nurses'
Nursing Times, June

1985 The Role of the Psychiatric Nurse, Irish Journal of
Psychiatric Nurses, November

APPENDIX FOUR

SAMPLE NEWS LETTER SENT TO THE TEAMS AND THEIR MANAGERS

MANCHESTER POLYTECHNIC/STOCKPORT HEALTH AUTHORITY

ORGANISATIONAL DEVELOPMENT PROJECT

NEWSHEET 3 DECEMBER 1983

PHASE ONE

Since the last newsletter (March 1983) the community nursing establishment for the psychiatric and the mental handicap teams has increased. Introductory talks on the background and development of the Problem Orientated Record techniques were given to the new staff and tutorial follow-up continued on an individual basis.

There are two further appointments expected in the New Year, the Problem Orientated Record approach will be demonstrated to these nurses at the earliest opportunity. The P.O.R. introductory talk has been 'built into' the initial, month long orientation programme for newly appointed C.P.N.'s.

Tutorial follow-up on a one-to-one basis has served a number of useful purposes, they have enabled the research associate to:-

a) Monitor transfers of patients from nurse to nurse, which has been brought about by clinical evaluation or internal staff rotation.

b) To keep up-to-date with the constantly changing problem lists, evaluations, discharges etc.

c) To discuss individual difficulties encountered in defining problems.

The follow-up tutorials offered to individual nurses remains flexible.

The frequency of these meetings depends upon:-

a) The difficulties which nurses encounter in employing the problem orientated approach, and

b) the frequency with which they are requested by the nurses themselves.

Finally the follow-up tutorials have provided the essential reassurance that progress is being made, in the sense that the P.O.R. case management approach

is being implemented in the correct manner.

CLINICAL SUPERVISION

The tutorials have proved a useful forum for the discussion of individual patients with notable case management problems. This has proved beneficial to both nurses and researcher. However, more evidence of the value of C.P.N. case management supervision is required, and would undoubtedly benefit from closer study.

PROBLEM LIST DATA SHEETS WITHIN THE NURSING PROCESS

The extent to which the Problem List data sheet is being employed varies from individual to individual. A number of C.P.N.'s and C.M.H.N. 's have problem orientated almost their entire caseload. Others find it relevant only within the context of the Nursing Process or other specialist assessment criteria (where community nursing care will be delivered over an extended period of time). The problem orientated recording approach is provididng a flexible framework for planning individualised patient care.

ANALYSIS OF DATA

The volume of collectable data has necessitated the development of a statistical package appropriate to the researcher's requirements. The Statistical Package for the Social Sciences (SPSS) has proved adaptable. We now have a computer programme providing data, which lends itself to immediate analysis.
The print-out can present data in a number of forms, these include:-

- a profile of the frequency of which problems occur.
- problems cross-tabulated with age and sex of the client.
- problems which are sucessfully resolved.
- a profile of problems which provide an indication of areas of nursing skills requiring further education and training.

PHASE TWO

ORGANISATIONAL DEVELOPMENT

The development of skills and the acquisition of specialist nursing knowledge are seen as an integral part of this project. The audit completed in July 1982 and an analysis of the computerised data illustrate the general and specific deficits that exist at present. The C.P.N.'s and C.M.H.N.'s recognise these limitations and have welcomed plans for a series of seminars, lectures and workshops to commence shortly.

COUNSELLING SKILLS

Both nursing disciplines recognise the importance of counselling skills in their daily contact with patients/clients and their relatives. An introductory seminar has been arranged to explore relevant aspects of counselling. The leader will be Mr Frank Ashton, course leader to the Polytechnic diploma in counselling.

Timetable

Initial meeting - Friday 16 December 1983 at 2.30 p.m. in the Conference Room, Department of Psychiatry, Stepping Hill Hospital.

At this meeting the dates of a series of eight seminars provisionally planned for JANUARY - MARCH 1984 will be discussed.

DRUG DEPENDENCY

A number of C.P.N.'s are involved in the management of drug addictions. Recognising this, they have actively sought contact with the Lifeline Drug Advisory service based in Greater Manchester. Since then we have had discussions with the School of Nursing/In-service training. A workshop has been arranged for 30 May 1984. It is clear that ward-based psychiatric nurses and other

non-psychiatric nursing disciplines will benefit quite as much as C.P.N.'s. Hence, a restricted number of places for this workshop will be available to C.P.N.'s.

Further information will be relayed to the community nursing services about future seminars/workshops when available.

Outside Interests

A number of nurses have shown interest in the Stockport organisational development project. This interest stems from the implementation of the Problem Orientated Record keeping approach and for a number of different reasons.

A ward at the Psychiatric Unit, Leigh Infirmary employs the P.O.R. approach as an integral part of the nursing process.

The C.P.N. service at Sandwell H.A. are interested in implementing this approach.

Finally, moves are underway at Calderstones to introduce this approach, pending the appointment of a full-time nursing process co-ordinator.

Tony Butterworth, Project Leader.

David Rushforth, Research Associate.

APPENDIX FIVE

THE IN-SERVICE TRAINING PROGRAMME

THE PROGRAMMES

In total some eleven experts were used for the in-service education and training programmes. Common approaches were used and each separate programme was evaluated in its own way.

Programmes are presented in this thesis for two reasons. Firstly, they demonstrate the case methodologies that the practitioners were exposed to; and secondly, as their evaluations were generally highly favourable, they serve as a record of programmes which other practitioners may find useful.

That which is presented here is of necessity a distillation of the programmes and cannot do them total justice for much of the content was experiential in nature. Notes are in edited form for the sake of brevity.

COUNSELLING

The programme on counselling was led by Mr Frank Ashton, a practising counsellor and senior lecturer at Manchester Polytechnic.

Sessions took place over a 9 week period and were attended by most nurses from both the psychiatric and mental handicap teams. Attendance varied between 9 and 14 nurses at any one session (from a possible 14). Mr Ashton stated from the outset that sessions were not compulsory but that nurses should make some contractual obligation if they wished to attend. Sessions were a mixture of experiential and participation exercises and to a lesser extent, lecture method.

SESSION 1

PERSONAL AWARENESS

2 Exercises

1) Woodcock Scale

'Beliefs about other people.'

Instructions Nurses were asked to:-

- Ring the appropriate number on a 7-point scale, which relected their own personal view on 'Beliefs about other people'.

- Join the line together.

Time was given to personally study the results and nurses were then asked to show results to another team member, discuss discrepancies, i.e. situations which illustrate the given choice.

2) Interaction Style

This exercise was supplemented by exercise sheets. They contained a number of grids.

A) A horizontal axis comprised of 5 personal characteristics which illustrate a 'personal style' of interacting with others.

B) Nurses were asked to score what they believed to be their own personal style of interacting on each of the 5 factors:-

Critical - Caring - Realistic - Spontaneous - Compliant

C) The information was then illustrated in a box and labelled 'Original'. Nurses were then asked to consider the items in another exercise sheet ticking off characteristics identified as applicable to their style of personal interaction with clients.

The workshop leader then ran through the items under the 5 headings mentioned previously, e.g.

Critical

- 5 critical
- 7 authoritarian
- 16 analytical
- 18 objective etc

Nurses were asked to score the number of ticks they had noted under each of the 5 headings. Time was given to shade the appropriate column in a second grid pattern with a vertical axis as a frequency counter.

Nurses were then asked to study the similarities and differences between the two patterns.

Summary from the workshop leader

AIM to increase personal awareness.

The first exercise focussed on issues such as a need to control others and perceived degrees of trust in other people.

The second exercise sought to heighten awareness of influence of personal characteristics in client interaction.

LIMITATIONS Nurses were discouraged from dwelling on choices (due to time factors). The degrees of personal insight and spontaneity varies so much that one cannot be sure that the same level of honesty and insight is proferred by the participants. This reinforced the validity of such exercises to anyone other than individual participants.

SESSION 2

PERSONAL AWARENESS IN INTERACTIONS AND PERSONAL SPACE

This session considered the perception of self in different situations. Nurses were asked to view a profile of 'me' based on the 5 category grid used in Session 1.

'ME' was asked to view itself in relation to:-

- client (last session)
- family
- in-laws
- friends (childhood)
- friends (current)
- colleagues

The second half of the session was devoted to exercises considering personal space and posture.

Exercise 1

- 2 volunteers, one standing still, the other moving closer, the stationary volunteer asked (by the workshop leader) how they feel as other moves closer. Asked to say 'STOP' when feeling uncomfortable/threatened.
- then other party asked for their views.
- repeat with 2 males, 2 females, 1 male and 1 female.
- observers were asked to note differences

- general feedback session.

Exercise 2

- 2 volunteers sat opposite one another
- one was nominated the client and they were instructed to model, the other volunteer was asked to provide appropriate postures to register impressions of concern, interest, attention etc
- when the nurse (as client) felt satisfied, observers were asked to make what they interpreted as the appropriate changes.

Alternative

- one nurse volunteer, as therapist, was seated in the middle of a circle
- the others took it in turns to request one change in posture, which pointed to a more appropriate posture.

Discussion

- on 2 sessions to date centred on interpersonal space in interviewing situation but also covered value of alternative means of communications, i.e. art therapy.

Homework and Feedback

Nurses were asked to consciously note personal space in relation to clients and report back next week. Homework and

feedback become a feature of most subsequent sessions.

Homework served to:-

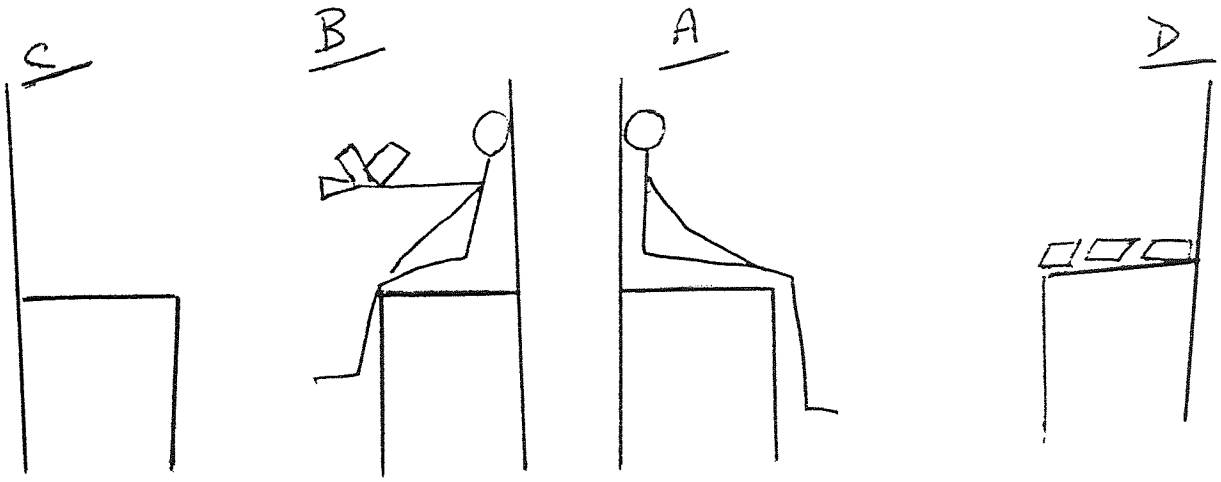
- maintain continuity between sessions
- allow workshop leader to recap/summarise the previous week's session
- apply workshop ideas to current practice.

SESSION 3

COMMUNICATION

Following feedback from nurses on experiences during the week relating to Session 2, participants centred on two further exercises which illustrated the great difficulties present when two individuals attempt to communicate.

In the first exercise, 4 chairs, two nurses volunteered and the rest observed. This session was repeated in order to confirm the difficulties experienced by the nurses were not peculiar to them.



FOUR CHAIRS

A asked colleague B to put the 3 pieces of paper in her hand on the chair, and in the same order as they appeared on chair D.

B could ask questions but could not look.

Workshop leader likened the exercise to a counselling situation where person A (the client) views what he sees D and tries to communicate this to person B. What B finally ends up with rarely bears any resemblance to the view of A.

Instructions should take B every step of the way.

- use perimeter i.e. edge of chair
- shape of paper etc. as framework.

e.g. Airfix kit depends on logical steps in a sequence of

instructions to construct the finished product in the correct manner.

Discussion

Communication was seen as a two way process and in effective communication both parties can clearly and logically state their point step by step. In the counselling situation the therapist and client rarely achieve universal/mutual understanding. The skilled therapist should have clear and logical communicating abilities plus the ability to compensate for the client's potential inability to communicate. Hence the therapist should develop a number of techniques including prompting, directing, reflecting etc.

Exercise 2 Word Wizard

Served a similar purpose, but gave all nurses an opportunity to particiate.

Instructions

Nurses gathered in pairs

- both partners were allowed only 4 words in their vocabulary
- 2 minutes were given to decide on the 4 words
- gestures/mimes were permissible
- no writing/speaking allowed other than the 4 words.

Participants were asked to bear in mind

- their thoughts when given task of thinking of 4 words
- what it felt like with such limited dialogue.

Next Entry into 2 minutes dialogue

When 2 minutes were up

- a request for one volunteer (of the 2) who continued for a further 2 minutes with only 4 words
- the other partner could speak freely, say what they wished to say with some explanation of what they were trying to say before.

after a further 2 minutes nurses discussed

- experience of choosing 4 words
- what it felt like after volunteering for another 2 minutes, restricted to 4 words
- what it felt like for the person who could speak freely
- what happened between the two during joint restricted dialogue and when one was given free rein.

SESSION 4

NURSE-CLIENT INTERACTION

Feedback on Session 3 was followed by a workshop focussing on three fundamental aspects of the counselling situation:-

- reflecting

- tuning into emotions
- prompting

After discussion of these topics, the group leader asked the participants to split up into groups of three.

- Each person was appointed either client, counsellor or observer.
- Each 'role' group was briefed.

Clients - Each CPN was asked to think of one recent disaster in their lives as a topic for discussion.

Counsellors - were reminded to consciously attempt to use reflection, tuning into emotions and prompting in the interview situation. They were given a brief resume of what to expect from the 'clients'.

Observers - were asked to observe clients, counsellors verbal and non-verbal interactions, with particular attention to be paid to counsellor's attempts to reflect, tune into the client's emotions and prompts.

Group Leader - gave 5 minutes for the interview.

- then asked teams to come back into group
- each 'role' group was asked for their feelings about the interview
- the interview was repeated after each CPN changed 'roles' (in different groups?)
- the large group was reconvened
- a final interview was undertaken ensuring that all

nurses had experienced all 'roles'

- final large group feedback sessions.

Homework - Nurses were asked to consciously apply these techniques on 2 occasions during the coming week.

SESSIONS 5, 6, 7

These three sessions concentrated on role playing situations using video camera and recording facilities to allow feedback and analysis of specific interactions.

Subjects covered included:-

- stating and rechecking
- paraphrasing
- asking open questions
- non-verbal cues - posture, eye contact etc.

The helping process and stages of interviews were outlined and handouts provided which covered this topic in greater detail.

Interactional Defences were described in brief and the group leader demonstrated his personal client interviewing technique in a role-playing situation.

Replay of the tape allowed participants the opportunity to detect specific techniques employed by the interviewer, to study non-verbal communications and note areas of questioning providing resistance from the client.

SESSIONS 8 and 9

Covered the subject of Transactional Analysis. The main themes were:-

- parent-adult child interactions
- game playing
- life scripts

The final session was concluded with a request by the workshop leader to complete a course evaluation.

BEHAVIOURAL PSYCHOTHERAPY

The programme on behavioural psychotherapy was led by two practising and qualified nurse therapists employed by Macclesfield Health District, Mr Andy Farrington and Mr Ken Allen.

They offered four half-day sessions and chose participative/experiential approaches. Although the community mental handicap nurses had indicated expertise in this area, and sessions were designed for the psychiatric nurses, the sessions were left open for them all to attend.

SYNOPSIS OF NURSE THERAPIST SESSIONS

GENERAL INTRODUCTION

- explanation on the role of Nurse Therapist
- client group worked with
- training required to qualify as Nurse Therapist
- discussion of the involvement/committment required by CPNs in following sessions.

Session followed broad subject themes:

Session 1: Phobia

Session 2: Social skills

Session 3: Sexual deviation

Session 4: Anxiety management

Sessions 1, 2, 3 and 5 followed the same format (described below). Session 4 was a more conventional teaching session where the physiological/psychological basis of anxiety was explained and extensive discussions took place. Session 4 was intended to demonstrate the universality of anxiety as a positive force, which harnessed can improve S-T performance, and the celeterious effects of anxiety and its prominent symptomatic features in a very wide range of psychotic states.

STRUCTURE OF SESSIONS 1, 2, 3 and 5

A) BRAINSTORMING

- All participants were encourage (in turn) to forward signs/symptoms - physical, psychological and environmental (cataloguing any disruption to daily living)
- Leaders wrote them up on a blackboard and offered prompts where required.

B) VIGNETTE

A short written or verbal biography was given to nurse participants.

- Leaders went into role, one as client, the other as interviewing therapist.
- The client stayed in role throughout the

interview.

The nurse therapist who interviews may ask one or two questions, then asked each nurse to interview client in turn.

FEEDBACK

- After asking a few questions, the nurse was stopped by the other leader, who now assumed the role of facilitator.
- Observing nurses (in turn) were asked to give positive statements about the nurse's interviewing session.
- Then negative feedback offered.

The second nurse interviewed the client and there was a repeat of feedback session.

Leaders as facilitators then asked to go back over information abstracted to date. THIS WAS WRITTEN UP ON THE BLACKBOARD. It discouraged repetitive questioning and allowed the leaders to guide (or at least offer hints) as to the most fruitful line of questioning.

The third and fourth CPNs interviewed with feedback sessions.

The leaders increasingly directed nurses to

a) isolate the problem

b) qualify the specific nature of that problem

e.g. in social skills (Session 2).

The problem - 'Has difficulty mixing with people' requires specific qualification and questions are encouraged which will elicit this information.

Hence:-

Q. What age group are you having difficulty mixing with?

"Own age group."

Q. Which sex do you find it difficult to mix with?

"Girls, the ones I find attractive."

H) The leader then prompted nurses to ask any further questions of the client.

I) The leader came out of role. Nurses were asked as a group to offer statements of the problem (guided by nurse therapists).

TARGETING

Leaders asked nurses what should be an overall target for dealing with this problem.

e.g. Session 2.

To meet people in a mixed group setting. To engage in conversation, twice a week for the duration of the evening.

In going over the overall target the leaders drew attention to:

- whom they must meet
- what they should do
- how often and for how long
- where these meetings should take place.

SUB-TARGETING

Nurse therapists draw attention of CPNs to adopting a step-by-step approach paying attention to targets which are achievable and incremental.

e.g. Systematic desensitization
Social skills groups.

ROLE PLAYING SESSIONS CAN BE RECONVENED

e.g. Session 2.

Leaders both went into role. A. the client, B. a stranger at a youth club.
Nurses were asked to observe:

- non-verbal contact
  - posture
  - eye contact

- listening
- facial expressions

- appropriate contact on meeting
  - handshake
  - smile.

Emphasis was put on the role nurses can play in convening social skills groups.

M) OTHER TREATMENTS

Leaders discussed supplementary treatments, e.g. relaxation, and also indicated whether drug therapy is compatible with behaviour therapy. This varied according to therapeutic regime employed and individual circumstances of client.

N) RATING SCALES

Various rating scales were distributed and their purpose and appropriateness explained.

The leaders carried out an evaluation of the sessions covered by them.

FAMILY THERAPY

Four practising family therapists were used to work with the four established sub-groups. They were:-

Tom Tomlinson - Lecturer, Manchester Polytechnic - allocated to the community mental handicap nurses.

Lynn Bradley - Social Worker, Salford Health District - allocated to one group of generic CPNs.

John Archer - CPN and family therapist, Tameside Health District - allocated to one group of generic CPNs.

Jane Harper - Lecturer, Manchester Polytechnic and family therapist - allocated to the E.S.M.I. group.

Family therapy sessions were participative events and although following common themes were inevitably experiential and consequently different. Casework of the participants was used to highlight the nurses' own experiences.

A distillation of group experiences is described for the purposes of the study and groups although different experienced most of the work described.

Evaluation of the sessions was varied and informed but there was general agreement that most participants had been

stimulated and the importance of case supervision had been reinforced yet again.

FAMILY THERAPY SESSIONS

The following is a distillation of meetings/workshops attended and some of the handout material provided to CPNs. No attempt is made to differentiate between group sessions run by individual leaders.

Familiarization

This essential exercise was covered in varying degrees by all of the therapists, and proved to be a case of demonstrating its importance by good example, as familiarization is perceived by family therapists to be an important initial step in engaging clients in therapeutic activities.

The workshop leaders allocated time to explore the background of team members, qualifications and previous experience. In addition, information about the organizational structure of service was sought from the CPNs. Details of the age groups and the likely place of family therapy approaches in individual CPN initiatives.

Limitations of this exercise

The workshop leader outlined the likely achievements of the next three sessions emphasising that family therapy skills require resources, expertise and live supervision to flourish.

The following courses were recommended by one workshop leader:-

1) Family Therapy Course: Institute of Family Therapy

Led by: Irene Gallagher,
Regional Training Officer.

2) Group Analysis Course:

Led by: Dr. Margaret Davenport,
Mike Kerfoot.

Venue: Monsall Hospital.

3) Family Therapy:

Led by: Ian Shuttleworth

Venue: Cardiff

SUPERVISION

There are a number of ways of conducting supervisory sessions and these were described, namely delayed, live and co-therapy/conjoint supervision.

Live supervision was viewed as the best method of training.

Delayed Supervision offers the opportunity to review cases, analysis, current interactions and the relationship with the family and its individual members. New avenues may open up as the result of tapping objective, expert advice.

The medium for case presentations may include:-

Written reviews or care plans which can be supplemented by family trees and are a useful test for illustrating family relationships. Delayed supervision does not allow an immediate response but can be built into the working week at multi-disciplinary meetings.

'Live' supervision - regarded as the most effective teaching method. This requires considerable capital outlay to design appropriate setting and materials, e.g. one-way screen, video tape recorders etc. Families are informed that experts are watching from behind the mirror. Supervision is usually maintained by intercom or pre-determined timeouts.

Conjoint Therapy - allows an active therapist the benefit of supervision from a passive co-therapist in a group setting,

e.g. home or therapy room at the out-patient clinic. Communication can be organized through timeout or deliberately built into the session.

Making Initial Contact

Example letters were given which aim to formalize the initial contact. The family therapists view formalizing such contact as important as it:-

1) gives the client exact details of the meeting in writing.
2) outlines the main points to be covered in this meeting, in such a manner as to reduce irrational fears or anxieties which may be generated prior to the meeting.

A second letter demonstrated how other members may be brought into the therapeutic milieu. The phrasing emphasises:

i) the difficulties the therapist has in progressing further
and ii) values the client's potential contribution.

The Initial Session

The structure of the initial session requires some preparation.

1) What is the aim of this session?

Therapists should aim to find out what is happening - in the

here and now. This should explore individual responses to specific problems and track what happens next. This way a pattern of response and counter-response can be traced.

2) Method - it is important to allow each member of the family their say, in their own time and in turn

- no interruptions from others should be allowed
- build in a break to allow for supervision, discussion of the case, and subsequent initiatives.

3) On reconvening the session, the therapist and family need to focus on negotiating rules. These should be considered as separate negotiations with rules for the parents and rules for the children, husband, wife etc.

4) A task should be set, this should be carried out between sessions and reported back upon at the subsequent session.

Dealing with Impasses

It is important to maintain control of family therapy sessions. At times this may require a tactical retreat, commonly known as ONE-DOWN. A variety of strategies can be employed:

1) Discontinue visits "until other members of the family become involved, I ....."
2) Colleague brought in "I feel as though I need further help at this point ....."

3) Take back to delayed supervision group.

"I need to discuss this with my colleague."

4) Offer live supervision "Need others to be involved."

5) Drawing parameters "I cannot help unless ....."

STRUCTURED FAMILY THERAPY

Minuchin[118] used as a reference point for these sessions. Structured family therapy always operated in the here and now.

Aim - to discover more about typical family interactions

- to discourage change where elements of family structure identified as 'dysfunctional'.

How? - by specific manoeures by the therapist during a family therapy session

- by giving the family/individual members tasks between sessions.

Structured family therapy:-

Asks - What do you do about ...? e.g. Johnnie's defiance.

- What does dad do?
- What happens then?

Tracking down behavioural sequences and operating in the here and now are two important tenants.

Does not ask - How do you feel? e.g. about Johnnie's defiance.

- Think back to ...?
- What happened when you were discharged from hospital?

Circumscribed boundaries

Parents have a function - children have a function but these sub-systems are neither static or immutable.

- children grow up
- marriage changes relationships
- setting up homes requires differentiation between in-laws and own identity.

Hierarchy of power

- parents have power over children
- dependency lessens as both parents and children grow older
- reversal of hierarchy whilst children still young is a serious dysfunction.

Enmeshed families

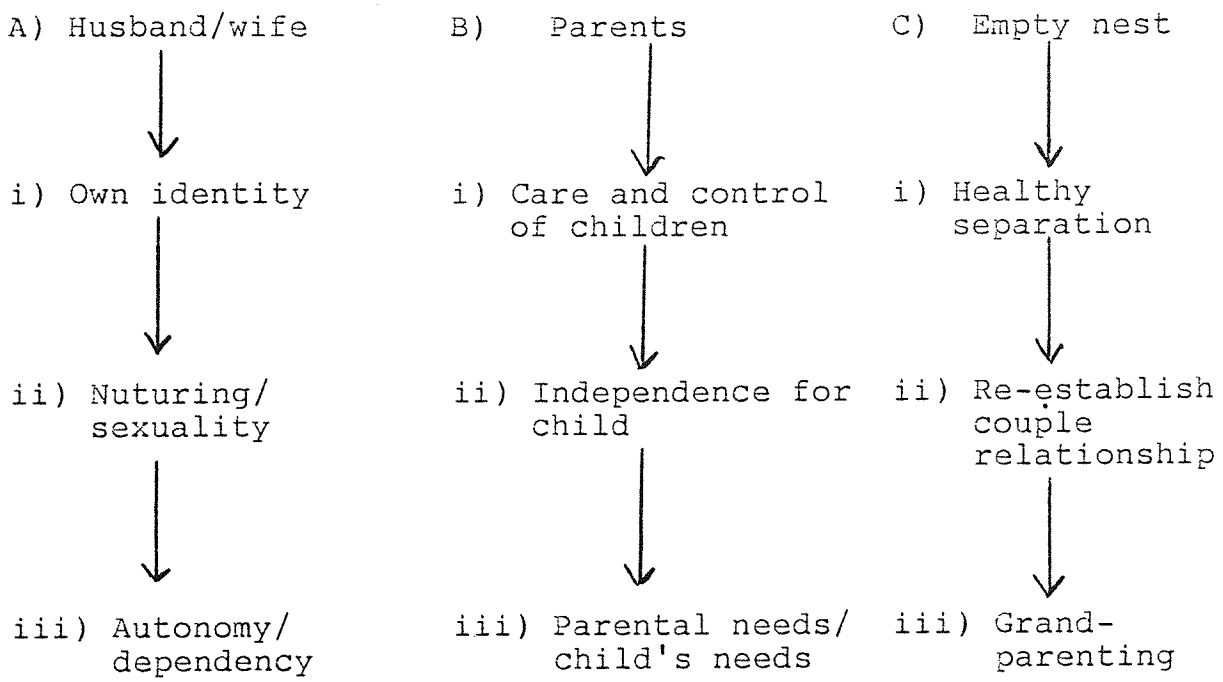
- members of the family know where each member is all of the time
- autonomy is discouraged
- growth of individual is severely restricted.

Disengaged families

- typically go their own way
- high level of autonomy
- disinterest in others' difficulties
- do not care, e.g. do not know or cannot recall birthdays.

THE FAMILY LIFE CYCLE

Christopher Dare (119)



Recognises the shifting patterns of relationships within a certain role and recognises the inevitability of shifts in these roles over time.

In the table above roles of husband/wife parents empty nest - are traced.

There are considerable pressures on these roles at most stages, for example:-

A) Husband and wife

Own identity - the identity of newly married couple setting out can be overly influenced in-laws.

Nuturing/sexuality - relationships outside the marriage can threaten both sexual relationships and the marriage.

Autonomy Vs Dependence - a balance needs to be struck between autonomy and dependence, a dependent husband may feel extremely vulnerable if his wife goes to work or earns more money.

B) Parents

Care Vs Control - negotiations need to increase as the child becomes older.

C) Empty Nest

i) Healthy separation

Departure of child requires parent to relinquish parent-child relationship to a greater extent. Adult to adult relationship grows.

ii) Re-establish couple relationship

The re-adjustment includes a shift in focus away from the children with the emphasis on strengthening the couple relationship.

CONTINUING THE INITIATIVES

In-service education and training was an introduction to therapeutic methods and attempted to provide a forum for change. It was also an opportunity for practitioners to continue adventures into new principles in practice.

This was demonstrated by nurses continuing case supervision by their own initiative and their attendance at the following workshops and courses.