THE PROFESSIONAL STATUS

OF THE

COMMUNITY PSYCHIATRIC NURSE

by

PETER ALAN MORRALL

DOCTORAL THESIS

SUBMITTED FOR THE AWARD OF

DOCTOR OF PHILOSOPHY OF THE

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Dedicated to my son, David.

With thanks to Professor Philip Bean for his potent tutelage, Dr Ted Glover for his fiscal support, Janice Gatenby for her technical skills, Sara Laine for her sustenance and proof-reading, and the mental health nurses for their time.

If we might put the letters but one way,

In the leane dearth of words what could wee say?

(John Donne, The Anagram, 1663)

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CERTIFICATE OF ORIGINALITY:

This is to certify that I am responsible for the work submitted in this thesis, that the original work is my own except as specified in acknowledgements or in footnotes, and that neither the thesis nor the original work contained therein has been submitted to this or any other institution for a higher degree.

Peter A. Morral.....(Signed)

1st April 1995.....(Date)

ABSTRACT

Many psychiatric nurses working in the community are changing their occupational base. They are working increasingly as members of a mental health multi-disciplinary team. This is a report on aspects of the role of the psychiatric nurse working in such teams.

Freidson's professional-dominance thesis is used as a theoretical framework to assess the occupational status of psychiatric nurses working in the community mental health team. In particular, the levels of clinical autonomy experienced by the nurse are explored.

Four community mental health teams are examined, using Diary-interview Schedules to record how new clients are processed by the psychiatric nurse. The other members of the teams were interviewed (as were the managers to whom the nurses were accountable) using Focused-interview Schedules. Furthermore, Field-notes were made of substantive, methodological, and pre-analytical observations made during visits to the team centres.

The report concludes that although there is an occupational hierarchy and inter-disciplinary rivalry in the teams, the psychiatric nurse enjoys a large amount of de facto clinical autonomy. The psychiatric nurse has also a dynamic and invariably unsupervised influence on the creation and pathway of psychiatric careers for those who are referred to her or him.

Recommendations include the need to affirm authoritative leadership in the team, and for formal supervisory

procedures to be installed. It is also recommended that psychiatric nurses in the community should re-assess their occupational strategy of professionalisation, with a view to a re-alignment with medical practitioners.

1.CHAPTER ONE INTRODUCTION

1.1.OVERVIEW and GENERAL CONTENT

This thesis provides an account of aspects of the working practices of members of a sub-section of the occupation of nursing, community psychiatric nursing. The goal of the research is an assessment of the occupational status of the community psychiatric nurse (CPN) within the context of a relatively novel organisational structure in the provision of mental health services. The organisational structure in question is the community mental health team (CMHT). This team encompasses such occupational disciplines as nursing, psychiatry, social work, psychology, and occupational therapy.

The main focus of the research is directed towards identifying the levels of clinical autonomy experienced by psychiatric nurses working in the CMHT. This includes an evaluation of the type of relationship the CPN has with her or his colleagues, supervisors, and managers, and the influence these relationships have on her or his clinical independence. A further aspect of the research is concerned with the question of how the CPN's clinical judgement affects the experience a user has of the mental health services.

Ten community psychiatric nurses, operating in four different teams in the North of England, were studied sequentially over a two year period between 1990 and

1992. The main research tool used was a Diary-interview Schedule. Information was recorded weekly about what action the CPN had taken in connection with new referrals to her or his case-load. Approximately twenty-five new referrals were monitored from each CPN (two-hundred and fifty-two in total). Furthermore, the CPNs' colleagues in the CMHTs and their managers were interviewed using a Focused-interview Schedule.

The presentation of the project is as follows. Following the introduction, there is an account of the purpose of the project, its substantive concerns, and reasons why these were worth researching. Next, the specific aims and sub-aims of the research, and its 'working' hypothesis, are delineated. There is also a description of the social and organisational setting of the four illustrative case studies.

In Chapter 2 there is a review of the relevant literature and theoretical debates. Here, attention is paid to the driving theoretical foundation of the research, which is taken from the sociology of the health professions. Firstly, a critical overview of sociological accounts of the professions is provided. This is followed by a discussion on Eliot Freidson's approach to assessing the occupational status of such professions as medicine. In the subsequent two sections, Freidson's perspective is applied to nursing in general and community psychiatric nursing in particular. The section on community psychiatric nursing includes a discussion on community mental health teams and their relevance to community psychiatric

nursing.

The research methodology is discussed in Chapter 3, which begins with a rationale for the choice of data-collecting techniques used in the study. This pre-empts a comprehensive description of the research process, and of the tools employed. Issues of sampling and selectivity, validity and reliability, reflectivity and reflexivity, methodological triangulation, ethics, and the problems of gaining access are then examined. A description of the procedures used to analyse the data is also provided. Extensive reference will be made to the methodological observations entered into a Field-notebook throughout the two years of data collection.

The research findings are juxtaposed with the analysis of the data in Chapter 4. The exemplary nature of the study, and the commitment given by me to the participants that they (and their respective health authority) would not be identifiable, means that the individual cases are not presented separately. Instead, a series of common cross-case conceptual themes are explored. These themes are supported by data (both quantitative and qualitative) accumulated from all of the cases [1] .

In the final chapter the overall conclusions from the study are presented. The chapter commences with an examination of the data with direct reference to the aims of the research, and to the working hypothesis. Next, the results of the research are discussed with reference to the social policy issue of caring for the

mentally ill in the community, and the role played by CPNs in the delivery of this care. In these discussions, a number of relevant reports that have been published since the beginning of this research project are highlighted. These include: (a) the 'Report of the Inquiry into the Care and Treatment of Christopher Clunis' (Ritchie, 1994); (b) the report of the Mental Health Nursing Review Team, 'Working in Partnership: a collaborative approach to care' (DoH, 1994); (c) the report of the House of Commons Health Committee, 'Better Off in the Community' (Health Committee, 1994); (d) the review of the mental health services for adults (Audit Commission, 1994); (e) the report of the Committee of Inquiry into the death of Georgina Robinson at the Edith Morgan Centre (Blom-Cooper et al, 1995).

The chapter ends with a review of the study. Specifically, this involves an account of the strengths and limits of the study (including some comments on the appropriateness of Freidson's thesis given the research detailed in this report), and suggestions for further research.

1.2.PURPOSE OF THE RESEARCH

1.2.1.The research problem

The research problem addressed in this study relates to the issue of the professionalisation of nursing, and the appropriateness of following this occupational strategy for all sections of this discipline. In particular, the study is concerned with the uncertainty over what the occupational standing of community psychiatric nursing is, and what direction in the future this "burgeoning speciality" (Devlin, 1985, p.19) should take.

Specifically, the research examines the problem of how much clinical autonomy is exercised by the CPN within the new organisational setting of the CMHT, on what basis does the CPN make her or his decisions [2] , and how much of the CPN's decision-making is affected by her or his relationship with colleagues from other disciplines.

In this project I am also concerned about how the CPN's clinical autonomy and inter-disciplinary relationships influence the psychiatric career of those people who come under her or his care.

The essence of the research problem is summarised by one member of a community mental health team (interviewed as part of this research) when asked the question, "what makes a good CPN":

> I think someone who can work in a team, which I think is the problem. I don't think a lot of CPNs do. Just from working here, a lot of our

people are not very good team workers - they work too autonomously.

(Occupational therapist, Team 3)

That is, does the advent of the CMHT, with the expectation that clinical independence will be sacrificed for the benefit of teamwork, indicate a retrenchment of the occupational objective of professionalisation for community psychiatric nursing? Furthermore, will membership of the CMHT result in a return to the conventional occupational position of nurses - that of subservience to the medical profession?

In part the occupational status of the CPNs is assessed in the study by examining the opinions of their managers, and the other members of the CMHT. Relevant questions with regard to how the CPNs' colleagues and managers view the CPNs include:-

Do the other members of the CMHT perceive the CPN as having the same occupational status as themselves?

Is there an indication that psychiatrists (and/or other members of the CMHT) wish to ensure that potential clients are referred to the team, rather than CPNs receiving direct referrals from (for example) general practitioners?

What forms (if any) of supervision exist? For example, is it inter-disciplinary, intra-disciplinary, or managerial? If inter-disciplinary, is it reciprocal?

Do the other members of the CMHT believe that the CPN

has the skills and knowledge to assess, implement treatment programmes, and discharge clients?

Is there any inter-disciplinary conflict?

Is there an inter-disciplinary hierarchy?

Principally, however, the evaluation of the professional status of the CPN involves an examination of levels of clinical autonomy. This was achieved by monitoring the referral process (and the decision making processes) from the stage when new clients are referred to the CPN to when they are discharged, or re-referred to another health care professional. Where clients were not discharged or referred (i.e. treatment by the CPN continued), the collection of data stopped after a three month period [3] .Questions relevant to these processes include:-

Does the system of referring clients indicate that the CPNs have clinical autonomy?

How much does having clinical autonomy affect the referral process?

Do the CPNs have autonomy over their decisions once a client is referred to them?

How much negotiation takes place between the CPN and other mental health professionals over the referral process? [4]

These questions provide the basis for the subsequent aims of the research.

1.2.2.Why it is worth researching

The study of a division of an occupational group such as nursing adds to the body of knowledge in the field of the sociology of the professions. In the late twentieth century, the professions can be detected as going through a period of transition [5]. Affected by significant economic, political, and social forces, even the well established professions of law and medicine may have to change their established relationship with the state, the consumer, other occupations, and society in general (Dingwall and Lewis, 1983). Ultimately, in the case of medicine, this may result in a loss of control over health care resources (Armstrong, 1990). If, in this scenario of complex societal and inter-professional developments, the occupational position of the traditional professions is altering, there is a need to research what is happening to the semi-professional occupations [6]. That is, any change in the status and practice of the established professions will influence inevitably the status and practice of the 'emerging' semi-professional groups.

In the field of mental health, a theory-driven examination of CPN practice is of relevance to the study of the power of the psychiatric profession. As Foucault (1967) and Scull (1979) illustrate in their critiques of the origins of the profession of psychiatry and the construction of madness, psychiatrists have dominated the group of occupational workers dealing with the mentally ill since the birth of the asylum. However,

the power of psychiatry may have been tempered by the development of community care, and the running down and closure of the asylums. Moreover, the rise of professionalism amongst such occupations as nursing may also challenge the dominance of psychiatry:

> More recently other professions have acquired autonomy, and medical direction of their work no longer happens or is necessary.
>
> (Ovretveit, 1993, p.112)

Conversely, new organisational structures, such as the CMHT, have the potential to alter fundamentally the relationship between the psychiatrist and other mental health workers in the opposite direction. Whether or not the team members share one site, for example in a community mental health centre (CMHC), or function from disparate locations, there is the probability of change occurring to the role behaviour of the various occupational groups (Sheppard, 1991).

Murphy (1991) acknowledges that psychiatrists have lost the leadership of those occupations involved in mental health. The advent of the CMHT offers psychiatrists the opportunity to re-assert their influence over these other mental health disciplines. That is, the CMHT may provide the venue for medical practitioners to re-assume their leadership role (Bean and Mounser, 1993).

Indeed, it was the reported move by a psychiatrist to control the CPNs in one health authority that stimulated

my interest to carry out this research study. During the late 1980's I was the lecturer responsible for a post-registration course for CPNs at Teesside Polytechnic (now the University of Teesside). Informal discussions with the CPNs on the course indicated that high on their agenda was a concern about clinical autonomy. The CPNs were worried about how this was being affected by a new set of relationships with other disciplines (in particular psychiatry) as a consequence of the setting up of CMHTs in many health authorities. One CPN stated that he believed the psychiatrist in his area was objecting strongly to the lack of influence she had over the work of the CPNs. The psychiatrist had decided to 'take on' the CPNs (who she apparently regarded as having too much freedom) and prevent them from accepting any clients other than those who were referred to the CMHT - of which she assumed leadership!

Multi-disciplinary work has been encouraged by various reports and pieces of legislation. These include the 1983 Mental Health Act (DoHWO, 1983), the revised 'Mental Health Act Code of Practice' (DoHWO, 1993), 'Community care: agenda for action' (Griffiths, 1988), and 'Caring for people: community care in the next decade and beyond' (DoH, 1989a). However, research into the area of CPNs and their relationship with other health care professionals, as Dean (1988) has commented in her own study which covered partially that topic, has been minimal. White has been a notable exception. In one study (1986) he concentrated on the relationship between

general practitioners and CPNs. In a second study (White, 1990), in which he surveyed the community psychiatric nursing services of all district health authorities, he did examine the relationship between CPNs and consultant psychiatrists, although this was not related specifically to CMHTs.

Another exception is Shephard (op. cit.) who has published an account of CPNs in the context of CMHCs. Sheppard concentrates in the main on the relationship between social workers and CPNs. As Watson (1994) acknowledges, the relationship between social workers and the other mental health workers will perhaps take a different form in the future following the implementation of a number of key reports and Government Acts. For example, 'Caring for people' (DoH, 1989a), with its division of care into 'health' and 'social' categories, and the 'Care Programme Approach' (DoH, 1990b), which is aimed at providing individual packages of care for people who are discharged from psychiatric hospitals, will affect social worker-CPN relationships.

However, the re-ordering of the relationship between social workers and CPNs does not detract from the need to research the CPN's relationships with other or all of the remaining members of the CMHT. It merely adds another dimension, which will require investigation in the future.

The most important justification of all for conducting research into how the CPNs operate in their practice is because of the direct influence mental health workers

have on the lives of their clients. The effects of CPNs on their clients, although already commented upon by many authors (for example, Sharpe, 1982; Horrocks, 1985; Morrall, 1987a; 1987b; Simpson, 1988; Wooff et al, 1988; Wooff and Goldberg, 1988; Illing et al, 1990; Pollock, 1990), requires on-going evaluation.
Butterworth, a leading exponent of community psychiatric nursing, has called for more in-depth studies of community psychiatric nursing. This is registered in MacMillan's editorial of a speech given by Butterworth:

> IN-DEPTH RESEARCH WAS A 'VITAL INGREDIENT' [my emphasis] in helping CPNs to develop their practice and avoid a 'knee-jerk response to expressed need', he [Butterworth] claimed. CPN services are a 'very significant force for change', he continued. 'There is no other group of nurses which has changed so dramatically in so short a space of time to a new role'..... [Butterworth] stressed that CPNs faced fresh challenges and said that research played a vital part in helping them to expose their work.
>
> (MacMillan, 1990, p.72)

As Butterworth recognises, research in this area is of particular importance at this point in time when CPNs are yet again changing their organisational allegiances. Furthermore, the results from this project

can contribute to the debate surrounding the proposals produced from the Government sponsored review of mental health nursing (DoH, 1994). It can also contribute to the growing public concern about how the mentally ill are being cared for in the community.

1.3.AIMS AND WORKING HYPOTHESIS

The specific aims of the research have been extracted from the considerations of the research problem, and from the adopted theoretical perspective:

Aim 1: CPN AUTONOMY AND THE REFERRAL SYSTEM

To evaluate the level of clinical autonomy the CPN exercises over the referral process, and the effect this has on the users of the psychiatric services.

sub-aims: (a) To assess what expectations the referral agents have of the CPN with respect to, for example, the delivery of treatment, and to ascertain whether or not these expectations are carried out.

(b) To describe the reasons given by the CPN for accepting referrals.

(c) To examine the methods by which the CPN organises (or 'constructs') her or his case-load.

(d) To identify the degree of discussion and negotiation undertaken by the community psychiatric nurse with, for example, colleagues in the CMHT, general practitioners, supervisors, and managers.

(e) To examine the processes used by the CPN when deciding to discharge a client from her or his case-load, or to have a client admitted to in-patient psychiatric care.

Aim 2: IDEOLOGICAL AND STRUCTURAL INFLUENCES

To analyse ideological and structural influences on the practice of the CPN working within the CMHT.

sub-aims: (a) To identify systems of belief that affect the CPN's practice.

(b) To describe the meaning of 'team membership' for the CPNs and their colleagues in the CMHT.

(c) To identify systems of supervision, and the degree of managerial control over the practice of the CPN.

(d) To establish the existence of any inter-disciplinary hierarchy within the CMHT.

Aim 3: RELATIONSHIPS IN THE CMHT

To evaluate the nature of the relationships between the CPN and her or his colleagues in the CMHT.

sub-aims: (a) To describe the level of conflict, and rivalry that occurs between the CPN and other members of the CMHT.

(b) To examine procedures employed by the CPN to deal with inter-disciplinary conflict and rivalry, and actual or potential 'professional dominance' by other members of the CMHT.

(c) To review the opinions of the CPNs' managers and colleagues in the CMHT with regard to the role and status of the psychiatric nurse working in the community.

The aims (and sub-aims) provide a framework from which the research methodology is extrapolated. They provide also the outline for the reporting of the results in Chapter 4.

However, these aims are a final version. The original set was influenced by the process of reflexivity, which was put purposefully into the design of the research. That is, the aims of the project, along with the methodological techniques, were subject to ongoing reflexive feedback (Adler and Adler, 1987, p.26; Hammersley and Atkinson, 1983, p.14). This resulted in a process of evolutionary and incremental modification for both the aims and the methods.

The hypothesis is deduced from the theoretical

considerations and aims of the research. It is presented in its null form:

COMMUNITY PSYCHIATRIC NURSES ARE NOT CLINICALLY AUTONOMOUS WHEN WORKING AS PART OF A COMMUNITY MENTAL HEALTH TEAM.

1.4.THE CASE STUDIES

In presenting background information about the four teams used in the study, the anonymity of the practitioners is maintained. Therefore what follows are general descriptions of the teams. I have added a number of modifications to decrease further the likelihood of the specific team(s) being identified.

All of the teams are situated in the North of England. Four health districts (including the pilot study) have been used, although Team 2 and Team 3 belong to the same district. The teams chosen for the study deal with clients in the eighteen to sixty-five years age range. Most of the information used to describe the teams has been accumulated through informal discussions between myself and the managers, the CPNs, and other incidental sources (for example, from the students I teach on courses at the University of Teesside, some of whom work in the relevant health authorities). Information has also been extracted from operational policy statements and management directives, supplied to me by the managers and the CPNs [7] .

1.4.1.Team 1

The work of Team 1 covers one of four geographical 'sectors' in a medium-sized British city. The city's economic activity consists mainly of light and service industries, and tourism. A population of approximately 40,000 people is covered by each of the sectors. The senior nursing management of the psychiatric services had attempted to establish sector-based CMHTs since 1986, but a number of problems had apparently impeded the full implementation of this policy. For example, neither the psychology service nor social services (for different reasons) seemed committed to the CMHTs as an organisational structure.

The Team is situated in a large house within the community, which contains an office for the four CPNs and an occupational therapist, a day centre, and a number of interviewing rooms (for sessions with the limited number of clients who visit the centre instead of being seen at home). The intention had been for the social worker, psychologist, and the consultant psychiatrist to have their offices (at least on a part-time basis) in the building, but this did not materialise at the time of the study. Fortnightly CMHT meetings recommenced following a number of months when no formal CMHT meetings were held at all.

The management of the CPNs was maintained by a nurse manager and a senior nurse manager, who were based at the local psychiatric hospital, approximately three kilometres from the building in which the CPNs were

located. Except for occasional visits by the managers to the building, and by individual CPNs to the managers offices, the CPN reported that they were at present 'left to get on with it' [8] .

The nurse managers, when interviewed for the study, reinforced the account from the CPNs of a laissez-faire approach by management. However, they suggested that the organisation of the CPNs was in a state of transition, and therefore this management style would only be temporary. They did not indicate what would replace the present style.

With regard to the specific management of the CMHT, during the time of the study no formal appointment of a CMHT co-ordinator was made. However, one of the CPNs acted as the convenor of the CMHT meetings (which involved only the setting-up of the meetings).

1.4.2.Team 2 and Team 3

Teams 2 and 3, whilst functioning from the same building (and sharing the same nurse manager and psychologist), maintained a separate identity. The site from which these two teams operate from is the only one in the study that is regarded explicitly as a CMHC. That is, it was described in all of the relevant official policy documents that I was provided with as a CMHC.

The CMHC opened in 1988, consisted of the two CMHTs (which cover two sectors), a day unit, and offices for the CPNs and other members of the CMHTs (psychiatrists, psychologists, social workers, and occupational therapists). Group therapy sessions (e.g. for anxiety management), which sometimes involve the CPNs, are carried out in rooms at the centre. Geographically, it was one of two CMHCs situated in a large town, and each team in the centre serves a population of over 50,000 people. The town's economy is supported by heavy industry, but it has one of the highest unemployment rates in the United Kingdom. The local university is now considered to be one of the major 'businesses' in the area.

Housed in a converted large Victorian building, with noticeable additions such as ramps for wheel chairs and signs/notices which could only be associated with an hospital environment, the CMHC lies approximately one mile from the town centre.

Two of the three CPNs at the centre (both from the same team) share an office. The other CPN has her own

office. It was expected, however, that another CPN would be employed to work in the same sector as the CPN who at present is working on her own.

The CPN nurse manager has his office within the centre. Generally, the consultant psychiatrists serve as co-ordinators to their respective teams, and act as chairpersons for the meetings. Both teams hold a meeting on a weekly basis.

1.4.3.Team 4

Team 4 is situated in a small town in a large rural area which is divided up into three geographical sectors, serving a population in total of about 80,000 people. The industrial base of the sector covered by Team 4 is essentially agrarian, but does include some light industry and a limited amount of tourism. Unemployment was well below the national average.

The centre from which the CPNs operate is part of a hospital building, separated by a main road from the district general hospital, which is about a hundred metres away. Although very obviously seen as a hospital facility by the town's population (the signs on the building state as much), the front of the building faces the town's main street. Hence, it gave the impression of being relatively integrated into the local community.

Within the building, the three CPNs have a large office, and there are offices for the consultant psychiatrist, occupational therapist, and the psychologist. However, the social worker is housed in the social services offices in another part of the town. The day hospital is accommodated in this building [9] .

The CPNs were managed before the study commenced by a manager who was not a nurse, whose office was also in the centre. However, during the period of the study, the management of the CPNs became the responsibility of a manager who had worked previously as a CPN (as with the other three teams). The co-ordination of the CMHT meetings was orchestrated predominantly by the

consultant psychiatrists.

1.5.SUMMARY

In this chapter I have set the scene for a thesis which examines community psychiatric nursing practice in the 1990's. Data were collected over a two year period from ten psychiatric nurses working in the community, and from twenty of their team colleagues and managers. These nurses are part of a new organisational structure, the CMHT. This new work location may change dramatically the potential for psychiatric nurses working in the community to become professionalised. This influence on the occupational status of the CPN is the main interest of the study reported here.

The data-collecting techniques used were: (a) a Diary-interview Schedule to monitor the activities of the psychiatric nurses with new clients; (b) a Focused-interview Schedule to explore the opinions of the other members of the CMHT and those of the managers, towards the psychiatric nurses; (c) the recording of substantive, methodological, and analytical observations in a Field-notebook.

The study takes its theoretical underpinnings essentially from the sociology of the professions. More specifically, the theoretical constructs offered by Eliot Freidson (in particular that of 'clinical autonomy') are applied to the practice of community psychiatric nursing. This theoretical framework is explored in detail in Chapter 2.

1.6.ENDNOTES

1. Yin (1984) quotes Kaufman (1981) who uses this method of presenting multiple case-study research. Kaufman examined the working practices of six federal bureau chiefs in the United States:

> The book's purpose.....was not to portray any single one of these chiefs. Rather, the book synthesizes the lessons from all of them and is organised around such topics as how chiefs decide things, how they receive and review information, and how they motivate their staff. Under each topic, Kaufman draws opposite examples from the six cases, but none of the six is presented as a single-case study.
>
> (Yin, op. cit., p.130)

2. The question 'on what basis do CPNs make their decisions' (in contexts other than the CMHT) has been posed by McKendrick (1980), and addressed in part by Pollock (1989) and Shephard (1991).

3. Referrals processes, as Goldie (1977) has argued, with specific reference to the mental health field, can provide an outline of the structure of relationships between medical and 'lay' occupations.

4. Quantitative data concerning 'referrals' are already collated locally by community based information retrieval systems set up following the 'Korner report' (DHSS, 1984). However, as a number of the subjects in this study commented openly, it is questionable as to how valid the data collected in this way is.

5. In April 1992 a major international conference was held at the University of Leicester. The conference addressed specifically the transitional nature of the professions in the last few decades. Issues on the agenda included: 'capitalism, state action and the collapse of professional power' (Elliott Krause); 'the market in trust - professions and the supply of regulation' (Robert Dingwall); 'professions: changing boundaries of social regulation' (Lorenzo Sperenza); 'Europe and the regulation of British doctors - the experience of the General Medical Council' (Meg Stacey); 'policing the mentally disordered - a case of professional dominance?' (Anne Rogers).

6. The term 'semi-professionals' was coined by Etzioni (1969) to describe such occupations as nursing. This was to distinguish between the more theoretically based and autonomous 'fully-fledged' professions (e.g. medicine).

7. The referencing of these sources is problematic. Some of the information relating to these policies and directives has been retrieved from the taped discussions with the CPNs and their managers. However,

the actual documents have not been included in the thesis as their content would identify the relevant health authority.

8. The comment of being 'left to get on with it' was made also by CPNs from other teams (see Chapter 4).

9. Shortly after the study was completed, the function of the building changed, and many of the facilities were transferred to the main hospital site. The CPNs were then housed in the psychiatric unit (attached to the hospital), although they may be re-sited in buildings in the community at some point in the future.

2.CHAPTER TWO LITERATURE REVIEW AND THEORETICAL CONSIDERATIONS

2.1.INTRODUCTION

The theoretical foundation for this research project is taken from the sociology of the professions. In particular, the concept of 'clinical autonomy' from Freidson's analysis of the medical profession (Freidson, 1970a; 1970b; 1988) is used to examine the working practices of CPNs.

To date, there is no systematic account of the occupational standing of community psychiatric nursing which is embedded in a coherent theoretical base. Authors of a number of research projects have utilised sociological theory as a frame of reference for certain parts of their research design (e.g. White, 1986; Pollock, 1989). However, none have demonstrated a commitment to a comprehensive and co-ordinated application of theory to their empirical studies. That is, this thesis stands alone in the sense that it is driven by sociological theory, and its conceptual base permeates all areas of the research design.

There are three general aims to the chapter: (a) to review the literature and theoretical debates concerning the sociology of the professions; (b) to justify the use of the Freidsonian approach as a theoretical tool in this study (b) to examine those aspects of the literature which are related directly to the

professionalisation of community psychiatric nursing. Specifically, my intention in this chapter is to provide background information concerning three questions which are central to this study. These are: what is a profession; what is the occupational status of nursing as a whole; what is the occupational status of community psychiatric nursing?

The chapter has four main sections, the first of which contains an account of the various perspectives that are used to understand the development of the professions. In the second section there is a critical analysis of the Freidsonian perspective. Reference is made to a number of influences on the professions which have occurred since Freidson presented his thesis in the early 1970s. These influences have to be taken into consideration when evaluating the saliency of Freidson's thesis in contemporary society, although I suggest it remains an appropriate theoretical perspective.

The third section contains a review of the occupational position of nursing, and the fourth focuses upon community psychiatric nursing. I shall argue that Freidson's approach to comprehending what the process of professionalisation is indicates that nursing is not, and will not become, a profession. However, I suggest that the literature indicates also that sub-groups of nursing (for example, community psychiatric nursing) have the potential to become professionalised.

2.2.OVERVIEW OF THE PROFESSIONS

Post-industrial society (Bell, 1973), or what has been described as the period of 'late modernity' (Giddens, 1990; 1991; Tester, 1993), 'postmodernity' (Crook et al, 1992;), or 'cybersociety' (Jones, 1995), is characterised by rapid change. This change is affecting the social, political, economic, and cultural fabric of most societies. The professions are not immune from the influence of these changes, and the conceptualisation of their role and function in society has had (or will have) to alter accordingly.

Early twentieth-century explanations of what constitutes a profession were dominated by two related approaches that were rooted in Durkheimian sociology (Johnson, 1972; Saks, 1983; Willis, 1990). Durkheim (1957) regarded the professions as an impartial and socially cohesive force. For Durkheim, they moderated individualism in society by reinforcing organic solidarity.

The first of these two post-Durkheimian approaches:

> .....became concerned with definitional issues.....about what 'traits' define a profession and how far along the process of professionalisation various occupations are.
>
> (Willis, op. cit., p.9)

Altruism, a specialised and exclusive body of knowledge,

lengthy vocational training, monopoly over practice, and self-regulation were perceived to be the trade marks of high prestige occupations such as law and medicine (Carr-Saunders and Wilson, 1933; Goode, 1957; Greenwood, 1957; Gross, 1958).

The second approach is much more overtly functionalist. Here the professions are regarded as directly helping to maintain the social order (Parsons, 1939, 1951; Barber, 1963). For example, Parsons (op. cit.) argues that the profession of medicine reinforces social stability by controlling entry into the sick role. The effect of this is also one of functionality for the individual in the sense that she or he receives expert assistance to become healthy again. Both of these perspectives:

> .....rest on the tenet that professions possess some unique characteristics which set them apart from other occupations and play a positive and important role in the division of labour in society.
>
> (Saks, op. cit., p.2)

The trait and the functionalist approaches have been subject to much criticism. Criticism is centred upon the sterile nature of the teleological explanatory framework in which they are situated, and the stance of self-justification they adopt. For example, with reference to trait theory, Johnson (op.

cit.) states:

> 'Trait' theory.....too easily falls into the error of accepting the professionals' own definition of themselves. There are many similarities between the 'core elements' as perceived by sociologists and the preambles to and contents of professional codes.
>
> (p.25)

Whilst the functionalist approach has the strength of being located in a general social theory (Morgan et al, 1985), both explanations are weakened by their inability to recognise and decipher other non-normative social processes and structures that fashion, and are fashioned by, the professions.

For example, Johnson (op. cit.) argued that these perspectives neglected to identify the power structures that are operated by the professions. He suggested that power could be exercised in different ways by different occupational groups. Members of a complete or 'collegiate' profession (e.g. medicine) exert power in a way that defines its membership, areas of work, and who the users of their service will be. Members of a 'patronage' profession (e.g. accountancy) wield power in contractual arrangements that occur between themselves and the users of their services. Members of a 'mediated' profession (e.g. nursing) have less direct power as their services are provided via a third person or

possibly the state.

Feminist critiques have also pointed to the weakness of the early sociological analysis (Gamarnikow, 1978; Hearn, 1982; Abbott and Wallace, 1990; Witz, 1990, 1992; Riska and Weger, 1993; Russell, 1995). These critiques have demonstrated that inequalities and oppression in the wider society are replicated by the professionals. With reference to medicine, they have revealed the centrality of gender divisions both within and between the various health occupations:

> .....feminists have argued that in the process of upward mobility, the male-dominated professions gain control over and subordinate female-dominated occupations. This is most clearly demonstrated in medicine where the medical profession is male-dominated and where the process of achieving its dominant professional status, the female occupations of nursing, health visiting and midwifery were subordinated.....
>
> (Abbott and Wallace, 1990, p.3)

It is, however, not only the structure of society on the basis of gender that has to be considered. Ethnic divisions in society are also reproduced in the division of labour. For example, in the NHS (which is the biggest employer of ethnic minority groups in Britain: Ward, 1993) black employees are noticeably

disadvantaged. Proportionally, they are much more likely to be employed in low status and low paid occupations than white people. They also hold lower status positions in both nursing and medicine, and enter the specialisms in these occupations which have little prestige (e.g. psychiatry) much more frequently than their white counterparts (Johnstone, 1989).

The reasons for the inequalities in the NHS can be explained in part by reference to personal and institutional racism (Nettleton, 1995). However, the causes of these inequalities can ultimately be traced back to the history of imperialism and colonialism, and to the recruitment patterns of the British Government in the 1950s (Williams, 1989).

The thrust of polemicist Ivan Illich's vehement critique on the professions is directed towards the process of industrialisation, which he believes has produced 'disabling' professions. He argues that:

> The Age of Professions will be remembered as the time when politics withered, when voters, guided by professors, entrusted to technocrats the power to legislate needs, renounced the authority to decide who needs what and suffered monopolistic oligarchies to determine the means by which these needs shall be met.
>
> (Illich, 1977, p.12)

Illich's radical utopian solution is the

de-professionalisation of all professions, the de-industrialisation of the developed world's economic base, and the creation of a system of 'intermediate' technology.

Marx (1969) perceived the role of the professionals in capitalist society as subsidiary, mainly due to their lack of direct involvement in the process of production. He did believe, however, that they had a negative contribution to the extraction of surplus value. Neo-Marxists have attempted to assess further the structural position of the professions. For example, Navarro (1979) sees the professionals aligned unambiguously with the capitalist class. They are, for Navarro, part of the exploitative elite in society. Scull (1979; 1983; 1984) refers to psychiatry (a branch of the profession of medicine) as an agency of social control which serves the capitalist state by keeping 'the mad' (one section of the proletariat) under control.

For Scull, psychiatry has been complicit in the implementation of a state sponsored policy ".....built on a foundation of sand" (1984, p.1), which has resulted in the mentally ill (and other segregated groups) being decarcerated into the community. The deinstitutionalisation of the mentally ill, argues Scull, is not the result of progressive developments in liberal-scientific psychiatry. Rather than the policy being driven by benevolence and the introduction of anti-psychotic drugs, it has been economically determined. Indeed, Scull argues that the reduction in

the in-patient numbers commenced both in the United States and the United Kingdom either before or during the 1950's, whereas anti-psychotic drugs were only beginning to be used in the middle of the 1950's. Scull's point is that in the post-war period there was a fiscal crisis in the delivery of social policy whereby:

> .....segregative modes of social control became, in relative terms, far more costly and difficult to justify.
>
> (Scull, op. cit., p.135)

Consequently, cheaper welfare options were sought, one of which was the programme of community care for the mentally ill. In part, Scull supports this position by suggesting that the former asylum inmates were not offered effective (and expensive) care in community, but were neglected and ghettoised. Although Scull recognises that in this country the pattern of decarceration has been to some degree different to that in the United States, the rise in the number of the mentally ill who are homeless, and who inhabit bed and breakfast accommodation, can be viewed as examples of the ghettoisation and neglect of the mentally ill in the community (Murphy, 1991).

However, Scull's approach can be criticised in a number of ways. For example, Busfield argues that with respect to the United Kingdom, Scull's account is

defective on the basis of timing:

> The fiscal crisis of the state to which he refers is a phenomenon of the early 1970s and later, and not of the 1950s.....
>
> (Busfield, 1986, p.329)

Busfield suggests that whilst Scull is correct to identify a ".....mystification and distortion of a reality of neglect and lack of resources to those discharged from mental hospitals" (ibid.), he ignores the expansion of psychiatric services into primary health care. Referring specifically to the United Kingdom, and in direct contrast to Scull, Wing and Olsen (1979) offer an optimistic view on the implementation of care in the community. They claim that not only has care in the community been resourced through general practitioner services, but many other services have been developed. For example, local out-patient departments, day hospitals, rehabilitation workshops, community nursing, and voluntary services.

Furthermore, far from viewing psychiatry as serving the capitalist class, some social theorists (e.g. Oppenheimer, 1973, 1978; MicKinlay and Stoeckle, 1988) believe that the professionals have become proletarianised. This has been caused through a prolonged process of de-skilling as a result of the subordinate relationship that psychiatry has had with state bureaucracies. Some neo-Marxists who take this

approach have described professionals as 'mental labourers' (Wright, 1980; Derber, 1982).

A synthesis of these two divergent conceptualisations of where the professions fit in the class structure is offered by another group of neo-Marxists (Carchedi, 1975; Gough, 1979). As Pilgrim and Rogers note, the professions are regarded by these theorists as occupying a contradictory relationship with the means of production in capitalist society:

> They are not capitalists but they serve the interests of the latter. They are not full members of the proletariat (as they do not produce goods and surplus value) but they are employees and so they share similar vulnerabilities and interests of the working class.
>
> (Pilgrim and Rogers, 1993, p.84)

Interestingly, some theorists have argued that the achievement of a professional status is most likely for those occupational groups who have social and cultural affinity with the dominant groups in society (Johnson, 1977; Witz, 1992). That is, if the occupational group in question is male-dominated and middle-class, then it is in a better position to achieve and/or maintain a professional identity.

Poststructural accounts of the professions identify what Foucault (1967; 1973) describes as 'discursive

practices' (i.e. particular technologies, procedures, and linguistic styles) which act as mechanisms of social subjugation through a control over knowledge. Foucault gave the example of psychiatry regulating morality, rationality, and the work ethic in bourgeois society. However, unlike the neo-Marxist analysis of the professions which emphasises their structural relationship with the mode of production, the discursive practices of the professionals are not aligned ideologically with any one social class.

The use of discursive practices by one group of professionals (surgeons) is illustrated in a research study carried out by Nicholas Fox (1992). Fox conducted an analysis of a health care setting (i.e. surgical wards and theatres) from which he attempts to demonstrate the relationship between power and knowledge:

> Within the enterprise of surgery, different professional groupings constantly sought to inscribe their DISCURSIVE PRACTICES [my emphasis] upon each other, and most significantly, patients.
>
> (Fox, 1993, p.62)

Hughes (1958) had sown the conceptual seeds of dissension, which were to germinate into a debacle of the self-perpetuating idealised view provided by the professions themselves. However, it was such theorists

as Freidson (1970; 1971; 1988) who made the most significant impact on the trait and functionalist approaches to analysing the nature of the professions. It was Freidson who was among the first to identify that the professions may be serving primarily themselves rather than society, and to indicate (together with Johnson, op. cit.) that the exercise of 'power' had to be taken into account:

> Freidson.....undercut the functionalist argument that professions were ordained by the 'hidden hand' of society, exposing the power games which must be played for successful professionalisation..... He stressed that the medical profession, like any other, pursues its own ends in preserving its members' autonomy and privileges.
>
> (Richman, 1987, p.110)

Freidson applied a neo-Weberian perspective and produced a coherent theoretical deconstruction of medicine, which he uses as a model for the analysis of other professions. His proposition is that a dominant profession stands in an entirely different structural relationship to the division of labour than does a subordinate one, and that it is having autonomy over one's actions (and influence over the work of

others) that defines a 'genuine' profession.

2.3.PROFESSIONAL AUTONOMY

Freidson's approach was pivotal to the movement away from comprehending the division of labour in society solely on the basis of core-traits and functions. What Freidson accomplished was a re-formulation of the question about professions. He argued that the concentration on definitional issues had produced descriptive rather than analytical accounts of how professions operate:

> A great many words have been spoken in discussions of what a profession is, or rather, what the best definition of 'profession' is. Unfortunately, discussion has been so fixed on the question of definition that not much analysis has been made of the significance and consequences of some of the elements common to most definitions.
>
> (Freidson, 1970b, p.133)

Freidson directed attention towards the use of social closure and occupational control by some occupations to achieve professional status (Morgan, op. cit.; Nettleton, op. cit.).

For Freidson, the medical profession was motivated far more by self-interest than social perceptions and its high social standing would imply. Furthermore, the assumption that medicine owes part of its success to

specialist knowledge is challenged by Larson (1977). Larson argues that the medical profession linked with bio-medical science as a strategy aimed at ameliorating occupational and social advancement. As Armstrong has noted:

> In this new analysis the success of a profession was not due to possessing the requisite 'core traits' such as esoteric knowledge, a service ideal, and so on, but depended entirely on the degree of control the profession had managed to establish over the conduct of its own work.
>
> (Armstrong, 1990, p.691)

That is, rather than bio-medical science being an inherent and natural feature of medicine's epistemology, it used this form of knowledge as ".....ideological ammunition for attaining the powerful position of professional status, as well as for maintaining it" (Morgan, op. cit., p.109).

Jamous and Peloille (1970) suggested that another strategy adopted by medicine to achieve occupational progress was to socially distance itself from the users of its service by mystifying the knowledge that it has. That is, the more medical practitioners are regarded as employing intuition which cannot be codified, and the less the public has direct access to their specialist knowledge, the higher the social status of medicine.

This is described by these authors as the 'indeterminancy/technicality (I/T) ratio'. However, there is a paradox here in that bio-medical data (the medical profession's preferred knowledge base) is highly susceptible to codification. Furthermore, intuition (as I shall argue in Chapter 4) is regarded as a characteristic of those occupational groups with a lower status than medicine. Therefore, medicine cannot rely on this strategy alone.

For Freidsonian theorists, the main method by which medicine and other professions attain high status is through the acquisition of discrete areas of work. That is, the power of the medical profession depended upon a large amount of autonomy over clinical work (Freidson, 1970a, 1988; Berlant, 1975; Larson, 1977; Tolliday):

> .....the only true important and uniform criterion for distinguishing professions from other occupations is the fact of autonomy - a position of legitimate control over work.
>
> (Freidson, 1970a, p.82)

This control with respect to medicine, argues Freidson, is legitimised through social and legal recognition of medical practitioners as experts who as a group are virtually unopposed in their ability to define health and illness:

> If we consider the profession of medicine

> today, it is clear that its major characteristic is preeminence. Such preeminence is not merely that of prestige, but also of expert authority. This is to say, medicine's knowledge about illness and its treatment is considered to be authoritative and definitive. .....there are no representatives in direct competition with medicine who hold official policy-making positions related to health affairs.
>
> (Freidson, 1988, p.5)

Not only has medicine gained control over its practice, but it also dominates what Freidson (1970b) describes as the 'para-medical professions' (for example, midwifery and nursing). Autonomy over its own work, and control over the content and limits of the work of related occupational groups, provides medicine with 'professional dominance' (Freidson, 1970b). A profession for Freidson, therefore, has autonomy from the subjugation of others, and has the autonomy to subjugate others. For example, Treacher and Baruch (1981) argue that psychiatry, as a branch of medicine, has dominated the mental health 'industry' in Britain since the nineteenth century.

Armstrong argues that the clinical autonomy of medicine has allowed the profession to exert control over the organisation of resources in health care:

> Medical power.....rested on a degree of autonomy in clinical work, which medicine had successfully claimed as its natural right..... In maintaining control over clinical work the medical profession established jurisdiction over the distribution of health care resources.
>
> (Armstrong, ibid.)

If the definition of professional autonomy, however, is to include the domination of other occupational groups together with the control over health policy and resources, then autonomy for medicine is not absolute. As Freidson (1986) himself has admitted, professional autonomy is relative to the historical, structural, ideological, and political parameters that encircle the negotiations that doctors (and other health care workers) undertake within both their organisational setting and society at large.

For example, Goldie (1977) carried out a study in which he addressed the issue of the division of labour between mental health professionals working in psychiatric hospitals. He recognised that the professionalisation of any occupation cannot take place in a social vacuum. Goldie examined the role of ideology, alongside the way in which the division of labour is negotiated within the social structure of various institutional locations. Goldie observes that the history of the psychiatric hospital and various internal and external

'institutional imperatives' (a term borrowed from Hearn, 1968), such as the resources and facilities available within the hospital and its catchment area, exert influences over the staff [1] .

Whilst Goldie perceives mental hospitals as forums in which there are ".....shifting balances of power" (op. cit., p.145), he concludes that the psychiatrists sustain their dominance in part through their ideological monopolisation of the referral process, and in part through acquiescence of the other occupational groups:

> .....while many lay [i.e. non-medical] staff remain critical of the psychiatrists for their inadequate training and reliance on physical methods, they continually re-affirm their authority through a process of defining themselves out of certain areas of work and seeking to involve themselves in various marginal activities. [2]
>
> (Goldie, op. cit., pp.158-9)

For Goldie, therefore, the status quo in the professional hierarchy is maintained both by the overt use of power by psychiatrists, and by the way in which the 'rival' professionals (psychologists and social workers) defined their own roles.

The proletarianisation thesis (Oppenheimer, op. cit.; McKinlay and Stoeckle, op. cit.) projects the view

that professional work is becoming increasingly subjected to management control at the instigation of the state. Supporters of this approach believe the fate of all professions to be downward social mobility. Haug (1988) argues that de-professionalisation will occur as a consequence of the rise in consumer scepticism about the efficacy of 'expert' services. Both of these critiques imply that bureaucratic processes will eventually lead to the demise of professional autonomy and dominance [3] . However, as Elston (1991) and Nettleton (op. cit.) have commented, these theories have emerged from the United States and their application to the British health care system has not been evaluated.

In the last twenty years the I/T ratio has altered. There has been an explosion in information, and access to information. Clinical knowledge has become more codified and less indeterminate. As Nettleton (op. cit.) records, computerised expert systems (used, for example, in the diagnosis of illness) allow members of non-professional and quasi-professional groups entry into bodies of knowledge that were formerly esoteric. Furthermore, the perceived existence of a more active and knowledgeable service-user may also threaten to narrow the social distance between the patient and the medical practitioner (Hugman, 1991; Morrall, 1995).

This active service-user could also be seen to be challenging medical hegemony by consuming alternative health care provision (now widely available) such as acupuncture, homeopathy, osteopathy, and chiropractice.

However, as Joseph (1994) recognises, there are signs that 'alternative' health care is formulating a set of beliefs and practices that will survey the boundaries of medicine, and serve to exclude 'unqualified' interlopers. The effect of this will be to legitimise alternative provision within the boundaries of conventional medicine.

From the 1980s onwards in Britain the structural and bureaucratic limitations on the clinical autonomy of the medical profession would include the restructuring of the health service and the rise of 'new managerialism'. New managerialism replaced what Harrison et al (1990) describe as the 'diplomacy model' which had existed since the 1960s. Managers under the latter system were not leaders or agents of change. Their role was primarily to help the professionals in their clinical work by solving organisational problems as they occurred. By contrast, the new managers are expected to be much more pro-active, innovative, and consumer-oriented. This management style also involves the comprehensive auditing of clinical work, which it can be argued erodes further the autonomy of the professionals.

The relationship between medicine and the para-medical professions, which Freidson perceives as one characterised by the domination of the former over the latter, is explored by a number of authors. For example, Stein (1967) discusses how nurses are involved in a 'game' with doctors. The nurses play this game by offering advice in subtle ways

(for example, through indicating non-verbally what policies, treatments, etc. they agree with) to the medical staff, whilst at the same time appearing to be passive:

> The cardinal rule in the game is that open disagreement between the players must be avoided at all costs. Thus, the nurse can communicate her recommendations without appearing to be making a recommendation statement. The physician, in requesting a recommendation from a nurse, must do so without appearing to be asking for it.
>
> (Stein op. cit., p.110)

Wright (1985) also describes the relationship between doctors and nurses as a 'game'. There is, suggests Wright, an elaborate and ritualistic facade erected between the two. The nurse tries to manipulate the doctor's decisions without weakening 'his' authority or status. Overt disagreement is avoided at all costs.

Tattersall (1992), in a study of triage in an accident and emergency department noted that although this method of organising patients was instigated by nurses (and had the potential effect of enhancing the occupational status of the nurses in relation to that of the physicians), it was usurped by the medical staff. That is, the doctors recognised the effectiveness of

triage, and thereby legitimised its use, only when they made the decisions with regard to its implementation. Hughes conducted a study of doctor-nurse interaction in an accident and emergency department. He criticises the professional-dominance thesis for presuming too much power to be in the hands of the medical profession:

> Many sociologists, possibly taking their cue from Freidson's.....seminal writings on the position of the 'paramedical' professions have chosen to view the [nurse-doctor] relationship in terms of a fairly unproblematic subordination of nursing staff to physician control. Among other things they note that the medical profession exercises considerable control over the knowledge base of the nursing profession; that typically nurses assist in, rather than initiate the focal tasks of diagnosis and treatment; and that much nursing work tends to be performed at the request of, or under the supervision of the doctor.
>
> (Hughes, 1988, p.1)

Whilst not wanting to debunk the professional-dominance thesis per se, Hughes believes that it needs one important qualification. He argues that it is 'over-deterministic', and its proponents have:

.....underplayed the situated nature of medical control and of nurse deference.

(op. cit., p.16)

As Hughes' adjustment to the professional-dominance thesis indicates, there is a clear need to examine the situational divergencies amongst health care professionals. With reference to this research study, psychiatric nurses working in the community, as Carr et al (1980) have pointed out, cannot be viewed as having the same relationship with psychiatrists (or other professionals) as those nurses who work within the hospital environment. There are, for example, major differences in levels of medical (and managerial) surveillance and supervision of ostensibly subordinate occupational groups.

The effect of these situational factors in the health care field can be to reduce the professional dominance of one occupational group (e.g. the medical staff) while at the same time increasing the clinical autonomy of another (e.g. nurses). That is, if medicine loses its dominance over nursing (and other health care groups) it is axiomatic that the former will experience some degree of de-professionalisation whilst the latter will move further towards professionalisation.

Another possible outcome may be a re-alignment of occupational loyalties as a consequence of the NHS reforms, and the post-Fordist division of labour (Harrison and Pollitt, 1994; Walby et al, 1994).

Post-Fordist economic production is characterised by consumer-led and fragmented market requirements, and demands of its workers' (including professionals) flexibility over working practices (Burrows and Loader, 1994). In this scenario it is probable that professional autonomy will diminish (Nettleton, op. cit.).

In a post-Fordist mode of production it is possible, however, that there will be a transformation in the relationships between the various occupational groups. For example, this new form of economic production may encourage nurses, who for Dixon (1992) are 'organisationally adrift', to relocate their allegiance from their own managers to doctor-dominated NHS Clinical Directorates (Walby et al, op. cit.). That is, nursing may be far more vulnerable to the processes of 're-skilling', insecure employment, and loss of professional autonomy than medicine. Therefore, domination of medicine over other occupational groups (e.g. nursing) may be re-established.

Moreover, there is growing evidence that although medicine's direct control over organisational resources has been lost, it still procures a considerable amount of freedom from the new managers with regard to resource prioritising and clinical work at a local level (Haywood, 1987; Clegg, 1989; Hunter, 1991). Baggott (1994), for example, states:

> .....it is clear that general managers made only limited progress in setting clinical targets..... Managers were largely unable to

> exert control over the resources for which they were held accountable because the demand for patient services was determined by clinicians.
>
> (p.134)

Baggott (1994) argues that most managers have capitulated or resigned when confronted by senior doctors. One recent report has suggested that managers can do little about the 'one in twenty' senior doctors who it states may be dishonest, abusive, guilty of sexually harassing patients, or incompetent (Donaldson, 1994).

If the power of medicine were to be challenged seriously by the new managers, then it (like other professions) has the capacity to take radical action. For example, some medical practitioners have threatened to leave the health service:

> Senior doctors are threatening to resign from National Health Service employment and establish themselves as independent contractors to escape management diktat.....Consultants believe they would have more freedom to determine treatment according to patient's needs if they were free of managers' budget constraints.
>
> (Brindle and Mihill, 1994)

Where do these influences leave the professional dominance theses and the professional status of medicine? In the second edition of Freidson's 'Profession of Medicine' (1988) the content is essentially the same as the first edition, except that he includes an 'Afterword'. It is in this afterword, and in a recent text in which he re-examines the role of the professions in society (Freidson, 1994), that Freidson addresses a number of the criticisms of his analysis of medicine. For example, Freidson recognises the development of consumer movements, and the 'active' and knowledgeable service-user. However he questions the effect these developments have had on the power of the professional:

> These movements have created a number of important changes in the administrative and interpersonal context within which interaction between doctor and patient takes place. However, while the traditional arrangement in which the physician is active or guiding and the patient passive or cooperative has been tempered somewhat, there is little evidence that it has changed so markedly as to have become routinely egalitarian, involving truly mutual participation.
>
> (1988, p.388)

Freidson argues that the creation of bureaucratic contractual systems [4], which are aimed at cutting costs, may have had a detrimental effect on the patient's ability to be active in her or his relationship with the medical practitioner. He goes as far as to suggest that the collective gains from, for example, the consumer movements, may not compensate for the loss of influence individuals have experienced through these contractual arrangements.

However, the explosion of information is entering into a new and dramatic phase. Computer based technology is now operating in a realm that has been described as 'cyberspace' (Freedland, 1994), and has the potential to offer consumers immense and immediate accessibility to knowledge on a world-wide scale, the power of which only the most Luddite-minded will be able to ignore. But, although access will be available to all, these information systems will be susceptible to expropriation by both established and new breeds of experts who have (or will have) the techniques and resources to analyse and synthesise data on this scale (Porter, 1994). Given the imperialistic and market-oriented tendencies associated with medicine in the past (e.g. in relation to accommodating 'alternative' medicine as 'complementary' medicine), and its success in promoting a techno-scientific base in modern health care, future occupation strategies are likely to include expeditions into and colonisation of cyberspace [5].

Furthermore, the formulation of a Citizen's and a Patient's Charter by the Conservative Government in

Britain, may not be achieving the projected goals of empowering the individual in her or his encounter with, for example, the health care industry:

> People know little of their rights under the patient's charter, a survey for the Royal College of Nursing suggests.....fewer than three in 10 people can identify any of its rights or standards.....
>
> (Brindle, 1994)

Illman (1991) also questions the reality of the active consumer. He argues that many consumers are not 'active' because they may not know what they need in the first place, do not have the skills or motivation to assess the quality of the service they have received, and most still believe that 'doctor knows best'.

More significantly, however, in order to accommodate some of the wider economic and political changes that have occurred over the twenty years since he produced his exposition of the professions, Freidson (1988) has produced a more concise definition of professionalism. Three forms of autonomy have been identified by Elston (op. cit.). The first is 'economic autonomy', which refers to the right of the profession to decide upon what remuneration its members will receive. The second is described as 'political autonomy', and relates to the ability of the profession to determine policy on health issues. The third type is 'clinical autonomy', and

refers to the right of the profession to regulate its own practice and decide upon the content of its work. Freidson counters his critics by arguing that his definition of professionalism does not need to include political and economic autonomy, and therefore:

> .....the loss of extensive political influence and economic independence does not represent the loss of professionalism as I have defined it..... Neither economic independence nor control of professional institutions independently of the state or of capital is essential to professionalism. What is essential is control over the performance and evaluation of a set of demarcated tasks, sustained by the established jurisdiction over a particular body of knowledge and skill.
>
> (Freidson, op. cit., p.385)

Technical autonomy (which equates to Elston's definition of 'clinical autonomy') is, for Freidson, the sin qua non of professionalism.

Freidson admits that even with this narrower definition of professionalism (in which there is no mention of domination of related occupations), some threat to technical autonomy has been experienced by medicine. He provides the example of how review committees in the United States have been set up to examine clinical work. Whilst there is no direct equivalent in Britain,

auditing and the emergence of the new occupational group of health economists with its emphasis on the economic regulation of professional practice may have a similar effect (Ashmore et al, 1989; Power, 1992).

However, Freidson insists that the professional status of medical practitioners remains intact as long as the work they do is under the control of its own members:

> .....in the United States, as in most other countries, only members of the profession have the right to establish legitimate and authoritative technical standards for medical work, and only they have the right to exercise authority over the technical conduct of medical work.
>
> (Freidson, op. cit., p.386)

It is, however, Freidson's original depiction of professionalism, with its emphasis on the professional being able to determine extensively ".....the content and the terms of work" (1970b, p.134) , and the ".....dominance of its expertise in the division of labour" (op. cit., p.136), that is subscribed to in this study.

Furthermore, it is this version that equates with accounts provided by the professionals themselves. For example, Tolliday (1978) reports on medical practitioners' interpretations of 'clinical autonomy'. They highlight independent practice, the primacy of

medical knowledge, and the authority to lead other health care professionals.

Medicine remains an occupation with a substantial power base despite contemporary bureaucratic, political, economic, and consumerist infringements. Consequently, I believe that this version of the professional-dominance thesis provides still the most appropriate theoretical tool to analyse the professions.

2.4.PROFESSIONALISM AND NURSING

If Freidson's (1970a; 1970b) initial account of professionalism (which includes the concepts of clinical autonomy AND professional dominance) is adopted, then what can be said about the occupation of nursing? That is, is nursing:

> .....essentially a subordinate occupation.....
> Or is it an autonomous profession like medicine?
>
> (Dingwall, 1986, p.27)

Traditionally, the protagonists of the occupational strategy of professionalisation for nursing, and other caring occupations (e.g. occupational therapy; physiotherapy), have adhered to the 'trait' theory of professional identity. That is, they have attempted first to assess what constituents of a profession these groups already have. They have then indicated ways in which the absent characteristics can be gained (Jolley, 1989; Atkinson, 1988; Wallis, 1987; Abbott and Wallace, op. cit.). Accepting implicitly the 'semi-professional' status (Etzioni, 1969) of these groups, these authors have promoted the policy of professionalisation in order to achieve what they consider to be the full professional identity of such occupations as medicine and law.

Perceptions of nursing vary, and are often

contradictory. A persistent image is one that stems from the assertion by Nightingale (1859) that nursing is a vocation, with nurses viewed as dedicated to the service of their patients. This was to counteract the prevailing negative image in the early nineteenth century of nursing as being delivered by women at the lowest level of the social strata. Nursing was therefore perceived to be akin to the work of prostitutes. The nurse (female) is also seen as dedicated to the role of handmaiden to the doctor (male) in the delivery of diagnostic techniques and treatments. This stemmed from the mid-nineteenth century, when the medical profession's engagement with scientific knowledge required reliable assistants to deliver the mundane and routine aspects of medical practice when the doctor was not present (Abel-Smith, 1960).

Wainwright (1994), using Ashdown's (1943) ideal typification of the 'good nurse', summarises the conventional approach to nursing:

> By tradition nursing has been seen as a dependent occupation, the nurse being expected to be the ears and eyes of the doctor, loyally carrying out instructions and faithfully reporting back. A nurse was expected to be 'punctual , good tempered, obedient, and loyal to all rules as the foundation of her work'. She must also remember 'what is due to authority' and 'must ever remember that discipline and obedience are the keynote to

satisfactory and efficient work in life'.

(Wainwright, in Hunt and Wainwright, 1994, p.3)

The nurse, therefore, was to be the doctor's 'good wife' in the workplace.

Commenting on the analysis offered by feminist critiques, Turner (1987) suggests that the apparent failure of nursing to become professionalised is in part because it is predominantly (in terms of the numbers of its members) female. Added to the problems of bureaucratic control [6], and the lack of coherent professional representation, the conflicting demands on the nurse of work and the family disrupt career development:

> .....the critical issue in the absence of professional status in the history of nursing has centred on the question of gender. The ultimate failure of nursing to achieve professional autonomy is explained in terms of the contradiction between family life and professional careers, bureaucracy and professionalism, the absence of a continuous commitment to a career to the exclusion of domestic involvements.....Women are exploited as nurses because they are socialised into a doctrine which equates nursing with mothering and sees the hospital ward as merely an

extension of the domestic sphere of labour.

(Turner, 1987, p.149)

For some feminist theorists, the structural nature of patriarchal society affects the division of labour both in the workplace and in health care organisations. At work the role of the 'wife' is played by the secretary, whilst the nurse plays the role of 'mother' in the hospital (Ehrenreich and English, 1976; Garmarnikow, 1978; Game and Pringle, 1983).

The public perception of nursing retains elements of sexuality and servility. For example, Salvage's (1985) study of lay, media, and nurses' opinions registered images of the nurse as an angel, sex symbol, as well as that of a battle-axe. However, Smith (1993) believes that a new image of nursing may be evolving.

The emergence of this 'new nursing' came about in the 1980s, and had been grasped by the leaders of nursing (managers, educationalists, and policy makers) with great enthusiasm:

> Since 1984 there has been an unprecedented burst of activity in and around nursing in the United Kingdom, culminating in proposals for the reform of various aspects of work and training.
>
> (Salvage, 1988, p.515)

In part, the new nursing is based on changes in the way nurses are educated. For example, in the 1980's a radically new syllabus for nurses undergoing state registration was introduced. Furthermore, there has been a huge increase in the percentage of nurses undertaking educational programmes in universities, both for initial training and for post-basic courses.
For Smith, the new image of nursing is concerned also with the separation of nursing from medical work, and with the ritualistic and hierarchical way in which care was delivered in the past:

> .....hospital nursing was organised around the execution of tasks as part of the medical division of labour..... In the 1960's, task allocation was still strong. The most junior and least experienced nurses undertook tasks perceived as basic or simple, such as dusting the ward furniture or cleaning the bedpans. As the nurse became more senior s/he graduated through a series of tasks from giving bedpans, doing the bed baths, taking the temperatures and blood pressures, and finally the dressings, drug round and injections.
>
> (Smith, in Taylor and Field, 1993, p.209/10)

The new nursing has been underpinned by the production of a conceptual foundation (the 'nursing process') which had been developed over the previous two decades by such

nurse theorists as Henderson (1966). Incorporated within this conceptual foundation is a philosophy of holistic care. Holistic approaches to nursing practice are aimed at including psychological and social factors alongside those of a bio-medical orientation. The philosophy of patient-centredness, which has its roots in humanistic psychology, has also been espoused as a legitimate ideological base for the new nursing. Here the identification and satisfaction of the patient's needs are seen as paramount, as opposed to the expert-centred diagnosis and treatment of illness and disease.

One other important element in the new nursing movement is the concept of primary nursing. This focuses upon:

> .....structural and organisational factors such as staff allocation and off-duty rotas which enable continuity of patient allocation.
>
> (Wainwright, in Hunt and Wainwright, 1994, p.14)

Primary nursing has been encouraged by a government initiative which has emphasised the importance of the identity of the particular nurse (and her or his 'associates') who has been given the responsibility for the care of individual patients. The idea is that the quality of care will be improved if patients, whether they are treated in hospital or in the community, know the name of this nurse.

However, the success of the named-nurse scheme has

been called into question. In the Royal College of Nursing survey mentioned above, less than one person in one hundred knew anything about the scheme. Moreover, out of over nine hundred people who had been treated by a nurse in the year prior to the study only 49% said that they were aware of being given a named nurse (Brindle, op. cit.).

Overall, the emphasis of the new nursing is the attempt to:

> .....redefine the nurse's role in order to assert its unique contribution to healing, the challenging of assumptions about nursing's subordination to medicine, and the idea of replacing a bureaucratic occupation with a profession.
>
> (Wainwright, in Hunt and Wainwright, 1994, p.3)

When the new nursing movement began, the reaction of medical staff was one of hostility. Smith (op. cit.) records that the introduction of nursing care plans and primary nursing caused an outcry from medical practitioners. For example, numerous letters and editorials in the medical journals referred to the resentment that doctors felt about nurses distancing themselves from their historical ties with the medical profession.

However, Smith (op. cit.) points out that despite some

movement away from (medical) procedures towards care focused upon the needs of the patient and controlled by nursing objectives, much of the nurse's work remains shaped and directed by medical imperatives:

> Although the organisation of nursing care in hospitals has become more patient-centred in line with the nursing process, many tasks and routines shaped by medical diagnosis and treatment are still apparent. These tasks and routines include doctor's rounds, diagnostic tests and therapies on and off the ward.
>
> (p.210.)

The desire by nurses to extend their role into more prestigious areas of work ((Hunt and Wainwright, 1994), which can be viewed as another characteristic of new nursing, may in fact have a detrimental effect on their status. For example, Muir (1993) reports that because the working hours of junior doctors are being reduced, surgeons are examining the possibility of using nurses to do their 'dirty work' (Hughes, 1971). That is, a nurse may be employed as a "surgeon's assistant" (a concept borrowed from the United States). This would involve her or him doing simple, routine and repetitive tasks during surgery.

The attempt by nurses to shed task-orientated work may be prevented also by the pressures on nursing staff to provide a cost-effective service with a high

turnover of patients. Medical commitment to positivistic and technical science contributes further to this reversal. Stated simply, patients may not spend enough time in hospital for the nurse to implement those principles of the new nursing that involve holism, care planning, etc., and for the patient to benefit from having a named nurse. Neither is it likely, because of the resource implications, that the new nursing can be delivered successfully in the community. Moreover, it is medicine, responding to the managerial cost-efficiency drives, that has been at the forefront of the techno-scientific advancements which have resulted in patients having shorter spells in hospital. Consequently, the same process that devalues nursing has the effect of improving the status of medicine.

Hart (1991) found that nurses still display deference to medical practitioners. When nurses talked to doctors they were much less articulate and less outspoken than when they talked to her. This discrepancy, the nurses explained to Hart, was because they believed themselves to be inferior to and of less importance than the medical staff.

If new nursing can be seen as having failed to change the traditional role of nurses (particularly with reference to their relationship with doctors) can nursing ever be a profession? Dingwall's position on the prospect of nursing reaching the same professional status as medicine is quite clear:

> .....the practice of.....[nursing] work remains firmly subordinate to that of the doctor. With the exception of health visitors, no nurse has an independent access to work or its allocation.....The doctor retains the sole control over the focal tasks of diagnosis and treatment. The nurse still requires his authority to penetrate the body physically or chemically.....functional autonomy for any group other than doctors is, at best, a pipe-dream.
>
> (Dingwall, 1974, P.53)

Freidson (1970a) is also clear that nursing can never be anything other than a 'semi-profession'. The knowledge base for nursing (despite the attempts of the advocates of new nursing) remains within the remit of the medical model. Furthermore, Freidson argues that as doctors control the admission of patients, they are ultimately responsible for the diagnosis and treatment, and therefore wield much influence over nursing practice.

A number of commentators on the future of nursing as an occupational group have questioned whether professionalisation is a suitable goal for nursing (Melia, 1987; Dingwall et al, 1988; Salvage, 1988) [7]. It may be, for example, that each sub-group of nursing has to develop and implement its own strategy to achieve either full professional status, or attempt to sustain

or improve its position in the occupational hierarchy by alternative methods to professionalism.

That is, given that nursing can be perceived as a non-homogeneous collection of workers (Abbott and Wallace, 1990, P.17; Butterworth, 1984), as is the case with many other occupational groupings (Bucher and Strauss, 1961; Bucher, 1962), it may not be politically or pragmatically astute for those representing its numerous factions to partake in a unified occupational strategy. A diversification in occupational strategies and goals has already taken place to some extent, and with variable success, for a number of health-care groups associated with nursing. For example, Abbott and Sapsford comment on the case of health visiting:

> Health visitors are not unaware of the contradictions and problems of their role position. In recent years these have led them on the one hand to seek professional status and on the other to monitor and evaluate their own work in more detail. They have been led to consider who they are, and what work they ought to be doing.....
>
> (Abbott and Sapsford, 1990, p.122)

Health visitors, along with midwives, have claimed independent practitioner status (Dingwall et al, 1988). In doing so, they have attempted to secure their position as aligned but separate to nursing, and

increase their standing as professionals ahead of that achieved by nurses.

This attempt to reach independent practitioner status is characterised by the health care worker being able to carry out her or his practice autonomously. That is, to be able to operate without recourse to medical supervision in practical day-to-day decision making and, at an ideological level, to be free from medical hegemony. It should be emphasised, however, that this is only an attempt by such groups as health visiting and midwifery to be independent. The degree of success and/or self-delusion involved in this quest is debatable (Dingwall et al, 1988, Chapts.8, 9, and 10: Willis, 1989, Chapt.5; Benoit, 1989).

With reference to midwifery there has been a growth in independent midwives, but doctors have effectively taken over child-birth due mainly to the hospital confinement of pregnant women. This leaves midwives vulnerable to medical and bureaucratic domination. Where midwives have attempted to avoid both of these forms of domination (e.g. through the setting up of groups aimed at self-help), they have not necessarily been successful:

> Midwives seeking to exercise their role to the full have often been constrained by the bureaucracy surrounding maternity care or by medical control to such an extent that some have gone into practice outside traditional structures..... These alternative patterns of

> practice are not always sanctioned by health care organisers to whom independent practice and/or the supporting of women to give birth at home can be seen to undermine the dominant mode of operation. Where midwives have formed self-help groups they have found it hard for their voices to be heard.
>
> (Silverton, in Hunt and Wainwright, 1993, p.154)

As Wainwright (op. cit.) observes, there are contradictory processes at work in relation to how nurses operate and perceive themselves, and this has an effect on their occupational status. For example, Wainwright suggests that at the same time as demanding independence, nurses also wish to remain "part of the team". In doing so, he argues, nurses proliferate the status quo (which by implication means occupational stagnation for nursing):

> Nursing is still very much in a transitional state. On the one hand we have the development of primary nursing and arguments for autonomy and self-governance, reinforced by initiatives such as the named nurse, nurse prescribing, the development of specialist and advanced practitioners, and the reduction of junior doctors' hours.....On the other hand we have, apparently, a deep desire on the part of many

> nurses to be part of the team and to continue in the STATUS QUO [emphasis by Wainwright].
>
> (p.17)

Furthermore, as with medicine, the introduction of managerialism into the NHS will influence how much of nursing work can be defined by either nurses or by doctors. Managers, as I have discussed in the previous section, may enact controls over nursing and medicine which will shift the balance of power and force both to reconsider their position in the occupational hierarchy. However, new managerialism in the NHS has imposed structures that are in the main more harmful to nursing than to medicine (Baggart, op. cit.) [8] .

For Wainwright (op. cit.), the options for nursing rests upon the ability of its members to take on extra responsibilities and thereby extend their role. This will help nurses ".....achieve authority over the nature of their practice" (p.19). I maintain, however, that the evidence suggests that nursing as a whole is structurally disadvantaged in the hierarchy of health care occupations. Any autonomy gained is only relative to the willingness of general managers, politicians, and the profession of medicine to allow this to happen. Nursing does not have the power base of, for example, medicine (which I argue has maintained its professional dominance), and hence this 'relative autonomy' [9] can be reversed at any time. The question to be addressed below is, has community psychiatric nursing

disentangled itself from the rest of nursing and achieved (or has it the potential to achieve) a professional status?

2.5.COMMUNITY PSYCHIATRIC NURSING

Following the application of Freidson's (1970a; 1970b) perspective to review nursing as a collectivity, in this section I employ his approach to explore the literature on community psychiatric nursing. As with nursing in general, the notions of clinical autonomy and professional dominance are used as focal points.

Specifically, data referring to the working practices of CPNs are examined to ascertain whether or not they have control over their work (in terms of defining what the content and limit of this work is). If they have this control, then they could be viewed as having moved substantially in the direction of professionalisation. However, if the literature indicates that the management of their work is susceptible to the dominance and hegemony of other health care professionals (e.g. medicine), then community psychiatric nursing can only be described as a subordinate occupational group. It can be regarded as remaining under the occupational umbrella of nursing as a whole, having the status of, in Freidson's terminology, a 'para-medical' profession.

The history of mental health nursing can be traced back to the 'keeper' of the various types of 'houses' in which the mad were accommodated prior to the 1845 Lunacy Act (Nolan, 1993). Hospitals were known to exist in the ancient world, and provided treatment in a religious context. The existence of hospitals in this country is

not established unambiguously until the tenth-century (Cartwright, 1977). Apart from the 'lazar house', which accommodated people suffering from leprosy, the purpose of a 'hospital' was not defined clearly:

> It could be a geriatric unit, an orphanage, a reformatory for unmarried mothers, a rest house for travellers, an infirmary for the sick, or much more frequently, it could serve all these purposes.
>
> (Cartwright, op. cit., p.30)

By the fifteenth century, special provision for the mad was being created. As Cartwright (op. cit., p.31) notes, in the mid-1400s 'Bedlam' offered sanctuary for ".....many men that have fallen out of their wits". Until the beginning of the nineteenth-century, the mad were still in general cared for by their families. However, thousands of the mad were contained within houses of correction, private madhouses, and local parish workhouses.

Following the 1845 Lunacy Act, local authorities were forced to provide for the mad through a massive public building programme. Along with the Poor Law Amendment Act 1834, this act heralded the beginning of the asylum system, and the segregation of the mad from the rest of the community (Foucault, 1967; Scull, 1979;). It also supplied the opportunity for both medicine and nursing to emerge as legitimate surveyors of the mad.

After 1845, the keeper became the 'attendant'. The attendants were responsible for the general upkeep of the new institutions for the insane, but were also to become ".....the medical superintendent's servants, with primary responsibility to carry out his orders" (Nolan, op. cit., p.6). Women who became attendants were in the main referred to as 'nurses'. It wasn't until the end of the 19th century that men were also accorded this title.

By the time the 1890 Lunacy Act was instituted, the medical profession had monopolised the market with regard to the care of the mad, and this resulted in the redefining of the category of 'madness' to one of 'mental illness' (Baruch, and Treacher, 1978). For Nolan (1990), the creation of a Register for Attendants under this act marks the start of the formal recognition of the occupation of psychiatric nursing. The title 'mental nurse' was inaugurated in the General Council's Supplementary Register for Mental Nurses of 1923 (Nolan, 1993).

Community psychiatric nursing, as a branch of psychiatric nursing, has a relatively short history. But the importance of CPNs in the mental health field leads Armstrong (1987) to claim that they are, the ".....frontline workers of psychiatric care" (p.4).

Community psychiatric nursing can be traced back to 1954 when two nurses were seconded from a psychiatric hospital in Surrey to work as 'out-patient nurses' because of a shortage of social workers. Their role was to keep contact with discharged patients and to help

maintain them in the community (May, 1965; Greene, 1968; Hunter, 1974; Sladden, 1979; Carr et al, 1980; Malin, 1988). Since then the CPN service has grown considerably, and is continuing to enlarge. By the year 2000 it is projected that twelve-and-a-half thousand psychiatric nurses will be community based (CPNA, 1985).

By the 1980s the role of the CPN is reported to have expanded to include such aspects as the formal and informal assessment of a client's mental health, the implementation of preventative, educative, and specific therapy programmes, and supportive visits (Beard, 1980; Carr et al, 1980; Williamson et al, 1981). Other aspects of the CPN's role are stated to be the provision of a consultative service to other health-related and voluntary agencies, the provision of physical care, and the giving of injections (Mangen and Griffith, 1982; Barratt, 1989).

The growth of community psychiatric nursing has, however, been observed to have been piece-meal and unco-ordinated. Pollock (1986) states:

> .....surveys (CPNA 1981 and 1985).....suggest that CPNing service development is of a local nature and ad hoc in character.....CPNing appears to share with other British social and health services a common history of isolated experimental development.....there is great diversity.....in the therapeutic settings in which CPNs work and in the forms of

intervention offered by CPNs.

(p.11)

Furthermore, Dingwall et al (1988, Chapt.7) perceive mental nursing as going through a crisis of occupational identity. This they argue, is due to a radical alteration in the way in which nurse education is organised (e.g. 'Project 2000'). These authors suggest that this threatens to leave mental nursing merely as a post-basic speciality (see Chapter 5 in this report). Kellehear (1987), examining the situation in Britain and Australia, records that mental health nurses are confronted with a multitude of changes. These changes include government cost-cutting exercises, and the shifting locale for the treatment of mental illness. Another factor causing this crisis for Dingwall et al (op. cit.) has been the encroachment on mental nurses' work from both social work and psychology. The development of community psychiatric nursing can be seen also as surrounded by occupational conflict between CPNs and other mental health professionals (Dean, 1988).

In the search for an occupational identity, mental health nursing, like health visiting and midwifery, has attempted to project itself as a profession:

> Psychiatric nurs[ing]....has, for the last decade, been engaged in strategies to move from being a semiprofession to a fully

autonomous profession.

(Pilgrim and Rogers, op. cit., p.149)

Community psychiatric nursing has tried to produce an identity which is not only separate from nursing generally, but is also distinct from psychiatric nursing. This has been attempted through, for example, its assertion that its members function already as autonomous practitioners. An account by Hally (1989) of her day's work as a community psychiatric nurse illustrates this. Describing what a CPN is, she states:

> The CPN is a community mental health worker who is an autonomous practitioner within a wide community network.....there is no other branch of nursing which offers the variety, the challenge, the autonomy and the satisfaction of community psychiatric nursing.
>
> (p.6)

In the outline syllabus for the post-basic qualification in community psychiatric nursing there is the statement that the aim of the course is:

> To produce a practitioner, beyond initial training as a Registered Mental Nurse, who is able to function autonomously.....
>
> (English National Board, 1989, p.1).

There is, therefore, the assumption that a Registered Mental Nurse does not operate autonomously (at least in the context of the community) until the course is undertaken. Moreover, there is the suggestion that autonomy is achievable.

The aim of this course, however, is stated to be not only to have the CPN work autonomously, but also to be part of the multi-disciplinary team. It is the tension between autonomy and team membership that is examined in this research study, and discussed in more detail below. As Dean (op. cit.) observes, with reference to professional rivalry between the mental health disciplines:

> The development of multi-disciplinary teams will not eradicate these tensions but bring them into sharp relief.
>
> (p.16)

The accomplishment of autonomy has been generally measured against how far removed the CPN is from medical domination. For example, Simpson (1988), in an article on the subject of CPN autonomy and medical hegemony, perceives the medical profession as restricting the CPNs' access to a particular group of clients:

> CPNs increasingly regard themselves as autonomous practitioners, especially when

> working with those who are experiencing disabling mental health problems but who cannot be considered mentally ill. But how can autonomy operate when another profession controls access to, and assessment of, this group of clients?
>
> (p.5)

Simpson provides evidence justifying professional status for CPNs from Feinmann's (1985) account of one CPN who, whilst working with a group of London GPs over a period of three years, assessed and treated (or referred on) six hundred clients. The CPN adopted a variety of 'non-medical' approaches and produced a dramatic reduction in the prescription of psychotropic drugs together with a large decrease in hospital referrals.

Simpson believes this example supports the quest of CPNs for autonomous practitioner status. It may also be an example of what Rose (in Miller and Rose, 1986) suggested was "....A NEW DISTRIBUTION OF PROFESSIONAL POWERS [his emphasis]" (p.83). Rose detracts from the radical criticism of psychiatry which perceives the mental health industry as dominated by positivistic bio-medical approaches. He believes that psychiatry itself is eclectic in practice, and that non-medical personnel (including nurses) play key roles in the delivery of treatment to the mentally ill:

.....there has been no simple medical monopolisation of mental distress, but rather the development of a FREE MARKET OF EXPERTISE [his emphasis].

(op. cit., p.83).

Alternatively, it could be argued that the CPN in Simpson's example was working under license, and that if the CPN undermined the ultimate authority of medicine, the license would be revoked. As White's (1986) research has illustrated, direct access by CPNs to clients continues to be restricted by medical practitioners.

In a further study by White (1990), he conducted a postal survey of all of the district health authorities in England. He observes that the data from the study indicates that the proportion of referrals received by the CPNs from consultant psychiatrists has halved over the last ten years [10] . This, according to White, is a consequence of the closer ties between the CPNs and the general practitioners. Certainly some psychiatrists have objected to the possibility of their monopoly over mental health care being challenged due to nurses forming stronger links with PHCTs, as well as through the closure of the asylums:

Many psychiatrists are doubtful about, or even openly hostile to the developments

(Sturt and Waters, 1985, p.507)

However, in his attempt to peddle the self-congratulatory slogan of CPNs being ".....the most important single profession in the process of moving the care of mental illness into the community" (p.197), White (op. cit.) underplays the fact that both general practitioners and psychiatrists belong to the profession of medicine. Whether referrals are controlled by general practitioners or by psychiatrists, community psychiatric nursing remains in a subservient relationship with medicine.

Many of the advocates of professionalisation for community psychiatric nursing believe, however, that CPNs are in a unique situation. It could be argued, for example, that the physical location of the practice of community psychiatric nursing (i.e. in the community) offers its members a greater opportunity to be autonomous than hospital based nurses. That is, the process of decarceration (Scull, 1983; 1984; Bean and Mounser, 1993) can be viewed as offering mental health nurses some degree of professional autonomy. As Freidson observes:

> The nurse, whose leaders in the United States and abroad have with great energy sought to establish unique skills and full professional status, seems fated to remain subject to the doctor's orders in part because of the fact that her work is largely carried out in the hospital.
>
> (1988, p.57)

Like health visitors, community midwives and, to a lesser extent, district nurses, CPNs work unobserved by medical and other colleagues (as well as their managers) for much of the time. However, Freidson points out the paradox for nursing with respect to its association with medicine and its occupational status:

> Interestingly enough, it appears that IN ORDER TO attain semi-professional status, the nurse had to become part of the subordinate paramedical division of labor, and so handicap her chance for subsequent professional status.
>
> (ibid.)

That is, the occupational position of nursing (and in many respects its raison d'etre) is dependent upon linkage with the medical profession. Complete separation of the two occupations might cause nursing to lose its semi-professional prestige, or even lead to its complete disintegration as an occupational category. As has been noted by Hughes (1988), situational differences for the nurse can affect the degree to which she or he exercises autonomy and is free from the domination of others (in particular, the medical staff). CPNs at present operate from any one of a number of geographical sites. Traditionally, they have been housed within the grounds of the psychiatric hospital. Many CPNs moved into the

psychiatric units of district general hospitals during the 1970's, and into health centres either as whole-time or part-time members of the primary health care team (Sheppard, 1991).

There remains, however, disagreement as to where ideally CPNs should be located. Some argue for CPNs to remain hospital based (Leopoldt, 1979), whilst others have encouraged the movement into primary health care teams (Mangen and Griffith, 1982; Brooker and Simmons, 1985).

A fairly recent innovation has been the creation of the CMHT, which in many cases function from community mental health centres (CMHCs). CMHT membership consists of, for example, psychiatric nurses, psychiatrists, psychologists, social workers, and occupational therapists (Dean, 1988; Ovretveit, 1993). The development of CMHTs and CMHCs in Britain was influenced by experiments in both the USA and Italy (Sayce et al, 1991) [11] . In the USA these institutional changes to the delivery of care for the mentally ill were supported by legislation (i.e. Community Mental Health Centre Act passed by Congress in 1963). The aim of the CMHCs was to offer local, accessible, free, and universal mental health services (Sayce, 1989).

Cohen (1988) observes that some social commentators have suggested that medical hegemony has been challenged by the creation of CMHCs in the United States. However, Greer and Greer (1984) note that the mental health movement that advocated de-institutionalisation and the

1963 Act had gained its intellectual leadership ".....from a new professional group, COMMUNITY PSYCHIATRISTS [my emphasis]....." (p.403). That is, the CMHTs in the USA may have provided an occupational territory for a new breed of psychiatrists.

Sayce (op. cit.) records that CMHCs started to emerge in Britain in the 1970s. Patmore and Weaver (1989) observe that in Britain the number of CMHCs had grown in the late 1980's from fifty to two hundred and thirty. This development is encouraged by Wooff and Golberg:

> There is general acceptance of the view that a multidisciplinary team will provide a better standard of mental-health care than that provided by a single professional working alone.
>
> (1988, p.36)

Simpson (1986) accepts that the Short Report (Social Services Committee, 1985), and the Cumberlege Report (DHSS 1986), '.....places CPNs firmly in the grip of the multi-disciplinary team....." (P.7). However, Simpson goes on to point out that the Cumberlege Report also argues that CPN attachment to primary health care teams or nursing services is a 'welcome trend'. Certainly, general practitioners appear to support the inclusion of CPNs in the PHCT (Robertson and Scott, 1985; White, 1986).

Pollock, however, like Wooff and Goldberg (op.

cit.) questions whether CPNs should work in isolation:

> The community psychiatric nurses themselves may not be the best people to comment impartially on their contribution in relation to individual patients.....it could be proposed that decisions by the community psychiatric nurses about who is treated may be more appropriately taken at a multidisciplinary level, where combined views of different professions can be brought to bear on the work of community psychiatric nurses.
>
> (Pollock, 1989, p.196)

It is the role of the CPN in primary prevention which appears to give rise to much criticism. For example, it is argued that the CPN's concentration in this area, and her or his individualistic and unsupervised style when working with clients who are referred directly from the PHCT, that has resulted in a lack of attention being given to the chronically mentally ill (Petroyiannaki and Raymond, 1978; White, 1987; Simmons, 1988; Goldberg, 1985; Wooff and Goldberg, op. cit.).

However, rather than the issue here being about appropriate or inappropriate role-function, it may be that as CPNs are colonising therapeutic areas previously not under their remit, they are perceived as a threat by their mental health colleagues. Therefore, the call for

the supervision and better management of CPNs (Wooff and Goldberg, op. cit.) may well turn out to be a strategy to re-affirm dominance over a previously subservient workforce. Of course the CPN may shift eventually from servicing the doctor to servicing the social worker, psychologist, or perhaps the multi-disciplinary team in its entirety - which may act as a kind of corporate-preceptor.

Carr et al (op. cit.) and Beard (1980) have suggested that the role of the CPN has moved far beyond that of medical adjunct, but Brooker (1989) has argued that this development is characterised still by inter-professional rivalry. Commenting specifically on inter-disciplinary work in CMHCs, Noon (1988) suggests that a fundamental issue is that of 'collaboration' between the various occupational groups.

Using a model proposed by Kane (1975), Noon describes two types of inter-disciplinary teams. The first is the 'co-ordinate team' in which all of the disciplines are considered important to the overall rehabilitation of the patient. However, each discipline tends to enter the situation at a different point in time, and has a rather specialised role to perform. Most significantly, with the co-ordinate team, the physician remains the 'leader'. The second type of team is the 'integrative team'. Here decisions are shared, roles overlap, and there is a shift from focusing on 'leadership' towards an awareness of the effectiveness of team group processes.

The idea that an 'integrative team' does (or could)

operate in the mental health field may well be idealistic to say the least. As Noon explains:

> Professional boundaries may be a problem. This includes the question of who is a legitimate member of the team and what the boundaries are between each discipline.
>
> (1988, pp.1160/61)

Simmons (1988) recognises that working in a team imposes a set of structurally organised role-relationships on the CPN:

> One of the main issues is surely that of leadership. We can espouse many wonderful and idealistic notions about how a team should work collectively with mutually agreed goals, shared or flexible leadership, and genuine blurring and overlapping roles. The reality is however often rather different.
>
> (P.16)

The issue of leadership is one which is not resolved. Consultant psychiatrists have voiced their opinion that they believe they are the natural leaders of multi-disciplinary teams (Black and John, 1986; White, 1990). Others (e.g. psychologists) believe that the CMHT offers the opportunity to break the psychiatrists

ideological and operational stranglehold over mental health care (Johnstone, 1989).

A further structural element is acknowledged by Simmons when she asks whether referrals will be made only through the CMHT. She is concerned that as CPNs are the largest group within the CMHT, they will be expected to:

> .....take on the work which is seen as the least rewarding and prestigious - work with long-term clients with major psychiatric illness.
>
> (ibid.)

There are indications that this indeed will be the case. This pattern of doctors off-loading work onto nurses in general has already been commented upon by Dingwall (1974). With reference to CPNs, White (1986) and Dean (op. cit.) identified a strong element of delegation, and a perception of 'subordinate status' by the medical members of the PHCT. With regard to CMHTs, however, Dean states optimistically that:

> The multi-disciplinary team approach would seem to offer a potential resolution of the observed misunderstandings between professional groups despite the potential problems of leadership and collegiality.
>
> (op. cit., p.335)

However, as Simmons (op. cit.), and Noon (op. cit.) have implied, CPNs may find that this relative freedom is curtailed if they join CMHTs. That is, there is a contradiction in trying to achieve autonomy and at the same time being a member of the CMHT:

> Practitioners used to working independently find that they have less autonomy in a team.....some team members raise 'lack of autonomy' as a problem.....
>
> (Ovretveit, 1993, p.116)

Simpson (1986) also spells out the ambiguous situation CPNs can be in with reference to levels of autonomy when they belong to a CMHT:

> While there are clear advantages to working in a multidisciplinary team.....there are also great benefits in becoming an autonomous practitioner.....
>
> (p.9)

CMHT membership, therefore, for the CPN (as well as for other occupational groups in the team) may dilute any claim to clinical autonomy, and may consequently reverse any advancement made in the direction of professionalisation.

The nature of team work in the community is due for further change in the future. Recent Government reforms will have direct and indirect effects on inter-disciplinary, and inter-agency relationships (DoH, 1989a; 1989b; 1989c; 1989d; 1990). These reforms include the development of market conditions in the NHS and local authorities, the creation of NHS Trusts, the separation of 'provider' of services from 'purchaser', and the ability of general practitioners to become fund-holders.

More importantly with respect to the role of the CPN is the separation of 'health' from 'social' care in the community, and the implementation of 'care management' (Ovretveit, 1993; Watson, 1994). White and Brooker (1990) suggest that these latter reforms may cause CPNs to concentrate more on working with the chronically mentally ill rather than the 'worried well', and reduce their involvement with general practitioners. The reforms may also, they believe, underscore the primacy of the consultant psychiatrist in the division of labour in the mental health field.

Furthermore, the recent debate over recommendations from the Royal College of Psychiatrists for the introduction of 'Community Supervision Orders' (Bean, 1993; Brindle, 1993a; 1993b) also has implications for the position of community psychiatric nursing in the occupational hierarchy. For example, if legislation is passed which will allow the use of supervision orders, then the CPN may be encouraged to be the key worker in overseeing patients who have had an 'order' placed on

them. This would necessitate CPNs working much more closely with consultant psychiatrists, as well as cause a re-defining of their role. That is, they would become more overtly 'agents of social control'.

However, at present the literature does not confirm that community psychiatric nursing has achieved a level of clinical autonomy, or occupational independence from other professions (particularly medicine), that would indicate it is becoming professionalised. Indeed the literature implies that CPNs are in a vulnerable position as far as their present status is concerned, and that membership of multi-disciplinary teams (whatever form this may take) could jeopardize their self-proclaimed wish for occupational advancement through the strategy of professionalisation.

2.7.SUMMARY

A critical review of the literature on the professions indicates that Freidson's (1970a; 1970b) depiction of a profession as an occupation that has autonomy over an area of work, and dominance over related occupations, is still of relevance as a theoretical tool in the late twentieth century. Taking the example of medicine, the literature indicates that there has been some loss of control over resources (because of the introduction of general management to the NHS). However, despite predictions to the contrary (Gabe et al, 1994), there has not been any significant degree of proletarianisation or de-professionalisation of medicine. Neither has the threat of competitive ideologies (e.g. from 'alternative' health care), the rise of sophisticated technology, the increase in the codification of knowledge, or the suggested existence of an active consumer, affected the relative power of medicine. Conversely, it can be argued that some of these contemporary processes and structures have allowed medicine to consolidate its professional status.

An increase in occupational status of the semi-professions in the health care field was also expected to weaken the position of medicine. However, in the case of nursing, not only has this not happened, but it may be that this occupational group is experiencing a reversal of any independence from medicine it could claim to have achieved.

Whilst nursing as a whole remains a subordinate

occupation, community psychiatric nursing may have been able to procure a greater degree of autonomy because of its situational advantage. However, the development of CMHTs is placing CPNs in a situation whereby they may lose their independence if not re-create their subservient relationship with psychiatrists. What this study explores is how much clinical autonomy the CPN has, and how this is affected by team membership.

2.8.ENDNOTES

1. Goldie states that his research was concerned with:

> .....the complex task of reconciling certain 'objective' features of the social structure of treatment settings found within mental hospitals, with the 'subjective' views of these features as held by the staff who were interviewed.....[A]ttention has to be paid to the way that actors themselves define their own situation, and how their actions, intentions and motivations form a dialectic with the institutions in which they participate.
>
> (Goldie, op. cit., p.142

Negotiated Order Theory was employed by Goldie in his attempt to account for the interplay of professional practice, individual perceptions and motivations, and organisational control (Strauss et al, 1971; Bucher and Strauss, 1961;1971; Bucher and Stelling, 1969). Strauss (1969) introduced the concepts of 'negotiated context' and 'structural context' to describe the relationship between individual action and formal rules, procedures, hierarchies, etc..

2. A more recent attack by a psychologist on the training and work of psychiatrists is offered by

Johnstone (1989). The nature of the relationship between the psychologists and psychiatrists in this study is examined in Chapter 4.

3. An example of the state sponsored bureaucratic processes that may in the future impinge on medical autonomy is that of the complaints procedures against doctors, which are presently under review:

> Doctors' traditional stranglehold on NHS complaints is being threatened by Health Secretary Virginia Bottomley..... Mrs Bottomley has said: "We believe the time has come to look, to uproot, to re-examine our mechanisms for dealing with complaints".
>
> (Bevins, 1993)

4. In Britain these systems would include the Conservative Government's legislation which created NHS Trusts, and the opportunity for general practitioners to become budget-holders (DoH, 1989b; 1989c; 1989d).

5. The link between computer technology and the delivery of medical treatment is well developed, and has recently received a major boost. Leading computer and bio-technology industrialists have begun collaborative exercises using computers and bio-technology to produce drugs:

> Two of the computer industry's most successful entrepreneurs have joined forces with a leading biotechnology company. Bill Gates and Paul Allen, cofounders of Microsoft, last week invested $10 million in Darwin Molecular, a company that hopes to use a better understanding of human genetics to design drugs.
>
> (Coghlan, 1994, p.4)

6. Davis (in Dingwall, 1983, Chapt. 8) examines specifically the position of nursing in the bureaucratic context.

7. See, for example, Melia's proposal that nursing as a whole could be replace the sought elitism of professionalism with the autonomy of the craft worker (Melia, 1987).

8. Owens and Glennerster (1990) believe, however, that nurses may in the future enter into senior management in the NHS as they are well represented in the lower and middle management levels at present.

9. The concept of 'relative autonomy' has been borrowed from Althusser (1969), who uses it to denote the degree to which the superstructure is free from the economic base. I have used this term elsewhere in an analysis of the level of freedom experienced by participants on

student-centred educational programmes (Morrall, 1989b).

10. White (1993), following these earlier studies, conducted a comprehensive survey of CPNs in England. He reported that 25% of CPNs did not have one client on their case-loads with the diagnosis of schizophrenia. That is, the trend appears to be for CPNs to concentrate more and more on working with clients with minor mental illness at the expense of those with serious mental illness.

11. See Mollica (1980) for a discussion on the inappropriateness of importing structures (such as CMHCs) without acknowledging their cultural and political specificity.

3.CHAPTER THREE RESEARCH METHODS

3.1.INTRODUCTION

An account of the research methods employed in the project, and of how these methods were implemented, is provided in this chapter. Firstly, there is a description of the reasons for the particular methods being chosen. In the second section there is a report on the pilot study, beginning with a review of a six month pre-pilot experience, during which I worked as a CPN in a CMHT. Neither the CMHT used in the pilot study or in the pre-pilot study was included in the main part of the research.

The details of the three research tools are then discussed. A researcher-completed diary (the 'Diary-interview Schedule') was used to collect data from the CPNs. Data were obtained from the other members of the CMHT, and from the managers of the CPNs, through focused-interviewing. Substantive, pre-analytical, and methodological observations were recorded in a field-notebook.

In the next section there is an exploration of the specific methodological issues that were documented in the Field-notebook. These issues include the problem of the data collecting period extending from the projected one year to two years, the difficulties and benefits associated with the tape-recording of the interviews, and the consequences of the researcher being an active

participant in the research arena. The major ethical dilemma of the research (i.e. the researcher having access to 'backstage' conversations and activities), is considered in this section.

The design issues of validity, reliability, generalizability, selectivity, and sampling are then reviewed. In particular, methodological and data triangulation are highlighted as techniques which support claims to validity and (to a lesser degree) reliability. Finally, there is an account of the procedures used to analyse the data.

3.2.SELECTING THE METHODS

The justification for choosing the diary-interview, focused-interviews, and field-observations, to examine the occupational status of the CPN in the organisational context of the CMHT is essentially one of pragmatism. That is, the methods flow logically from the project's aims and working hypothesis. The aims and hypothesis are themselves the logical consequence of the theoretical considerations of the research (explored in Chapter Two), and the reported concerns of the CPNs during, for example, the pre-pilot experience (see below).

Furthermore, these particular methods have been chosen, not only because they are effective in meeting the aims of the research, but also because they are efficient. That is, given the inevitable restrictions on time, resources, and access to research arenas, they are the most practicable.

In addressing the goals of the research, both inter-methodological and intra-methodological triangulation has been adopted. Inter-methodological triangulation refers to the use of different methods within a research design (there are three in this study), and intra-methodological triangulation refers to the use of different techniques within each method (for example, open and closed questions in the Diary-interview Schedule; standardised questions and investigative probes in the Focused-interview Schedule). Consequently, the methodological tools in the

study transgress the conventional divide between quantitative and qualitative research methodologies [1] [2].

3.3.PILOT STUDY

3.3.1.Pre-pilot experience

In the late 1980's I was seconded by Teesside Polytechnic, where I was employed as a lecturer, to work part-time as a CPN in a CMHT for the period of one academic year (the equivalent of six months full-time). This was ostensibly to provide me with the experience of community psychiatric nursing which would enable me at some future date to lead post-registration courses for CPNs [3] . However, this experience also allowed me to assess more specifically the concerns of CPNs with regard to their membership of CMHTs, and to formalise the research design for this study.

As has already been mentioned (see Chapter 1), these concerns had been expressed during earlier discussions between myself and the CPNs. The CPNs expected involvement in the CMHTs to alter the relationship between themselves and members of other disciplines (particularly psychiatry). The consequence of belonging to a CMHT, the CPNs argued, re-established the former hierarchical structure that existed in the psychiatric hospitals whereby the consultant psychiatrist was dominant in his or (less frequently) her professional relationship with the nursing staff. For the CPNs, therefore, membership would undermine their clinical independence.

For example, the CPNs and their managers in the health authority in which I worked had challenged the position

of dominance by the psychiatrists over nurses through the adoption of an open referral system (i.e. accepting clients from any source rather than just from the psychiatrist). However, confirming what other CPNs had explained to me, the psychiatrists (and some members of the other mental health disciplines) in this health authority were indicating that they were discontent with these arrangements. It was this area of inter-occupational strife that became the focus for the study reported here.

The pre-pilot experience also helped in my acclimatisation to the cultural, behavioural and linguistic norms of community psychiatric nursing. It therefore increased my understanding of the CPN's occupational role, and role generally in society. Moreover, it helped me to avoid 'communicative blunders' (Briggs, 1986) in the collection and analysis of data extracted from this source.

3.3.2.Aim and Objectives

The aim of the pilot study was to judge the feasibility of implementing the chosen research methodology. Specifically, the objectives of the pilot study were to:

1. assess the validity of the Diary-interview Schedule questions and the Focused-interview Schedule questions

2. evaluate whether or not any questions in the Diary-interview Schedule and Focused-interview Schedule were ambiguous, inappropriate, or without meaning to the interviewees

3. practice the recording of the field observations

4. provide an indication of factors related to time-management with regard to the collection of data

5. take cognizance of any material that may refer to CPN clinical autonomy or collegiality in the CMHT which had not already been included in the prepared questions

6. evaluate the skills of interviewing.

3.3.3.Context

The pilot study was conducted during 1990 in a health authority which was not included in the main part of the study. A CMHT consisting of a consultant psychiatrist, a social Worker (jointly funded between the Health Authority and Social Services), a senior house officer, an occupational therapist, a psychologist, and seven CPNs, was researched over a two month period. Two of the seven CPNs specialise in dealing with people over the age of sixty-five years and were not used for the pilot study. The remaining five described themselves as generic CPNs. The generic CPNs deal with the all types of referrals in the sixteen to sixty-four age range, and are all at 'G' grade in the nursing hierarchy except CPN(3) who is employed in the junior position of grade 'F'.

Covering a geographical area with a population of approximately 28,000, the team is situated in a coastal town which has fishing and tourism as its main industries. The team's operational policy document indicates that referrals are taken from any source, and that referrals to the team would be preferred. However, the policy document suggests that a referrer can ask for a particular person or discipline if they wish.

A 'duty officer' is appointed collectively by the team to deal with referrals which the referrer (e.g. a general practitioner) deems to be urgent. Each member of the team takes this role on a rotation basis. The duty officer assesses the prospective client, and then a key

worker is allocated at the weekly referral meeting. The functions of the key worker are listed in the team's policy document. These functions include references to the CPN being responsible for her or his own clinical work, a requirement to give and receive supervision, to liaise with all other workers (hospital and/or community based) who may be involved, and to be accountable to her or his intra-professional line-manager.

None of the other teams in the study have clearly recorded statements on the role of the key worker, or if they did the CPNs were not aware of them. The lack of written guidelines on the various roles and functions of members of the teams (and/or the members ignorance of their existence) was a common feature throughout the study.

As with the duty officer, a team co-ordinator is elected by the team on a rotation basis (for a period of one year). Again the responsibilities attached to this role are documented. These responsibilities include the requirement of the co-ordinator to act as the 'gate-keeper' to the team with regard to referrals. That is, the co-ordinator is expected only to allow what she or he considers to be appropriate referrals to be passed on to the team.

3.3.4.Gaining access

Contact was made with the manager of the CPNs, and with the team co-ordinator, in December 1989. The co-ordinator acquired the team members' approval in principle for the pilot study to go ahead. I then spoke to the team to explain in more detail what was required from them (especially how much of their time I would need), and to talk through issues of confidentiality and anonymity. Permission from the ethics committee was requested and obtained through a personal presentation of my research proposal [4] .

Following the meetings with the manager and co-ordinator, I talked to the five CPN informants individually. These initial sessions allowed me to discuss further with each CPN the research process, and arrange future appointments. They also provided me with the opportunity to make sure that I had her or his explicit agreement to be involved. Furthermore, during these sessions I was able to begin recording data on the CPN's professional profile in the Diary-interview Schedule.

Gaining access to the research arena was to be relatively easy as I knew a number of the CPNs personally, and was recognised by the CPNs as 'one of them' because I had worked as a CPN and was (at the time) a tutor on a course for CPNs. However, I played down my identification with the CPNs when I interviewed the other members of the team to avoid being perceived as partisan.

The process I went through to ensure that I was able to carry-out the pilot study with the active co-operation of the team members proved to be successful. Therefore, this process was replicated, with the same measure of success, to gain access to the other teams in the main part of the study.

3.3.5.Methods

The CPNs were interviewed every week for eight weeks. Information about all new referrals during that period was recorded in the prototype Diary-interview Schedule (Appendix 1). Sixteen clients were monitored from the initial receipt of the referral form (or verbal request) to when the client had been discharged, re-referred, or the pilot study had been completed.

The sessions with the CPNs were tape-recorded to allow a flow of conversation to occur between myself and the interviewee without the distraction of having to constantly write in the diary. Taping the sessions also enabled the accuracy of the quantitative entries made at the time of the interview to be checked at a later time. Moreover, it allowed a richer supply of qualitative data to be collected and analysed (i.e. compared to the taking of notes).

Furthermore, tape-recording the pilot provided me with the opportunity to reflect upon the effectiveness of my questioning and probing in terms of content and delivery. The qualitative data from these sessions were transcribed in full, which allowed further reflections to be made on my interviewing style and the agenda [5] .

Towards the end of the eight weeks, the consultant psychiatrist and the social worker, as members of the CMHT, were interviewed using the first version Focused-interview Schedule (Appendix 4). Topic areas relating to the role of the CPN and the CPNs' control over the referral process were pre-formulated , but as

with the open questions in the Diary-interview Schedule, these interviews with the CMHT members became more like purposeful conversations. That is, although specific questions were asked, my intention was to encourage a dialogue between myself and the interviewee rather than maintain a formalised and role-set interchange. This was made possible by me becoming gradually more relaxed during the interviews, and by the judicious use of communication skills.

These interviews were also taped, and later transcribed verbatim (Appendices 8 and 9). The transcribing of the tapes took four times the length of the interview, which indicated that an enormous amount of time would have to be made available for this task in the main study.

Substantive, methodological, and analytical observations made throughout the time I spent at the centre were written into a Field-notebook (Appendix 7). Usually these notes were written immediately after the visit, or when this was not possible (for example, due to time constraints), later that same day. Of particular importance with respect to the pilot study were the comments made in the field-notes about the intricacies of the research tools (e.g. the clarity of the questions; technical problems with the tape recorder). Recording these methodological observations as the pilot study was being carried out meant that an accurate account of how the research tools performed could be referred to when redesigning the methods for the main study.

3.3.6.Assessment of pilot study

The method of interviewing the CPNs for the completion of the Diary-interview Schedule proved to be effective in producing both qualitative and quantitative data which related to the aims and sub-aims of the research. However, many of the Diary-interview Schedule and the Focused-interview Schedule questions, and a number of the sub-aims, required reformulation.

Reviewing the taped sessions and the methodological notes made in the field notebook indicated strongly the need for the skilled application of communication skills. I recognised that in the interviews in the main part of the study, I would have to ensure that I was relaxed, that I listened carefully to what was being said by the interviewee, and responded appropriately to what they said or implied with their non-verbal communication. What was happening, because of my nervousness, was that I tended to assume some of the answers, and I reacted to what I thought had been said and not to what actually had been stated.

Another problem at this stage was that I hadn't rehearsed the questions (in the Diary-interview Schedule) and topic areas (in the Focused-interview Schedule) to the point where I didn't need to keep referring back to the script. I would have to learn my lines so that I could probe into novel issues brought up by the interview without feeling anxious about not being able to return to the subjects I had pre-selected.

I decided that the benefits from taping the sessions

outweighed the disadvantages and therefore I would continue to tape all of the interviews in the main study. However, I would only transcribe the interviews with the CPN's team colleagues verbatim, transcribing material selectively from the interviews with the CPNs.

Lastly, I realised that I would have to allow much more time for the interviews than I had thought previously. Although I had calculated that I would ask for no more than about half-an-hour from each of the CPNs per week, and up to forty-five minutes for the focused interviews, in both cases the time actually taken was considerably longer. None of the interviewees, however, complained about this. Conversely, they appeared to welcome the opportunity to talk about what was going on in their everyday working lives.

3.4.THE DIARY

A Diary-interview Schedule (Appendices 1, 2, and 3) formed the core research tool for examining the clinical autonomy and levels of negotiation exercised by ten CPNs working in four CMHTs. The CMHTs were studied consecutively during the period 1990-1992, with the action reportedly taken by the CPNs on two-hundred and fifty-two new referrals (made to them directly or via the CMHT) being monitored. The style of the Diary-interview Schedule provided a detailed account of the relevant aspects of the CPNs' professional practice, and her or his interpretation of that practice, from which quantitative as well as qualitative data has been extrapolated.

The interest of this researcher lay not only in what the CPNs did (which would have necessitated prolonged direct observation), but in how the CPNs constructed the perceived reality of their experiences. Furthermore, it was not just an insider's report on particular social incidents that was being sought, it was also the insider (i.e. the CPN) who was being studied.

On a weekly basis, each CPN from the CMHT being studied at the time, was interviewed. Rather than the informant entering the data in the Diary-interview Schedule, I recorded the data during the interview, or (using the tape-recording of the session to maintain accuracy) later the same day [6]. The Diary-interview format reduced the problem of non-compliance, and allowed the data to be checked for internal validity. It also

offered the opportunity for the immediate probing of incidental data.

The probing style in this research is an adaptation of two probing schemas. Zimmerman and Weilder (1977) provide the first schema with their general 'who, what, when, where, and how' questioning formula:

> The 'What?' involved a description of the activity or discussion recorded in the diarist's own categories. 'When?' involved reference to the time and timing of the activity, with special attention to recording the actual sequence of events. 'Where?' involved a designation of the location of the activity..... The 'How'?' involved a description of whatever logistics were entailed by the activity.....
>
> (op. cit., p. 486)

The second is offered by Adams and Schvaneveldt (1985) and contains six categories:

> .....The COMPLETION probe is an invitation to expand.....CLARIFICATION.....[is] primarily concerned with explaining something in more detail.....[the] CHANNEL probe is used to determine the origin.....of a comment.....HYPOTHETICAL probes are useful.....to understand alternatives or

> variations of attitude.....REACTIVE probes are designed to bring out additional affective reactions or feelings.....HIGH PRESSURE [probes].....to.....push a respondent to the ultimate truth as he or she sees it. [emphasis by Adams and Schvaneveldt]

(p.224)

The structure and content of the Diary-interview Schedule (the type of questions, the phrasing of the questions, and the order in which they appeared) was pre-formulated, standardised, and pre-coded after the pilot study. However, the questioning remained flexible by taking into account the individual concerns of the CPNs, incidental and unexpected happenings which required probing, and the element of evolutionary change to the agenda.

Therefore, the Diary-interview Schedule took on the character of a longitudinal in-depth interview. That is, the meaning of the CPN's actions was investigated through a number of closed questions, open questions (some of which were retrospectively coded and categorised), and a rolling programme of innovative questions - all of which occurred over a prolonged period of time.

All sessions were tape-recorded in their entirety. Tape-recording the sessions with the CPNs allowed for the material disclosed to be analysed later. It provided the security that no data would be forgotten or missed,

and it offered the opportunity to clarify notes made during the interview. What was not usually recorded on tape were the back-stage and hidden-agenda discussions to which I had access.

The Diary-interview Schedule contains three distinct sections. The first section records personal and professional information about the CPN. This was completed in a preliminary interview with the CPN following at least one visit to the centre in question to talk to the CPNs collectively. During this first visit, the CPNs were briefed about my research. In the case one CMHT, all of the team members were present for this briefing. When completing this first section of the Diary-interview Schedule, I concentrated upon building a relationship, and on allaying any anxieties concerning the research (for example, about managers being able to identify exactly who the informants were).

The second section of the Diary-interview Schedule records data about the referral-pathways of the clients who were to be monitored in the study. The first part of this section contains specific details relating to the source of the referrals, and the social and medical background of the clients. The reasons why the CPN had accepted the clients onto her or his case-load were also recorded here [7].

What action the CPNs had taken, with respect to the treatment and management of the clients, was recorded in the third section of the schedule. A series of probes are listed at the start of this section, based on Zimmerman and Weilder's (ibid.) and Adam and

Schvaneveldt's formulae (ibid.). This list served as an aide-memoire and checklist during the interviews.

Specific data were collected relating to any direct contact that had occurred in the week preceding the interview between the CPN and the client (for example, how much time had been spent with the client, and the content of the interaction). Details were also entered in the third section concerning any discussions that had taken place between the CPN and, for example, other members of the CMHT, or the general practitioner.

3.5.FOCUSED-INTERVIEWING

Interviewing was used as the specific tool for the retrieval of data from the CPNs' colleagues on the CMHT and their managers (as well as being used to complete the Diary-interview Schedule). The type of interview employed to gain data from the CPNs' colleagues and managers can be described as semi-structured or 'focused'.

A number of themes relating directly to the aims of the research were prepared prior to the interview, and indicative questions were written in the Focused-interview Schedule. However, the manner in which specific questions were delivered in the interview, and the order in which they appeared, varied according to the style and content of the interaction. The interviews of the CPN's colleagues and managers, therefore, had a framework which consisted of topics I wished to explore. However, other relevant areas not contained explicitly in the schedule, but which surfaced during the interview, were also probed. Thus, as with the Diary-interview Schedule, the Focused-interview Schedule's pre-formulated categories became (at least in part) catalysts for producing some interviewee-centred data.

Furthermore, the dynamic character to the collection of data in this project came into play in respect of the content of the focused interviews. Topics that were either specific to the interviewee or the CMHT in question were fed into the interview. Issues that were

referred to in the focused interviews were taken, where appropriate, to subsequent interviews (either with the CPNs or other members of the CMHT). A number of amendments were made to the Focused-interview Schedule when issues were constantly being raised by the interviewee, but which had not been included in the original schedule (see Appendices 4,5, and 6).

Six consultant psychiatrists and five social workers (including those from the pilot study), three psychologists (one of whom represented psychology in two of the CMHTs), four occupational therapists, and four nurse managers, were interviewed. The length of the interviews ranged from approximately half-an-hour to over one hour. They were conducted in a room at the informant's place of work, with only myself and the informant present. The focused interviews took place generally between the middle and the end of the period spent extracting data from the CPNs at the centre in question. However, occasionally, because of holidays or difficulties in arranging appointments (one consultant psychiatrist cancelled two meetings), the interviews were carried out after I had completed the collection of data from the CPNs in that particular CMHT.

As with the Diary interviews, the focused-interviews were tape-recorded. However, one consultant psychiatrist and two occupational therapists refused to be taped [8] . For these three unrecorded interviews, notes were made during the interview, verbal notes made immediately after the interview, and then a full set of notes compiled either that day or the next day.

Following all of the other interviews, verbal notes were made into the dictaphone, and then transcribed alongside the interview. When appropriate, written comments were added to the relevant section of the Field-notebook. For example, this occurred when amendments to the interview schedule were required, or if I needed to clarify an issue with the CPNs that had been raised by their colleagues in the focused interview sessions.

An attempt was made at the beginning of the interview to relax the interviewee and to engender trust. The specific strategies used to accomplish this varied depending upon the interviewee's social role, whether or not they were already known to this researcher, and how much time they said they could give to the interview. In the main, this consisted of small-talk, and a general description about the aims of the research.

This introduction to the research, however, was deliberately vague (for example, I stated that I was "examining the role of the CPN in the CMHT") to avoid the informant becoming biased or inhibited in her or his responses. Furthermore, The initial scene setting involved me selecting a role title from a number of possibilities. Taking a lead from Freidson's observation that medical practitioners were more forthcoming with patients with whom they believed they had 'cultural affinity' (Freidson, 1988, p.321), I stated I was a 'researcher' to all of the informants, except the CPN managers. With regard to the latter group, most of the managers either knew me (or knew of me) as a nurse and

lecturer.

The final version of the Focused-interview Schedule contains five categories of questions (Appendix 6). Although the questions are grouped, the sequence of the questioning, and concomitant probing, followed the natural flow of the interview. The first category invited the informant to comment on what she or he understood the role of the CPN to be. Next the informant was asked for her or his views on the CPN's clinical function with the client, particularly in relation to how much autonomy the CPN should have in accepting referrals, assessment, making decisions about treatment, and in discharging clients. Questions in the third and fourth categories elicited opinions from the informant about the type of management, supervisory, and organisational structures she or he believed the CPN should belong to. The last category contained questions which asked the interviewee to describe a 'good' and 'bad' CPN as ideal types, as well as what could be put into place to improve CPN practice. At the end of the interview the informant was asked to add any comments that they hadn't made already.

3.6.FIELD OBSERVATIONS

More than one-hundred-and-fifty hours of observation took place during this study. Extended periods of time were spent sitting in the team office, or a central area within the team centre. The periods of observation took place following each set of interviews with the CPNs, and after the interviewing of their colleagues and managers.

The observations were entered into a Field-notebook (Appendix 7). Following Burgess (1981), the entries consisted of observations of substantive events, pre-conceptual interpretations of these events and the data from the interviews, and comments on methodological issues (Appendix 11).

The substantive observations had, at the outset of the data collecting period, been perceived as fulfilling the secondary purpose of complementing and triangulating the data obtained from the other two methods (i.e. the Diary-interview Schedule and the Focused-interviewing). However, unique substantive areas emerged from these observations. Many of these areas were explored further during subsequent interviews with the CPNs, their colleagues, or their managers. The process of reflecting upon the observations also contributed to the refining of the questions in the Diary-interview Schedule and Focused-interview Schedule.

The practical side of recording the data involved the writing of key descriptive words and short statements in the notebook as events were occurring (but only if this

didn't become distracting or intimidating for the people under observation). In the early stages of collecting data a full description of the observed significant events, methodological comments, etc., was written in the notebook later the same day. Eventually, however, what I found more effective (as with the interviews) was to tape-record my observations, using the dictaphone, as soon as I had left the relevant centre. This meant that what I had seen and heard could be reported upon at the earliest possible moment. The information recorded in this way had the advantage of being fresh and relatively undistorted from its original form.

My role was at times that of non-participant as I would be observing without being referred to. At other times I was more participatory as I would be included in the discussions that were held between, for example, the CPNs or between the CPNs and other team members. Involvement in these discussions occurred both within the working environment, and occasionally, at social events which I had been invited to attend by the CPNs.

In this latter role I was perceived as an interested, and familiar visitor who, whilst not essentially part of the team, was nevertheless seen to be associated with the team. This association was most noticeable when the research was coming to the end in the respective CPN teams. For example, I found it difficult to close my involvement with a team as I realised that I would be losing contact with people I had gained some degree of personal attachment to, and some of the CPNs openly

expressed their (apparently genuine) sorrow at my eventual departure. This element of 'going native' was probably due to me having a background in psychiatric nursing, and having worked as a CPN. I was therefore identified by the CPNs as someone who understood their role and problems.

3.7.METHODOLOGICAL FIELD NOTES

A number of problems (practical and ethical) occurred relating to the implementation of the research methods and the collecting of data, which had not been foreseen at the design stage. Nor had these problems come to light in the pre-pilot or pilot studies. Issues concerning the methodology were recorded in the Field-notebook, and this section contains an evaluation of these notes [9] .

3.7.1.Rate of Referrals

At a very early stage of collecting data I began to realise that there was an enormous discrepancy between what the CPNs and their managers stated would be the rate of new admissions and what this was in reality. In preparing the research design I had contacted the nurse managers responsible for the CPN teams in the study, and asked them how much time it would take for twenty-five clients to be referred to each of the CPNs. I had also discussed this with the CPNs themselves, and with many other CPNs who were not part of the study. Virtually everyone who was asked expected that this would take three months. Consequently, I expected to complete the monitoring of the referrals from the four teams in approximately one year.

However, the average time it took for twenty-five clients to be referred to the CPNs was six months

(although this ranged from one year for one CPN and three months for another). Therefore, the data collecting period stretched to two years.

Explanations offered by the CPNs for the dearth of new clients were contradictory and unsubstantiated. Most believed that this was an unusual occurrence which couldn't be accounted for, but often they would then offer intuitive reasons for why they thought it was happening. These justifications frequently included blaming it on seasonal fluctuations, as these extracts from the field notes indicate:

> CPN 11 [said] ".....referrals have just dried up. [CPN 10] is in the same position, I think, unless he's had a couple since I saw him, which was last week". She [CPN 11] stated that now Christmas was over the new referrals "would probably start picking up again". She said that there was traditionally a lull in new referrals at Christmas. CPN 10 later confirmed that his new referrals had "dried up" as well.
>
> (Field-notes)

> I hadn't come to interview CPN 13 but I met him in the office, and he explained that CPN 14 had got nine new referrals this week. He said that this was unusual for this time of year as during the summer he would have

expected the number of referrals to drop. CPN 14 later confirmed the unusualness of this amount of referrals during the summer. She added that it didn't normally happen because, amongst other things, people go away on holiday [instead of going mad?].

(Field Notes)

The rate of referrals was consistently low throughout the two years, therefore the CPNs' 'seasonal' explanations were unconvincing. An alternative explanation is that the CPNs were consciously or unconsciously influencing the rate of referrals by, for example, altering the amount of visits made to GP surgeries. More visits meant more clients being referred, less visits meant that the CPN's case-load was reduced because at the same time other clients were being discharged. This issue of the construction and management by the CPNs of their workload will be examined in detail in Chapter 4.

3.7.2.Tape-recording

Technical problems with the taping of the interviews were multifold, and frequently the resolution of these problems led to new difficulties. For example, an expensive and highly sensitive microphone was used until I discovered that any noise in the vicinity of the interview was audible on the tape at the expense of what was being said by the interviewee. The original tape-recorder (which was unreliable and intrusive) was replaced by a dictaphone with an internal microphone.

Overall, the dictaphone was far more functional than its predecessor. It wasn't as bulky to carry, and its presence (judging by the reactions of the interviewees) was less imposing. This was despite the dictaphone having to be placed close to the interviewee, particularly if she or he was quiet spoken (my own voice recorded clearly no matter where in the room I was positioned) as its microphone was not as sensitive as the one used with the tape-recorder.

However, placing the dictaphone close to the interviewee meant that it was more difficult for me to control the On/Off switch. In this position it was also problematic to observe the warning light, which indicated that the batteries were running low. Although I nearly always managed to carry out a check on the mechanical operation of the dictaphone before starting an interview (and I took with me a spare set of batteries), in two of the sessions with CPNs the batteries had stopped working

without me being aware, and therefore these interviews went unrecorded.

Taping the interviews had the obvious benefit of providing an accurate chronicle of what was said. However, communication is not merely about verbal utterances. What is also of relevance is what is implied non-verbally, as I was to note with reference to two of the informants:

> CPN 12 non-verbal behaviour (e.g. rolling her eyes) indicated that she was cynical about the supervision she received..... There is a problem in not being able to record the non-verbal behaviour accurately, as with CPN 12 (see above) and CPN 10 who said that he had written to referral 2's GP but his non-verbal behaviour was incongruous.
>
> (Field-notes)

As these entries indicate, I would attempt to record non-verbal behaviour in the Field-notebook. Furthermore, I would, either at the time or at the next interview, challenge any inconsistencies between what was being verbalised and what the interviewee's non-verbal behaviour implied.

However, notwithstanding these efforts to ensure that the data had a high level of content validity, an enormous amount of data relating to what was being communicated was not recorded and clarified. But, there

has to be a balance between investigating communicative nuances and ambiguities, and being too rigorous in one's investigations:

> When an interviewee comes up with a topic I might wish to probe and pursue further at times I have to stop going too far as I might appear to be too inquisitive. This may disrupt our relationship, therefore what to probe and how far to take it has to be judged carefully.
>
> (Field-notes)

3.7.3.Rapport and role

My awareness of the need to be discriminating when probing the interviewees' communications affirms the interpersonal nature of interviewing. As I have indicated above, when interviewing and observing the CPNs, I did not try to camouflage my existence. In fact I purposefully interacted with the CPNs in such a way as to encourage their perception of me as being trustworthy and sympathetic to them. This involved engaging with the CPNs in small-talk, talking about issues concerning mental health nursing and community psychiatric nursing, and providing them with reassurances about anonymity, etc.:

> Spent most of this session gaining a rapport with the CPNs. I attempted to let the CPNs know that I was on their side, that the research would be anonymous, and that I wouldn't be reporting the results to management (this was a particular concern of CPN 8). I pointed out clearly how often I would be there, and how much of their time I would take up.
>
> (Field-notes)

The role of participant-observer resulted in much more data being supplied by the CPNs about how they operated with their clients than I believe would otherwise have

been forthcoming. When this role was combined with other techniques aimed at increasing the informality of the relationship between the researcher and the respondent during an interview (such as not referring continuously to the Diary-interview Schedule), then the content and form of the interchanges became much more fluid:

> What seems to happen is if I put the diary down and still use the questions (from memory), we slip quite easily into a 'conversation'. This does encourage the interviewee to talk more openly. It's as if putting the diary down is the same as switching the dictaphone off. In these circumstances the interview becomes much more like a conversation between two people who have a common agenda (e.g. mental health). This means that there is a lot more of a dialogue.....
>
> (Field-notes)

The development of an effective rapport with the informant, is made all the more possible if the communication skills of active listening and empathy are employed by the researcher. In the pursuance of extracting qualitative data, the skill of listening serves a complex series of functions. It involves not just 'attending' (i.e. demonstrating to the informant through one's non-verbal behaviour that she or he is

being 'listened to'), but engaging in a dialogue with the other person. That is, there is a need not only to use eye contact, posture, etc., but also to participate in the conversation.

However, my role was at times affected by other identities that the CPNs were aware of:

> My role as researcher is often contaminated by my role with some of the CPNs as lecturer to them in the past sometimes I have to switch from being relatively passive and open (researcher) to being more active and directive (lecturer).
>
> (Field-notes)

Where my prominent identification was in the role of lecturer, this probably made the CPNs more guarded in what they said, both in and out of the interviews, as it emphasised a discrepancy in the allocation of power.

3.7.4.Ethical dilemma - backstage data

The development of an effective rapport with the CPNs, however, produced the major ethical dilemma of the research. Using skills such as active listening and empathy stimulated the CPNs and their colleagues into producing in-depth responses to the questions I posed. But the more carefully and empathically I listened, the more I was given access to information that Goffman (1959, p.114) has described as "back-region" or "backstage" conversations. The access to this type of data caused me some concern at the time:

> Am I getting too familiar with the CPNs? This may help me to uncover more material as they trust me, but that they would not want me to if they thought I might record it.
>
> (Field-notes)

For example, when team members congregated in a communal office I was privy to what appeared to be natural and unguarded interchanges between the CPNs, and between the CPNs and their colleagues. I was also often accepted as a 'confidante' in the one-to-one interviewing sessions. This resulted in the CPNs (and sometimes their colleagues) providing me with intimate details about the other team members, managers, and the organisation to which they belonged. Moreover, I was occasionally allowed to observe, and even partake in practices, that

could be regarded as unprofessional. This occurred in each of the teams, and was to cause me increasing anxiety:

> I am getting many instances of 'backstage' conversations and incidents that I can't report because of the ethics of doing so (i.e. not having asked explicitly for the CPN's permission to record that particular piece of data), and the potential disciplinary consequences for that CPN if they were made public.
>
> (Field-notes)

These backstage accounts and observations were, however, invaluable in contextualising and validating data obtained through the interviews. The compromise I have reached over this material is to regard the CPNs as having accepted implicitly that I was actively researching throughout my contact with them, and therefore only if I was asked specifically not to report on a particular event would I deliberately ignore data. Where I have used information supplied in this way (i.e. in Chapter 4) it is unattributed.

However, this doesn't resolve completely the ethical dilemma with regard to having access to backstage data. It could be argued that when the subjects of a study agree to allow themselves to be observed or interviewed in-depth, they are doing so without knowing the rules of

the game. That is, they would be unaware of exactly what might be observed and recorded, or how events might be packaged, and interpreted.

3.7.5.Reactivity

When a participative role in research is adopted, it is usual to perceive the effect that the researcher is having on those that are being observed or interviewed as a disadvantage. These effects may be so insidious that they are not noticeable to either the researcher or her or his subjects.

The tape-recording of the interviews, however, enabled me to appraise the effects of reactivity to some degree. For example, following an interview I would listen to the tape and ensure leading, biased, value-laden, ambiguous, or unclear questioning was not repeated in the next interview. Where reactivity had occurred, and was not eradicated at the time, attempts have been made to account for this when the data was analysed.

On occasions in this research my presence had not a small and hidden effect, but a major and very noticeable one. It was, for example, to alter radically the clinical practice of the CPN, the psychiatric career of a client, or the size of the CPN's case-load:

> CPN 10 commented upon something I had already realised was going on. He said that when I asked him questions I "jogged" his memory and prompted him to do things that he had otherwise forgotten to do (for example, contacting people he should have liaised with; discharging clients he should have discharged

earlier).

(Field-notes)

> When I was interviewing CPN 8 (and this had happened before) I said, ".....so you're thinking of discharging her?", and she answered with, "I've just thought about it now - she's discharged! [i.e. she decided to do it then and there]. What would I do without you keeping me numbers down!".

(Field-notes)

The act of asking questions about what the CPNs had been doing with their clients, and offering inadvertently the CPNs an opportunity to reflect upon their practice, resulted in action that otherwise may not have occurred (or at least wouldn't have happened until a later date).

Rather than viewing this as a methodological disadvantage, however, the very fact that my presence served as an aide-memoire and a stimulus for a change in procedure, provided a further source of data which had direct relevance to the aims of the study. The CPN reacting to a researcher in this way demonstrated clinical fallibility (by forgetting to carry out certain actions that she or he regarded as necessary). Where clinical 'mistakes' can be corrected without recourse to discussions with colleagues, supervisors, or

managers, then this indicates that the CPNs in these circumstances enjoys a high degree of individual freedom in their practice.

3.8.VALIDITY and RELIABILITY

3.8.1.Internal validity

To have internal validity a research design must demonstrate that it observes or measures what it intends to measure, rival causes or alternative hypotheses are discounted, and spurious conclusions avoided. That is, the results must be representative of what happened in the research.

The most obvious form of internal validity is that of face validity. Face validity is when the design of the research is subjected to peer and 'expert' scrutiny, and opinions are sought about the fit between the aims of the research and its methodological procedures. The design of this study was shown to a number of CPNs and academic colleagues, and their views taken into consideration.

Achieving internal validity is of particular importance in experimental research. However, attempts have been made in this study to deal with a number of the extraneous variables that weaken this form of validity (Cook and Campbell, 1979). For example, the effect of my presence in the research situation (as I have already commented above) was to some extent monitored by the CPNs themselves reporting on the influence I was having on their practice. Furthermore, the effect of 'maturation' (i.e. the changes that occur in people and organisations over a period of time) can be measured in

this study. That is, the early tape-recordings of the interviews can be compared with the later ones. To reduce researcher bias in selectivity, the nurse managers in the health authorities used in the study were asked to nominate the CMHTs. However, the health authorities were selected by me in the first instance because they were accessible geographically, and because I was aware that CMHTs had been set-up in these particular areas. Consequently, there may be an unmeasurable element of bias in the research due to constraints such as that of accessibility.

Internal validity is substantially enhanced by the use of methodological and data triangulation (Denzin, 1970). Methodological triangulation was secured both 'within method' (one research tool was used consistently on many different occasions with the same subjects) and 'between method' (with three different methods used) [10] . Data triangulation was obtained through the study of the CPNs over a fairly long period of time, the collection of data at various levels (i.e. individual and group), and through the comparison of the four CMHTs.

3.8.2.External validity

External validity refers to the ability of the concepts and theories propagated by the research to be applied generally. As this research project is a case-study, there is no intention to generalise from the specific in any positivistic sense. The sample used is not described as representative of all CPNs or CMHTs.

However, qualified observations which may have broader implications are made with regard to community psychiatric nursing, the care of the mentally ill, and sociological theory (i.e. in Chapters 2 and 5). This I believe is legitimate on the basis that case-study research can provide useful insights, which can then inform policy decisions and/or stimulate further research. Furthermore, this project is in effect a multiple case-study in that four CMHTs were studied. This provides comparative data, which doesn't compensate for the selection and sampling requirements necessary for statistical generalizations, but has some merit in terms of what can be deduced about the workings of other CMHTs.

The potential generalizability of these insights, however, is also dependent on content, construct, and ecological validity of the study. Content validity examines the representativeness of the items measuring the construct being studied. In this project I followed the 'brainstorming' and 'best fit' procedure as described by Kane (1984) when selecting and grouping items for inclusion in the Diary-interview Schedule, and

the Focused-interview Schedule. Individual test items have also been collected through a thorough examination of the literature on the 'professionalisation of community psychiatric nursing', and the consequent extraction of key elements (i.e. constructs and variables).

Construct validity deals with the question of how well are the underlying theoretical constructs being measured? There are two elements to construct validity, convergent validity, and discriminant validity (Kidder, 1981). Convergent validity has been achieved by gaining information on CPN practice from the CPNs themselves, and by comparing their accounts with those of their colleagues and managers, as well as with my own observations. The achievement of discriminant validity has been made possible through the inclusion of appropriately discriminating questions in the schedules (e.g. relating to perceptions of autonomy in the professional practice of non-CPNs, and ideal role-performance criteria for CPNs).

Ecological validity refers to the question of is a match between the everyday world of the people being researched and the techniques employed by the researcher when carrying out the research? The longitudinal nature of the interviewing I conducted with the CPNs, and the cultural compatibility I had with them, gives a high level of ecological validity. The ecological validity of the interviews with the CPNs' colleagues and managers, however, did not achieve the same standard as they were one-off sessions. This meant that there was less time to

account for the intricacies of the everyday world of these informants and how that related to what was occurring in the interview.

3.8.3.Internal Reliability

Internal reliability is achieved if other researchers find that constructs produced from data in a prior research project coincide with their own constructions. External validity is closely linked with internal reliability.

Strategies adopted by this researcher to increase internal reliability include a description of the analytical process used to refine the data (see section 3.9.). Substantial extracts from the interview transcriptions, field notes, and quantitative data have also been implanted in the analysis section to illustrate further the logic of the inferences being made. Furthermore, the tapes of the interviews, and the remaining interview transcriptions that have not already been included as appendices in this report, have been retained and are available for review. However, because the individuals recorded on the tapes could possibly be identified either through the content of the dialogue or their voices, the tapes will be erased three months after the final draft of this thesis has been produced.

Moreover, two of my colleagues, who have a background in research and in community psychiatric nursing, were asked to peruse the original qualitative data and the subsequent conceptual extractions. Their comments were used to help modify the final theoretical conclusions.

3.8.4.External Reliability

If independent researchers (operating in a similar situation) produce the same constructs and conclusions as a previous researcher, then the first research design can be said to have external reliability. This can be extraordinarily difficult to accomplish in any research project, even those that are experimental in design.

However, LeCompte and Goetz (1982) suggest a number of ways in which external reliability may be attempted. For example, they recommend that the researcher states clearly the role (or roles) that she or he enacts in the research situation, and the underlying premises, units of analysis, and methods of data collection and analysis are delineated. These strategies (which have been introduced into this study) enable any future researcher to identify the nuances of the project she or he wishes to replicate.

LeCompte and Goetz (op. cit.) suggest also that the characteristics of the informants and the social settings in which the data are collected should be described in detail. Unfortunately, such details would jeopardize the commitment I had made to all of the participants in the research to maintain anonymity, and therefore I have been circumspect in my accounts of the personal attributes of the participants and their social settings.

Re-testing of the methods and comparing results has occurred in this project as the four case-studies were researched consecutively. However, this was not an

independent test of reliability as I was the sole researcher involved in all of the cases.

Furthermore, I have made a case for the active and deliberate inclusion of methodological reflexivity in this project, and this undermines considerably the external reliability of the study. That is, altering the research design whilst data is being collected (in order to increase internal validity) has the effect of decreasing external reliability.

3.9.ANALYTICAL PROCEDURES

Following the collection of the data from the interviews and the observations, the tape-recordings of the CPN interviews were scrutinized first. Areas relevant to the aims of the research were transcribed from the tape-recordings of these interviews (Appendix 12). The tape-recordings of the interviews with the CPNs were also used to help check the accuracy of the data inserted in the Diary-interview Schedules at the time of the interviews, and to complete any missing factors.

Data relating to the open questions in the Diary-interview Schedule (Questions 72, and 94: Appendix 3) were extracted from these tape-recordings, and categories produced and coded retrospectively. Although Question 76, which refers to the therapeutic style used by the CPN when she or he was with a client, had categories that were organised prior to the interviewing of the CPNs, it was delivered as an open question ("What did you do with the client?"). Therefore, qualitative data from the tape-recordings addressing this question were also collated.

The quantitative data from the Diary-interview Schedule were then subjected to statistical analysis using the Statistical Package for the Social Sciences (SPSS) [11] . Initially, descriptive statistics (e.g. frequencies; means; modes; medians; cross-tabulations) of all of the pre-coded and post-coded quantifiable data were produced. These were reviewed, and selected variables were then measured for levels of association

(Appendix 15). Specifically, the selected variables were analysed using Chi-square and non-parametric correlation testing (e.g. Cramer's V; Phi Coefficient; Kruskal-Wallis; Spearman's RHO) [12] .

The tape-recordings of the interviews with the CPNs' colleagues and managers were transcribed verbatim [13] . All of the transcriptions (together with the notes taken from those interviews which were not tape-recorded), and the substantive and pre-analytical Field-notes, were analysed.

The procedure for analysing the qualitative data from the Diary-interview Schedules, the Focused-interview Schedules, and the substantive and pre-analytical Field-notes, involved the following stages:

(a) immediately after the CPN interviews and focused interviews took place, comments on the content of the interview were entered in the Field-notebook

(b) at the end of the data collecting period all of the tape-recordings of the interviews were listened to, and the notes from the interviews that were not tape-recorded were read, without any comments being written

(c) the tapes of the CPN interviews were then listened to again, and a number of headings produced: data supporting these headings were transcribed, coded, and classified

(d) all of the interviews of the CPNs' colleagues and managers were transcribed; these were read and re-read, and then the data were coded and classified under headings

(e) the substantive and analytical Field-notes were read and re-read, and data coded and classified under headings.

(f) the headings from the CPN interviews, focused interviews, and the Field-notes were compared with with the pre-organised headings. A composite list of headings was then collated from these two sources.

Finally, a file containing all of the quantitative and qualitative data relating to each of these categories were created.

3.10.SUMMARY

A description of the data collecting tools employed in this project, and the justifications for their selection, has been presented in this chapter. Ultimately, however, the selection of research methods had also to be based on what was possible in a practical sense. Considerations of validity, reliability, triangulation, and a coherent, integrated and rational set of research methods inevitably are tempered by external restrictions such as time, resources, and accessibility.

Throughout the data collecting period, a commentary on the research methods was made in the Field-note Book. The analysis of these comments has also been presented. In particular, these notes demonstrate the methodological reflexivity that formed a central part of the research design, which meant that there was a constant reshaping of the research tools. Juxtaposed with the data and methodological triangulation in the research design, this reflexive process had the advantage of producing data with high (internal) validity, but this was at the expense of (external) reliability.

3.11.ENDNOTES

1. For Bryman (1988) the overlapping of quantitative and qualitative methodologies is not only vindicated for pragmatic reasons. He suggests that the epistemological bifurcation of research in this way is based on a false premise. Bryman provides examples of ethnographic studies which at various levels operated with some of the principles associated with positivism. For example, he suggests that ethnographers are committed, either tacitly or manifestly, to empiricism. Bryman demonstrates also that many quantitative researchers attempt to discover 'meaning' behind social action, which is seen usually to be a principle of qualitative research.

2. Despite the methods in this study being selected for pragmatic reasons, there is an attempt to be conceptually coherent throughout. That coherence has three strands, the first of which is the Freidsonian (neo-Weberian) perspective which forms the theoretical base to the study. The second is the research theory of interactionism. Interactionism concentrates on uncovering the meaning (or 'verstehen') that social actors attach to their actions. Not only does interactionism allow for an appreciation to be gained of the social actor's experience of, and participation in, the world in which she or he exists, it also accounts for the structural elements that shape her or his actions. Interactionism acknowledges, for example, that

the processes of interpersonal negotiation operate within a social and political environment that contains formal rules, contracts, sub-group membership, and hierarchies.

Interactionism has concomitant precepts to that of Weberian interpretative sociology. The third component of the research epistemology underpinning this study (i.e. postmodernism) complements the first two, but adds a new dimension. Postmodernism rejects the modernist belief in a knowable and definitive social reality which can be discovered by the application of scientific laws. Consequently, whilst in this report every effort is made to reconstruct 'reality' as it was experienced and reported by the social actors involved (and thereby produce a 'valid' account), I recognise an unavoidable epistemological dilemma in that there are ".....always other stories that could be told" (Rogers, 1991, p.11).

3. The English National Board for Nursing, Health Visiting, and Midwifery, requires a minimum period of six months working as a CPN (along with other criterion) before a lecturer can become a leader of a post-basic community psychiatric nursing course.

4. Although patients were not involved directly in this research, permission was sought and gained from the ethics committees of the three health authorities used in the main part of the study.

5. Appendix 10 contains a transcription of one of the interviews of a CPN from the pilot study.

6. The studies by Zimmerman and Weilder (op. cit.), Parnell (1978), and Burgess (1983) are examples of where diaries were used with the informants entering the data.

7. The question relating to the expectations of the person who referred the client to the CPN was compiled from Barratt (1989). The list of possible situations for CPNs to conduct their sessions with clients has been taken from Parnell (1978).

8. The consultant who refused to be tape-recorded explained that he was afraid that his remarks might be taken "out of context". He made reference to the now late Lord Denning, who was in dispute with a journalist from the also late 'Spectator' newspaper about material that had been tape-recorded and used against Denning's wishes. The dispute had surfaced in the media on the previous day to my interview with the consultant.
The two occupational therapists who didn't want to be tape-recorded were from different teams, but the same centre. They both stated, independently of each other, that they were "nervous in front of a microphone".

9. The substantive and analytical observations recorded in the Field-notebook are explored in Chapter 4.

10. The terms intra-methodological triangulation and inter-methodological triangulation used earlier, correspond to Denzin's concepts of 'within method' and 'between method'.

11. The PC version of SPSS for Microsoft Windows was used for all of the statistical analysis.

12. A number of these tests of association of the nominal data (using for example Pearson and Mantel-Haenszel Chi-square) are of limited value. This is because many of the cells had expected frequencies of below five. The remedy for this problem is to collapse categories in order to ensure that all cells have frequencies of five or above. Unfortunately, this is not feasible in this study as each category is discrete. Therefore, amalgamating one with another would produce invalid results.

13. Appendix 13 contains a selection of the verbatim transcriptions of the tape-recorded interviews with CPNs' managers and colleagues in the CMHTs.

4. CHAPTER FOUR FINDINGS AND ANALYSIS OF DATA

4.1.INTRODUCTION

This chapter contains the results from the research. An analysis of the results is presented alongside the findings. The chapter is organised into four parts. In the first part, background information about the CPNs who participated in the study, and about the two hundred and fifty two referrals which were monitored, is supplied. The remaining three parts correspond to the aims of the research (see section 1.3.).

That is, in Part 2, the degree of clinical autonomy experienced by the CPN in relation to the referral process (and how this influences the psychiatric career of those referred) is evaluated. In particular, issues concerning the referrer's expectations, and the reasons given by the CPN for accepting a referral, are examined. The amount of discussion that is reported to take place between the CPN and her or his colleagues, supervisor, and manager, is also discussed. Furthermore, there is an account of the procedures utilised by the CPNs to discharge a client, or to gain in-patient care for a client.

In Part 3, ideological and structural influences on the CPN's practice are considered. Specifically, the reported content of the CPN's direct involvement with her or his clients is analysed. The question of what membership of the CMHT means for the CPN (and for her or

his colleagues), and the issues of supervision and hierarchy are also addressed in this part of the chapter.

The relationships between the CPN and the other disciplines in the CMHT are discussed in Part 4. The three sections in this part of the chapter cover the issues of, firstly, the conflict that exists between the CPN and her or his colleagues; secondly, the methods used by the CPN to undermine the 'professional dominance' of her or his practice; and thirdly, the role of the CPN, as perceived by her or his manager and colleagues.

4.2.PART 1 BACKGROUND DATA

4.2.1.The community psychiatric nurses

Six of the CPNs in the study were male, and four female. Four of the CPNs were aged between twenty and twenty nine years, three between thirty and thirty nine years, and three between forty and forty nine years. All of the CPNs were registered mental nurses, with three also being registered general nurses. Only two of the CPNs had a community psychiatric nursing qualification, although two others were undertaking a course to gain this qualification at the time of the study. One CPN had a counselling qualification, one had a diploma in psychotherapy, and another a diploma in nursing.

Four of the CPNs had gained their basic mental nurse qualification before 1980, four between 1980 and 1985, and two after 1986. Three had been trained under a relatively new syllabus introduced after 1982. The previous syllabus emphasised medical approaches to the treatment of the mentally ill, whereas the 1982 syllabus pointed to the importance of including social factors, interpersonal skills, counselling, personal development, and aspects of 'new nursing' in the training and education of mental health nurses (ENB/WNB, 1982).

A core element of the new nursing introduced in the 1982 syllabus was the 'nursing process'. This encourages nurses to formulate specific plans for the treatment of each client. However, as I discuss below, there is

little evidence of the nursing process being implemented by the CPNs in this study. Nor does the data indicate that the majority of CPNs have moved significantly from the influence of medical interpretations of mental distress [1] .

Seven of the CPNs had spent more than one year working in this role (with three of the seven having spent at least five years), and three less than one year. All of the CPNs apart from one were employed at the level of charge nurse (either grade 'F' or 'G'), with the one exception who was employed as a staff nurse (grade 'E'),

The managers of the CPNs reported that some differentiation in role function was to be existed between the grades. For example, charge nurses were expected to supervise the clinical work of staff nurses, and staff nurses were not supposed to undertake assessments. However, the CPNs reported (and their assertions are supported by the data from the study) that there was very little difference in how the different grades operated in reality:

> .....actually in job content there is no difference whatsoever between what we do.
>
> (CPN 8)

The size of the CPNs' case-loads ranged from between ten and twenty clients (for three CPNs), to more than forty one (for two of the CPNs). The remaining five CPNs

had case-loads of between twenty one and forty clients. However, although I asked specifically for the number of 'active' clients on the CPN's case-load, comments made by the CPNs indicated that some 'dormant' [2] clients were included in the overall figures given:

> CPN 8 said that she had three categories of clients within her case load:
>
> > (a) the 'active' clients receiving continuous input on a regular basis
> >
> > (b) those on the health authority's computerised 'monitor' system, whereby a reminder would be sent to the CPN to visit certain vulnerable clients (who were not formally on the CPN's case-load)
> >
> > (c) a number of 'inactive' clients who might be re-referred at some time in the future.
>
> (Field-notes)

That is, the clients in this third category were retained on the case-load because it was assumed by the CPN that they may need some form of active intervention at some time in the future. The way in which the CPNs organised (or 'constructed') their case-loads is examined further in section 4.3.3..

4.2.2.The referrals

The measurement of the CPNs' levels of clinical autonomy is centred upon the forms of action that were taken with the two hundred and fifty two new clients received over the two years data was collected. The amount of time each client was monitored in the research varied depending upon whether or not they were discharged (or re-referred) before a 'maximum research period' of approximately three months expired.

Fifty three (21%) of the referrals in the study were monitored for eleven weeks or more, and seventy one (28.2%) for between five and ten weeks. The remainder were included in the research for periods between one week and four weeks (Table 1).

The direct referral source for 38.9% (n = 98) of the clients was a general practitioner, with 22.6% (n = 57) being referred by the consultant psychiatrist or a member of her or his psychiatric medical team (Table 2). Forty-one (16.3%) of the clients were referred by other agencies. These were predominantly from the staff of residential homes, hospital-based sources (e.g. where the client was an in-patient, a nurse on the ward may send the referral to the CPN), relatives or neighbours of the client.

Self referrals accounted for nineteen (7.5.%) of the clients. However, only 0.8% (n = 2) of the clients were stated by the CPNs to have been referred by the CMHT as a collective entity.

TABLE 1

LENGTH OF TIME THE REFERRALS WERE MONITORED (Q.70)

Value Label	Value	Frequency	Percent	Cum Percent
one week only	1	46	18.3	18.3
two to four weeks	2	82	32.5	50.8
five to seven weeks	3	45	17.9	68.7
eight to ten weeks	4	26	10.3	79.0
eleven or more weeks	5	53	21.0	100.0
	Total	252	100.0	

Mean - 2.833 Valid cases - 252

Median - 2.000 Missing cases - 0

Mode - 2.000

TABLE 2

IMMEDIATE SOURCE OF THE REFERRALS (Q.55)

Value Label	Value	Frequency	Percent	Cum Percent
consultant psychiatrist	1	40	15.9	15.9
other psych	2	17	6.7	22.6
general practitioner	3	98	38.9	61.5
mpota	4	2	.8	62.3
social worker	5	3	1.2	63.5
psychologist	6	3	1.2	64.7
cpn	7	16	6.3	71.0
cmht	10	2	.8	71.8
health visitor	12	6	2.4	74.2
manager	15	5	2.0	76.2
self-referred	16	19	7.5	83.7
other	18	41	16.3	100.0
	Total	252	100.0	

Mean - 6.865 Valid cases - 252

Median - 3.000 Missing cases - 0

Mode - 3.000

Key:

other psych - other member of psychiatric medical team

mpota - medical practitioner other than above

A high proportion (76.6%; n = 193) of those referring the client directly to the CPN were also the originator of the referral. That is, only a small number of cases occurred where the client had been passed from one referrer to another before reaching the CPN.

The gender division of the clients was 61.5% (n = 155) female and 38.5% (n = 97) male. Nearly a third (32.9%; n = 83) of the clients were single, with 42.5% (n = 107) married, and 17% (n = 43) separated or divorced.

The age of the clients spread from below twenty years (3.2%; n = 8) to over sixty years (13.5%; n = 34). Sixty four (25.4%) were between the ages of twenty and twenty nine years, and fifty one (20.2%) between thirty and thirty nine years. Forty eight (19%) were between forty and forty nine years, and 18.7.% between fifty and fifty-nine (Figure 1).

The majority of the clients were not in paid employment (Figure 2), with 36.5% (n = 92) unemployed, 19.8% (n = 50) described as housewives/househusbands (although all but one were women), 14.7.% (n = 37) retired, and 1.2.% (n = 3) full-time students. Of those clients in paid employment, none were in the Registrar General's socio-economic group A (professional/managerial). Ten (4.0%) of the clients were in group B (semi-professional/supervisory), twelve (4.8%) in group C (skilled manual and non-manual), twenty (7.9%) in group D (semi-skilled), and eleven (4.4%) in group E (unskilled). A further seventeen (6.7%) were in part-time paid employment (semi-skilled and unskilled).

Figure 1

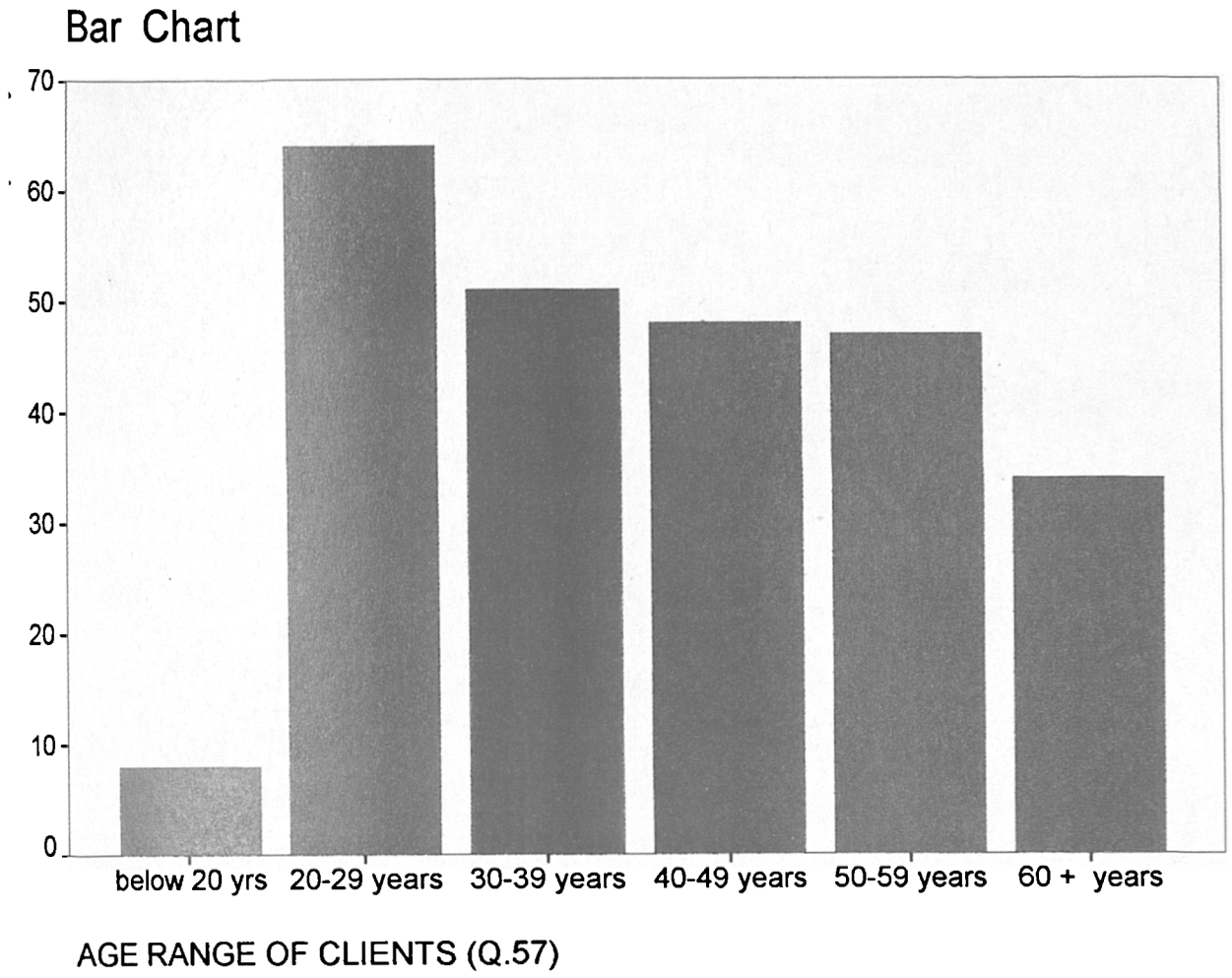
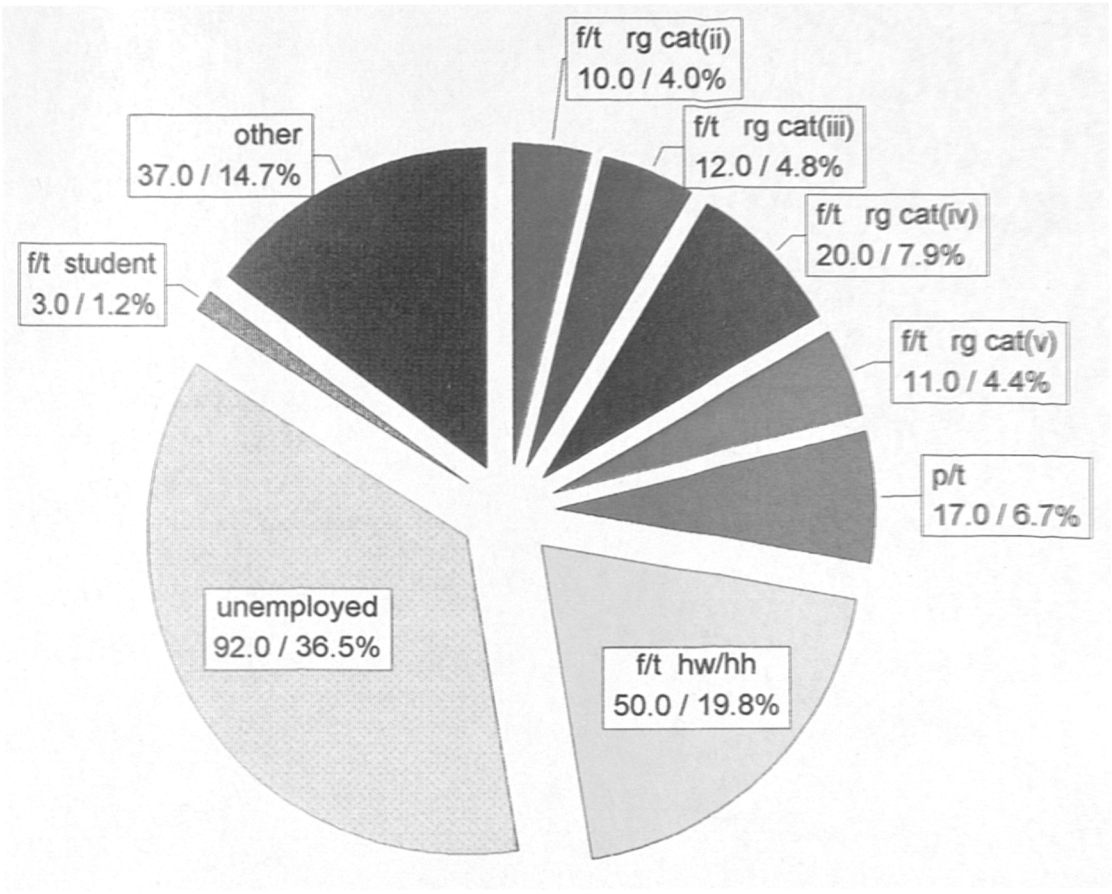

Bar Chart
70
60
50
40
30
20
10
0
below 20 yrs
20-29 years
30-39 years
40-49 years
50-59 years
60 + years
AGE RANGE OF CLIENTS (Q.57)

Fig re 2



PIE CHART of EMPLOYMENT STATUS OF CLIENTS (Q.61

key

f/t	=	full / time paid employment
p/t	=	part / time paid employment
rg cat	=	Registrar General 's social class classification I - V
hw/hh	=	full - time housewife / husband

Only 21.4% (n = 54) of the clients had no previous involvement with a general practitioner or the formal psychiatric services with respect to their mental health. This contact with the formal psychiatric services included hospitalisation, out-patient treatment, and/or having been a former client of a CPN. In-patient psychiatric treatment itself had been experienced by 44.4% (n = 112) of the clients.

The CPNs were asked, in completing the Diary-interview Schedule, to state what they considered to be the major problem with each of the new referrals (Table 3). Sixty four (25.4%) were described as suffering from depression, and forty nine (19.4%) from anxiety. The CPNs, however, often found it difficult to separate out the two categories of anxiety and depression, as this quotation illustrates:

> I Did she [the health visitor] give you any indication why she wanted you to see her [the client]?
>
> R She referred her over the phone, and gave brief details over the phone.....possibly has had a mild post-natal depression since the birth of the last baby, husband has just recently left her, although that appeared to be agreed between them, but at the moment she is feeling quite a lot of stress and strain, and tired.....finding it quite hard to cope.

I What would you classify as the major problem, issue, symptom?

R I don't know really, I don't really look at presenting symptoms. Stress? Anxiety? Not coping? Where I got to with working was that she is very stuck at the moment with her life. She's lost direction with herself. There's a lot of resentment, and anger around.

(CPN 6; referral 3)

That is, the CPNs tended to associate one with the other, and therefore the cumulative figure of 44.8.% (n = 113) is more representative of a combined anxiety-depression category.

The client experiencing delusions and/or hallucinations was seen by the CPN to be the client's paramount issue in 16.7% (n = 42) of the cases. Reasons which either explicitly or implicitly were given as 'problems with living' accounted for 11.5.% (n = 29) of the referrals.

A further 7.9% (n = 20) were unclassified because the CPN could not identify any problem at all, or one issue in particular. These clients, however, did in the main remain on the CPNs' case-loads.

TABLE 3

PRESENTING PROBLEM OF THE REFERRALS (Q.68)

Value Label	Value	Frequency	Percent	Percent
anxiety	1	49	19.4	19.4
depression	2	64	25.4	44.8
phobia	3	7	2.8	47.6
delusions	4	7	2.8	50.4
delusions & hallucinations	6	35	13.9	64.3
confusion	7	2	.8	65.1
overactivity	8	8	3.2	68.3
aggression	9	5	2.0	70.2
self-harm				
self-harm (actual)	10	4	1.6	71.8
self-harm (implied)	11	4	1.6	73.4
drug/alcohol addiction	12	12	4.8	78.2
problems with living	13	29	11.5	89.7
sexual problems	14	4	1.6	91.3
eating problems	15	2	.8	92.1
other	16	20	7.9	100.0
		---	---	
	Total	252	100.0	

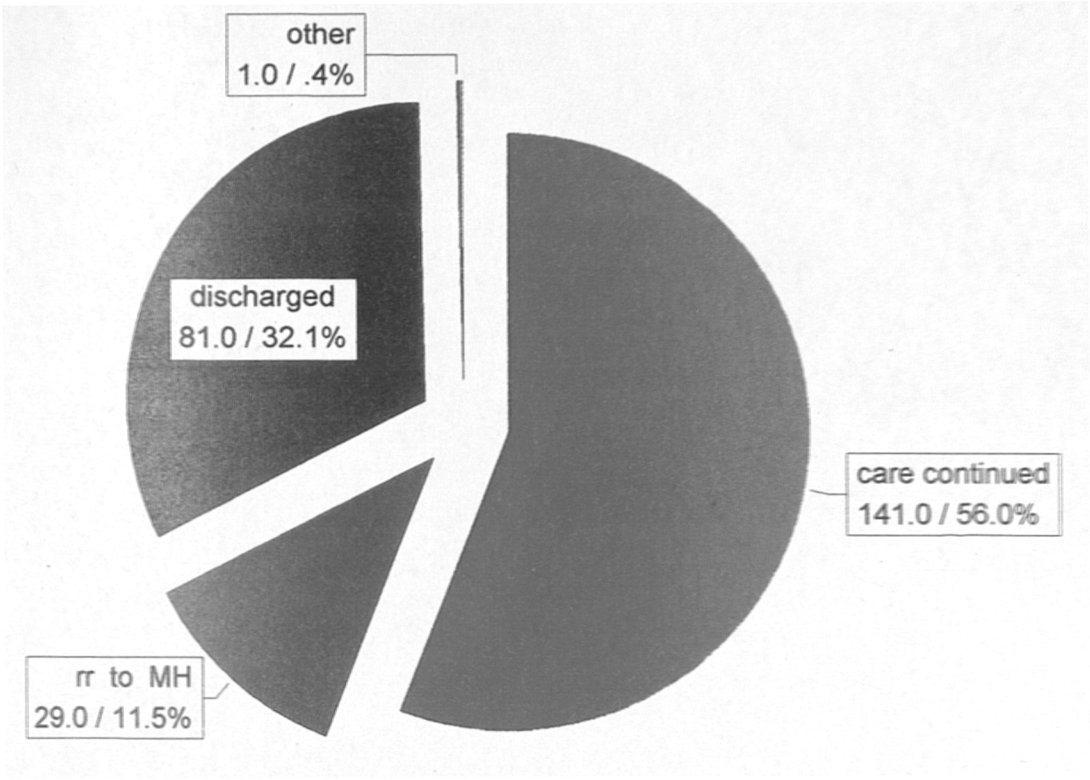
Mean - 6.230 Valid cases - 252

Median - 4.000 Missing cases - 0

Mode - 2.000

At the end of the period of monitoring, 56% (n = 141) of the clients remained under the care of the CPN who had first accepted them. Twenty nine (11.5%) of the clients were re-referred to another health professional specifically for the continuation of mental-health care. The majority of these re-referrals were to health care professionals who did not belong to the CMHT. Eighty one (32.1%) of the clients were discharged during the research period (Figure 3).

Figure 3



PIE CHART of CLIENT OUTCOME
AT END OF THE RESEARCH (Q.71)

key
rr to MH = re-referred to other mental health professional

4.3.PART 2 (Aim 1) CPN AUTONOMY AND THE REFERRAL PROCESS

4.3.1.Referrers' expectations

During the completion of the Diary-interview Schedule, the CPNs were asked if the person referring the client had stated what she or he wanted to be carried out [3] . This question was aimed in part at establishing how the referrer perceives the CPN. That is, if the CPN is requested to carry out a particular task then this may suggest that the person making the request views the CPN as someone in a subordinate position to herself or himself. Alternatively, if the referrer does not ask for a named therapeutic intervention to be undertaken, then this may imply that she or he believes the CPN to be an independent practitioner who is capable of reviewing effectively the client's condition and deciding upon the correct approach to take without any guidance [4] .

More fundamental to the evaluation of the CPN's level of clinical autonomy is the reaction of the CPN to the requests from the referrer, and whether or not these requests were actually carried out (the latter is discussed in more detail in section 4.4.1.). The expectations of the referrer serve as a base-line from which the CPN can decide (or not decide) to act autonomously.

For example, if the CPN perceives herself or himself as merely the provider of technical services (i.e. as a skilled worker as opposed to a fully-fledged

professional), then the request would be accepted without marked disapprobation. On the other hand, if the CPN perceives herself or himself to be an autonomous practitioner, then she or he may be antagonistic towards the person making such requests. If the CPN is autonomous in reality, then she or he may reject the suggestion made by the referrer.

I was interested also in what kind of tasks the referrers were asking the CPNs to execute. For example, were they predominantly routine, menial, and low status tasks, or relatively prestigious and sophisticated.

Status of interventions:

Assessing a client's mental state should be regarded as complex and high status work. The consequence for the client of entering into the psychiatric system can be quite dramatic (e.g. in terms of the stigmatising effect of labelling). If a client is not offered help from the psychiatric services when this is needed, the effect may be as equally dramatic (see for example the discussion on Christopher Clunis in Chapter 5). However, the task of assessing the client's mental state was explicitly asked for by the referrer in only 17.5% (n = 44) of the referrals (Table 4).

The two most common referrers, the general practitioner and the consultant psychiatrist, differed in the frequency of their requests for assessment. The consultant psychiatrists asked the CPNs to assess five

of their forty referrals (12.5%), whereas from the ninety eight referrals made by general practitioners, assessment was requested for twenty five (25.5%).

But the issue of assessment is not a straightforward one. For example, the CPNs stated that they made their first (and sometimes more than the first) direct contact with a client with the specific purpose of assessing her or him. However, later in this chapter I shall be showing that the CPNs did not appear to carry out assessment procedures as often as they implied they did (see section 4.4.1.). Furthermore, as I discuss in section 4.4.4., some of the consultant psychiatrists believed that it was their ability to perform psychiatric assessments that differentiated their role from that of the CPNs. That is, 'assessment' was used by the psychiatrists as a criterion to justify their status as professionals.

In the context of the expectations of the referrer, it would appear that when the task of assessing a client was requested, it was in the belief that the CPN would take the client off the referrer's hands. There were, for example, no reported instances of the referrer asking for a detailed account of the assessment. Where one was supplied, this seemed to be the consequence of ritualistic and bureaucratic role performance by the CPN, rather than a serious attempt to provide a detailed account of the client's mental health for subsequent consideration by the referrer.

TABLE 4

EXPECTATIONS OF THE REFERRERS (Q.62)

Value Label	Value	Frequency	Percent	Cum Percent
assessment	1	44	17.5	17.5
counselling	2	13	5.2	22.6
giving medication	3	18	7.1	29.8
advising	5	4	1.6	31.3
specialist therapy	7	18	7.1	38.5
reassurance/ support	8	25	9.9	48.4
monitoring	9	14	5.6	54.0
evaluating	10	1	.4	54.4
unspecified	11	102	40.5	94.8
other	12	13	5.2	100.0
	Total	252	100.0	

Mean - 7.476 Valid cases - 252

Median - 9.000 Missing cases - 0

Mode - 11.000

The referrers indicated that they wanted the CPN to provide reassurance and/or support for twenty five (9.9.%) of the clients, and to monitor the client in fourteen cases (5.6.%). The monitoring of a client implied that the CPN should report on her or his general mental health and social circumstances, whether or not she or he was taking prescribed medication, and if there were any side-effects to the medication.

The consultant psychiatrists requested these relatively low status tasks for a much higher proportion of their referrals (reassurance/support: 22.5%; monitoring: 12.5%) than did the general practitioners (reassurance: 8.2.%; monitoring: 2%). This could be interpreted as the consultant psychiatrists being more willing to place the CPNs in the role of medical adjunct than are the general practitioners.

However, although the comparatively high status task of providing a specialist therapy (e.g. de-sensitization; anxiety management) was requested for just eighteen (7.1%) of all of the referrals, the consultant psychiatrists asked the CPNs to undertake this in ten (25%) of their referrals, whereas the general practitioners requested this for only five (5.1%) of their referrals. If the requests for the relatively prestigious tasks of assessing a client and providing a specialist therapy, are combined with other higher status forms of involvement (such as counselling, and giving the client advice about her or his diagnosis, treatment, and prognosis), then the consultant

psychiatrists and general practitioners have virtually the same rates (40% for the former, and 38.8% for the latter).

Surprisingly, given the emphasis placed on the CPN's role by her or his colleagues as being concerned with medication (see section 4.5.3.), the CPN was asked specifically to supply a client with medication (including the giving of tranquillizers by injection) on only eighteen (7.1%) occasions. The majority of these requests (n = 7) came from 'other' referral agencies (in the main these were the staff of residential homes where the client lived). Some also came from other CPNs (n = 5) because, for example, the client was moving away from their area of practice into the catchment area of the CPN to whom the referral was being made.

Unspecified expectations:

Most significant of all, however, was that the referrer did not indicate what she or he expected the CPN to do with the client in 40.5% (n = 102) of the two hundred and fifty two new clients in this study. Although social workers and the CMHT referred only three and two clients respectively, for none of these was the referrer's expectations specified. No details of what the referrer expected of the CPN were given for twelve of the nineteen (63.2%) self-referrals, or for three of the six (50%) referrals made by health visitors. Nor were they supplied for seventeen of the forty one (41.5%) clients referred by agencies in the 'other'

classification, two of the five (40%) made by the CPNs' managers, one of the three made by psychologists (33.3.%), and five of the sixteen (31.3%) made by other CPNs.

Of the ninety-eight referrals made by general practitioners, forty-six (46.9%) were referred without any mention of expectations. For at least one CPN this lack of specificity was commonplace (if exaggerated):

I The GP wasn't specific about what he wanted you to do?

R Never is. Never. I'd reckon nine out of ten referrals we get are non-directive.

(CPN 9; referral 11)

Even when the referrer provides information about the client (as recalled by the CPN), there is little specificity about expectations. For example, in this quotation, the CPN has been asked only to 'talk' to a client:

I Did the GP give you any indication as to what he or she wanted you to do.....

R Yeh. [laughs] He's a person who's broken his arm.....drunk, which wasn't for the first time [laughs], he's lost his licence as well.....and he'd actually not been eating

> for about three weeks due to the amount of alcohol he'd been consuming, and he was quite frightened because [the GP] had told him that basically his liver was not good due to the fact he'd been abusing alcohol for about twenty years. So basically she asked me if I could go and see him because he had agreed to actually see someone to talk it over and hopefully give up.
>
> (CPN 13, referral 9)

Going against the trend, however, the consultant psychiatrists made their expectations clear in thirty-two (80%) of their forty referrals.

The reactions of the CPNs to the consultant psychiatrists being more directive than the other referral agents is, in many instances, one of expressed hostility. This is then followed by tactics that include various forms of 'skulduggery' (see section 4.5.2.).

One of these forms of skulduggery is when the CPN is intentionally non-compliant. If the CPN follows this course of action, she or he attempts initially to be seen as complying with the consultant's wishes, but later adjusts the client's treatment according to her or his own assessment of what is required. The following quotations are examples of how one CPN purposefully refuses to comply with direct requests from the consultant psychiatrist with regard to the treatment

approaches of two clients:

I Did the referrer [the consultant] indicate what he wanted you to do?

R Um, he particularly said [smiles] he wanted relaxation therapy and desensitization programme.....

I What would you describe as the major problem?

R Um, her problems are the anxiety, and the agoraphobia, but there's a lot of underlying things from childhood to present day really that we need to explore, so there's going to be quite a lot of counselling.....

I What did you do with her?

R Firstly, it was just information taking, second visit, I had asked her to write down what she thought her problems were in-between the visits, so we discussed those.....

(CPN 12; referral 18)

I Did the consultant indicate what he wanted you to do?

R Yes [both laugh].

I You're smiling because?

R He'd sort of said "relaxation, anxiety management, then a desensitization programme, then day unit care". So.....

I Pretty specific.....

R It was quite planned out [laughs] really.

I Did you follow [the consultant's] plan?

R Well I've only seen the lady once, and I've decided not to keep her on with me being the key worker, so I passed it back to the team.

P Have you actually done the passing back?

C Yes.

(CPN 12, referral 20)

My notes made following the interviewing of CPN 12 reinforce the impression of deliberate non-compliance, and indicate that CPN's non-verbal behaviour highlighted her irritation about being told what approach to take with these clients:

> CPN 12 had clients 18 and 20 referred to her by the consultant with requests for specific treatment by the CPN. I discussed with CPN 12 how she felt about this [on tape], and asked her whether or not she followed the consultant's requests. Her non-verbal communication indicated that she was not happy about being told what treatment to offer to clients (and I challenged her non-verbal behaviour). As it happened, she didn't follow his advice.
>
> (Field Notes)

In both of these cases, the CPN implies (through smiling when I asked about what the consultant psychiatrist had expected to be done with the client) that she believed such a firm request to be inappropriate. Furthermore, when I explored what had been the content of the CPN's contact with the client it was not the form of treatment or action recommended by the consultant psychiatrist, but something quite different. That is, in the first case the CPN stated that she embarked on a process of counselling the client rather than a programme of desensitisation, and in the second case the CPN 'passed back' the client to the consultant.

The significant amount of referrals being made without the referrer stating what she or he wanted the CPN to do may indicate that the CPN was regarded as appropriately skilled to perform the function of assessing the client

and to implement treatment programmes. However, the evidence from the interviews with the CPNs' mental health team colleagues would suggest the contrary (see sections 4.4.4. and 4.5.1.). Moreover, what seemed to be the implicit and overriding requirement of the CPN was not that a particular form of clinical intervention took place, but that the referrer was relieved of the problem of dealing with the client.

When expectations were specified, the CPNs responded in ways which would suggest much dissonance with regard to her or his occupational position. That is, the strategies employed to counter apparent directives from, for example, the consultant psychiatrists, are not those that would be expected from an occupational group that is certain of its status (whether high or low) in the hierarchy of health care professions.

Consequently, although the data relating to the expectations of the referrers implies that the CPNs make independent decisions about what type of involvement they will have with clients, this does not imply that the CPNs are clinically autonomous. The control by the CPNs over this aspect of the referral process appears in the main to be the result of a lack of clarity by the referrers with regard to what exactly they want from the CPN, and/or a lack of insistence that requests are followed through.

4.3.2.Accepting referrals

The reasons supplied by the CPNs for deciding to accept the two hundred and fifty two clients onto their case-loads are examined in this section. The purpose for asking the CPNs why they had agreed to accept a referral is, firstly, to ascertain whether or not it was the CPNs themselves who independently made the decisions to accept the clients. That is, I wanted to know (as an indicator of clinical autonomy) if the CPNs have control over who they offer their services to.

Secondly, I wanted to know what type of explanations were given for accepting the client. For example, was the decision to accept a client based on the objective testing of a client's mental condition, or on a subjective and unstructured assessment. Thirdly, the answers to this question indicate the ways in which the CPNs are able to influence the psychiatric careers of those who have been referred to them.

In total, there were ten categories relating to the acceptance of referrals in the Diary-interview Schedule. Two of these categories were pre-formulated (i.e. 'objective assessment', and 'unspecified'), and eight were produced inductively from the data contained in the tape-recordings of the interviews with the CPNs (Table 5).

TABLE 5

REASONS GIVEN BY THE CPNs FOR ACCEPTING THE REFERRALS

(Q.72)

Value Label	Value	Frequency	Percent	Cum Percent
arbitrary	1	123	48.8	48.8
interesting	2	7	2.8	51.6
speciality	3	5	2.0	53.6
delegation/ request	4	35	13.9	67.5
appropriate	5	58	23.0	90.5
cmht	6	3	1.2	91.7
other	9	5	2.0	93.7
re-referral	10	16	6.3	100.0
	Total	252	100.0	

Mean - 3.194 Valid cases - 252

Median - 2.000 Missing cases - 0

Mode - 1.000

Referral systems:

All of the referrals sent to the CPNs during the research were accepted as 'clients' in the sense that they were included in their case-load numbers (albeit that a number were discharged after a relatively short period of time, or were categorised as 'inactive'). An apparent indiscriminate acceptance of all referrals was perhaps in part because all but one of the CPNs stated that they had an open referral system. Under this system, the CPN accepts referrals from any source. These sources include consultant psychiatrists, general practitioners, social workers, psychologists, representatives of voluntary organisations, self-referrals, and the CMHT as a collective referral agency.

The one CPN who stated that he does not work with an open referral system, identified all of those listed in the Diary-interview Schedule (see Questions 29-45, Appendix 3) as referrers that clients could in principle be accepted from. However, he stated that 'medical cover' would have to be gained first. This meant that no client could be accepted without either the consultant psychiatrist or the client's general practitioner knowing about the CPN's involvement. The psychiatrist or general practitioner 'knowing' about the client receiving treatment by the CPN appeared to be taken by the latter to mean that there was tacit agreement for him to continue providing treatment to the client.

Key worker:

For the majority of the referrals, the CPN became the key worker (75.8%; n = 191), although forty five (17.9%) of the clients accepted onto the CPNs' case-loads had no key worker identified at all. The concept of 'key worker', however, was not used consistently amongst the CPNs. Two of the CPNs (not from the same team) had a fairly clear definition of the term, and took it to mean that they were responsible primarily for the co-ordination of the client's treatment where there were other health personnel associated with the case, and for the delivery of treatment if she or he was the only worker involved. The rest of the CPNs seemed to adopt the title of key worker as a term of convenience to describe the situation whereby they were indeed providing treatment for the client, but no responsibility for co-ordinating the input of other health care workers was accepted.

In at least one case the responsibility for taking the role of key worker, no matter what the definition, was avoided assiduously:

I Are you the key worker?

R [pause] No.

I Who would you describe as the key worker?

R Um. I would say the consultant psychiatrist

who's seeing him.

I Is there some kind of political reason for saying that? It's just you smiled when you said it.

R No. It's, I don't, I think it's. I don't think anybody wants to hold out their hand and grab that responsibility because everyone feels that, you know, no matter what we do we are not going to achieve anything. Somewhere along the line this man is going to commit suicide, and you know it's one of those situations where everybody knows or feels very gloomy about, but you've got to do as much as you can to try and prevent that.

I Given that situation, why did you accept him as a referral?

R Because the man is obviously depressed, or does become depressed very quickly, um, and needs help. As a nurse we have difficulty saying no, by and large anyway, and I think that you, I sometimes think that you've got to keep trying as long as he's holding out his hand.....

(CPN 15, referral 5)

Here the CPN is deliberately refusing to be named as the key worker (as are, apparently, his colleagues) because the client may commit suicide. The CPN appears to fear being held accountable if this happens, and/or a sense of professional failure. However, the person concerned is still accepted by the CPN as a client. This is in part justified on the basis that a nurse finds it problematic to refuse to accept any client. Incongruously (given the prediction of suicide), the CPN also states that he will see the client because he "needs help". It is not, however, as a result of a rational evaluation of the client's plight.

Justifying acceptance:

None of the CPNs gave the reason for accepting a new referral as having been the result of a formal assessment. Formal assessment forms were used in two of the four teams, but even when they were used they were not referred to as a justification for continuing to be involved with the client, for stopping involvement, or for re-referring the client to another health care professional.

On only five occasions (2%) did the CPNs state that they had accepted the client because they believed that they had the specialist skills to deal with the issues the referrer had indicated the client needed help with, or the client presented with when seen. Seven (2.8%) of the referrals were accepted by the CPNs because they thought (judging by the details on the referral form,

conversations with the referrer, or their initial contact with the client) that the individual would be interesting to work with.

The CPNs reported that they had accepted only three clients (1.2.%) as a result of being identified during CMHT discussions as the person with the relevant skills or experience. However, when questioned in more depth, on at least one of these three occasions the CPN implies that the decision to accept the client was more to do with the number of clients he had on his case-load than whether or not he was competent to provide the appropriate treatment for the client:

I Why did you take the referral, I mean why you rather than anybody else?

R I suppose, I mean apart from the informal thing of just generally knowing whether you feel, there's that kind of like unsaid thing of whether you know where you are with your case-load.

(CPN 10; referral 7)

The CPNs explained that they had accepted seven (2.8%) of the referrals because they had found the case 'interesting', and sixteen (6.3%) of the referrals were accepted by the CPN because she or he had been a client of that particular CPN service at some time in the past. The client being known to the psychiatric services

seemed to be taken as a valid reason for making contact, and offering treatment.

Thirty-five (13.9%) clients were accepted on the basis that they were delegated (by another health care professional, or a manager) to a named CPN. Nearly one-third of the clients that were referred in this way were from consultant psychiatrists. In a few cases the CPN reacted to being directed by the consultant to accept a client by re-framing the reason:

I Why did you accept this referral?

R Well, because we're told to, if it's the consultant. But, they're mostly justifiable, I mean they're mostly appropriate ones I'd take anyway.

(CPN 15, referral 25)

When delegated a referral perceived not to be appropriate, one CPN described how she negotiated with the consultant:

P What would happen if you didn't think a referral was appropriate from the consultant?

C I'd go and see them and tell them.

P And the consultant would accept that?

C It depends on the case. One of them I'd rung up and said 'there's nothing I can do', and he said 'well, because she's a suicide risk can you keep going in'.

(CPN 8; referral 10)

Here the consultant justified his insistence on the CPN continuing to visit the client by claiming that there was a risk of suicide even though the CPN clearly didn't believe this to be a correct assessment of the situation. These reactions by the CPN to delegation could be described as further strategies employed by the CPN (alongside those discussed in sections 4.4. and 4.13) to avoid conflict between herself or himself and the consultant psychiatrist when the latter is attempting to direct the practice of the former.

Apart from the clients who were re-categorised as 'appropriate' by the CPNs (when they believed that they had no other choice than to accept these clients), another fifty-eight (23%) were accepted primarily for this reason. Frequently the CPN would state simply that they had accepted the client because she or he believed that the referral had been appropriate, and provided no other explanation (unless probed further). There were, however, a number of occasions when a referrer's good record of providing appropriate referrals encouraged the CPN to accept more willingly subsequent referrals:

I Why did you accept him as a referral?

R I accepted him because the GP, well, the GP who referred him, we'd had referrals in the past and the referrals he had gave us in the past had been appropriate referrals, so that was my first response, I thought well he usually does refer people who do need our type of help. When I went to see the chap and assessed him, he needed a lot of support, and his family did.....

(CPN 12; referral 13)

Twenty-nine (virtually 30%) of the referrals from general practitioners were classified as 'appropriate'. Hence, of the total number of referrals classified as appropriate (n = 58), 50% were from general practitioners.

However, when I asked the above CPN to distinguish between what she considered to be appropriate referrals and those that were inappropriate, she suggested that even the general practitioners were not consistent:

The inappropriate ones are people who possibly the GPs are at the end of their tether and don't know what to do with them, and they might not have a sort of severe mental health problem really, and they could have used alternative services. I mean, I sometimes

think some GP's perception of what we do is quite wrong, whereas there are other GPs who will give you a referral, they will give you lots of information, they are very willing to discuss it, and they'll give you time, and they will actually listen to what you've got to say, and they are jointly involved with you in the care. Then there's others that once they've referred to you it's not their problem anymore. That type of thing.

(CPN 12; referral 16)

The issue of general practitioners, and other colleagues, 'dumping' clients on to the CPN is examined below (sections 4.12, 4.14., and 4.15.).

Arbitrary acceptance:

Most significant of all, however, is that 48.8% (n = 123) of the referrals were contacted by the CPNs (and the vast majority then placed on their case-loads) for reasons that I have described as arbitrary. That is, for nearly half of the referrals, the CPNs provided explanations for accepting the referred individual as a client which were incidental to such criteria as the apparent appropriateness of the referral, whether or not the CPN possessed the relevant skills, or whether or not the referral had been delegated to that particular CPN. The following quotations from three of the CPNs are

representative of the arbitrary explanation given for accepting a referral:

I Why did you accept her?

R I don't know with this one, really. My turn I suppose. It was there so I took that one.

(CPN 6; referral 13)

I Why did you accept [referral 10] as a referral?

R Why did I accept him as a referral? I think, because, um, he was left on my desk.

(CPN 9; referral 10)

P Any other new referrals?

C All new referrals have been snatched up by other members of the team.

(CPN 10)

These chance reasons for a CPN treating a client may suggest that CPNs are inherently generic, and that the CPNs behave capriciously in determining who takes a particular referral because in effect it doesn't matter which CPN provides treatment for which client.

Conversely, it could be interpreted as a less than well organised and effective approach to matching available resources to the perceived needs of the client.
However, even when the CPN decides that she or he has the specialist skills, knowledge, and/or experience to provide treatment for a client, it does not always seem to be the result of some formal appraisal, but merely the CPN's own opinion of her or his abilities, or again the product of relatively arbitrary processes:

P Why did you accept the referral?

C Um [5 sec. pause] I tend to take ladies with depression and anxiety problems.

(CPN 8; referral 6)

Accepting a referral, therefore, appears to be dependent on factors other than the objective testing of a client's suitability to enter into the psychiatric system. In this study, 71.8% (n = 181) of the individuals referred to the CPNs became 'clients' because the CPNs were of the opinion that they were appropriate referrals (and as discussed in section 4.3.4., this is an assertion that was not verified with any formal assessment in most cases), or for reasons not related directly to their psychological condition.

4.3.3.Constructing case-loads

In this section I explore further the ways in which the CPNs in the study organise their case-loads. What became of interest during the research was not just how the characteristics of the CPNs' case-loads were affected by their subjective and undiscerning acceptance of clients, but the other ways in which they construct their workload. That is, it became apparent when talking with the CPNs that they had a considerable amount of freedom to influence the size and shape of their case-loads.

Informal clients:

As has been mentioned above (see section 4.2.1.) a number of clients, with whom all active involvement by the CPN had ceased, were kept on her or his case-load:

> He's like not formally on my case-load, and I don't know if I highlighted that? Although I saw him, I assessed him, and I've written to his GP, I was due to go out and see him but I haven't put him formally on my case-load. I've told the GP what my opinion was, and I've referred him for group involvement to [the day centre], but I'm not intending to provide individual counselling at this time. So he's not really on my case-load, I haven't taken him on. After having said that, I will be

visiting him. Kind-of-like formally he's not on my case-load, but informally he is.

(CPN 10; referral 4)

Retaining clients 'informally' may be a useful way of ensuring that if an individual requires urgent treatment then she or he can be seen by the CPN without both having to get involved with time-consuming bureaucratic formal referral procedures. In this sense it is advantageous for the client as it will mean that not only will she or he be seen by the CPN more quickly than would otherwise be possible, but she or he will be treated by someone who has been previously treating her or him. The CPN may also be acting in the client's interest by reducing the chance of stigma being attached to her or him, as may by happen if a formal psychiatric career is created:

CPN 14 stated that some CPNs didn't register some of their clients because, she said, they " know what happens to them in the psychiatric system". In particular, she said that computerised data, with full details about the client, passed through the system, fully exposing the client's identity (although she did recognise, she said, that these details were somewhat disguised by being coded, etc.). She stated that this happened if the person was connected with the health service,

particularly if they were senior personnel. CPN 14 talked about "stigma" being attached to people who entered the psychiatric system. It was, she stated, difficult for the client to "remain anonymous".

(Field-notes)

However, creating a case-load with high numbers may also be a politically expedient strategy, for example, to support an argument for maintaining the present staffing level, or for increasing it. Furthermore, it perpetuates the surveillance and psychiatric career of certain clients (perhaps even without her or his knowledge) beyond the period when she or he has had formal contact with the mental health services [5] .

Visiting the general practitioners:

Most interesting of all was how the construction of the CPNs' case-loads, and the creation of psychiatric careers for those individuals referred to the CPNs, was influenced by the decision of the CPN to visit or not visit the general practitioners' surgeries. These two quotations from the interviews with the CPNs, and my comments from the Field Notebook refer to this process:

I Why did you accept her as a referral?

R Um, well what we tend to do is on a Monday go

down to one of the surgeries, and obviously if you go there and receive a referral then you usually take it on.

(CPN 13; referral 1)

..... I try to control the amount of referrals, you know, from the GPs, I get by not visiting their surgeries so often. [laughs].

(CPN 14)

I asked CPN 15 about the rate at which new referrals would come in. He said it was cyclical as the more he attended GP surgeries the more referrals he got, but the more referrals he got the less he could attend the GP surgeries. CPN 14 added that she knew which GPs to go to if she wanted some new referrals, and that some GPs didn't refer at all to the CPNs.

(Field-notes)

The variability in the number of clients on a case-load, however, may not always be caused through conscious manipulation. It can be the consequence of the lack of assertiveness identifiable with nursings' traditional position in the occupational hierarchy. Whilst one CPN

stated that he could "....always say no" (CPN 15), others found that they had great difficulty in refusing to accept a referral onto their case-loads.
One of the CPN managers expressed concern over the pressure some nurses allow themselves to be put under from the general practitioners:

> .....I find CPNs often find it difficult to say no - and that comes from all sorts of reasons I'm sure - that comes from one thing, for example having such a really good firm relationship with the GP and the GP's feeling really lost, the CPN's got thirty four people on the case load and really can't manage anymore, but the GPs saying 'look, I'm really in the cart here', and it's pretty easy to say yes and it's quite difficult to say no.
>
> (Nurse Manager, Team 1)

Therefore, for some CPNs deciding to visit or not visit a general practitioner's surgery may simply be a method of avoiding pressure to take on more clients.

Absence from work:

Another aspect to the construction of the case-loads is connected to what happens when the CPNs are on holiday or are off work on sick leave. Whilst I was collecting data, three of the CPNs were on sick leave for a number

of weeks, and obviously over the two year period of collecting data all of the CPNs took holidays. Although there were exceptions to this, in the main none of the clients with whom the CPNs were involved actively were contacted by their colleagues when holidays or sickness occurred.

This was despite assurances from the CPNs that their policy was to cover for each other during these periods, as my notes made at the time indicate:

> Although I've been told by CPN 10 that the clients who need seeing when a CPN is sick are seen by the other CPNs or the CPN manager there is little evidence of this in the diary data (i.e. when I've retrospectively asked about what had been happening to the client).....
>
> (Field-notes)

Deputisation for CPNs who were sick or on holiday didn't appear to occur even when she or he was absent from work for considerable periods:

> CPN 11 had been on holiday for three weeks, and had been back at work for one week when I interviewed her. Two of her clients had not been seen by anyone (i.e. for four weeks).
>
> (Field-notes)

Tension between two CPNs did arise on one occasion when one of them returned from sick leave:

> I was interviewing CPN 10 when CPN 11 came in to their office (she has now returned from sick leave). There was a lot of joking between CPN 11 and CPN 10, particularly over CPN 11 accusing CPN 10 of not doing any work. CPN 11 (jokingly?) said that CPN 10 had not seen any of her clients while she had been sick (for about four weeks). She pointed to a pile of case records and said, "See, I had all of these schizophrenics when I left [on sick leave], they're still here".....

(Field-notes)

The humour displayed here appeared to have its serious side in that CPN 11 was to express annoyance later in the interview about her colleague not visiting "these schizophrenics". What was surprising was that there was not a formal procedure to deal with this situation.

However, where there was a system for a client's treatment to be continued by another mental health worker or manager, this did not mean necessarily that the client would be contacted:

> It was noticeable that the referrals being monitored before CPN 12 went sick hadn't been

seen during her period of sickness (which ran for many weeks). CPN 12 stated that she had given the CPN manager a list of those clients who would need attention and those who wouldn't. Many of those 'less urgent' clients had either not been seen or hadn't got in touch.....

(Field-notes)

In the last part of the above extract there is the implication that it is to some extent the client's responsibility to contact the psychiatric services if she or he requires treatment when the CPN is not available. Interestingly, in the case of one of the clients who had not been contacted during this CPN's absence was reported to have "got better" without receiving any treatment from anyone, and was to be discharged!

This situation raises the question of just how necessary are CPNs if they are not replaced if absent for prolonged periods without any other health professional providing active involvement. When the CPN returns from being sick, there does not appear to be any deterioration or crisis in the condition of those clients who have not been attended to. Indeed there was at least one example of a spontaneous cure having taken place. There is, therefore, the suggestion that many clients are kept on the CPNs' case-loads for reasons other than there being a direct need for them to be receiving care from the psychiatric services.

Contact with clients:

Furthermore, the amount of direct contact the CPNs had with their clients is surprisingly low (Table 6). The CPNs had no direct contact for 59% (n = 1006) [6] of the accumulative number of weeks (n = 1712) that data were collected on the two hundred and fifty two referrals in the study. Moreover, the CPNs had no other involvement (e.g. telephone conversations with the client, or with the referrer) for 70.3% (n = 1203) of the weeks.

The lack of direct contact may indicate that clients do not require personal contact with the CPNs on a weekly basis. However, there is no evidence that the decision to meet or not meet with a client is made through an objective evaluation of needs. Alternatively, it could be that an ineffective delivery of care is connected to problems of resourcing. That is, it could be that the CPNs are over-stretched and can therefore only manage to have a limited number of meetings with a client.

Another explanation might be, as I have suggested above, that many clients are kept on the CPNs case-loads who don't need to be there, who could be discharged, or might not have needed to be labelled as mentally ill in the first place. Furthermore, as has been mentioned already, and will be discussed again below in section 4.3.5., a number of clients who the CPNs intended to discharge (and with whom all active involvement had ceased) were unintentionally left on their case-loads.

TABLE 6

TIME SPENT BY THE CPNs ON DIRECT CONTACT WITH THE CLIENTS (Q.73)

Value Label	Value	Frequency	Percent	Cum Percent
none	1	1006	58.8	58.8
less than one hour	2	319	18.6	77.4
1 hour or more, less than 2	3	372	21.7	99.1
two hours or more	4	15	.9	100.0
	Total	1712	100.0	

Valid cases - 1712

Missing cases - 0

In addition to this, the CPNs admitted that they occasionally accepted clients for the primary reason of fostering good relationships with general practitioners and consultant psychiatrists (see section 4.5.2.).

The data indicates, therefore, that CPNs organise their case-loads by various methods which are not always related directly to the individual requirements of their actual or potential clients. In doing so, they demonstrate the existence of a form of clinical autonomy that could be described as 'de facto' (see Chapter 5). Furthermore, the CPNs are not exercising legitimate freedom of action over their practice, but are covertly constructing the conditions under which they work.

4.3.4.Discussions with colleagues

> CPNs make decisions about clinical situations that they have to deal with, often without consultation with anybody else, not necessarily by design but often because there isn't anybody else to consult with.
>
> (Nurse manager, Team 2)

The issue of the CPNs consulting with other mental health professionals about the treatment of the clients on their case-loads is considered in this section. What is of interest with reference to clinical autonomy is how often the CPNs discussed their clients with the general practitioners (where they had been the referral agents), members of the CMHT, supervisors, and managers. That is, if the CPNs worked alone this might imply a high degree of clinical freedom. If the CPNs discussed their clients constantly with colleagues this could indicate that their actions were being scrutinised by others.

Lack of discussion:

In the early weeks of commencing this study, I started to question how much the CPNs were acting alone in their practice, as this comment from my Field-notebook in the sixth week demonstrates:

> I get the impression that not many (if any, in some cases) other colleagues are involved or contacted about the referrals during the treatment/care process.
>
> (Field-notes)

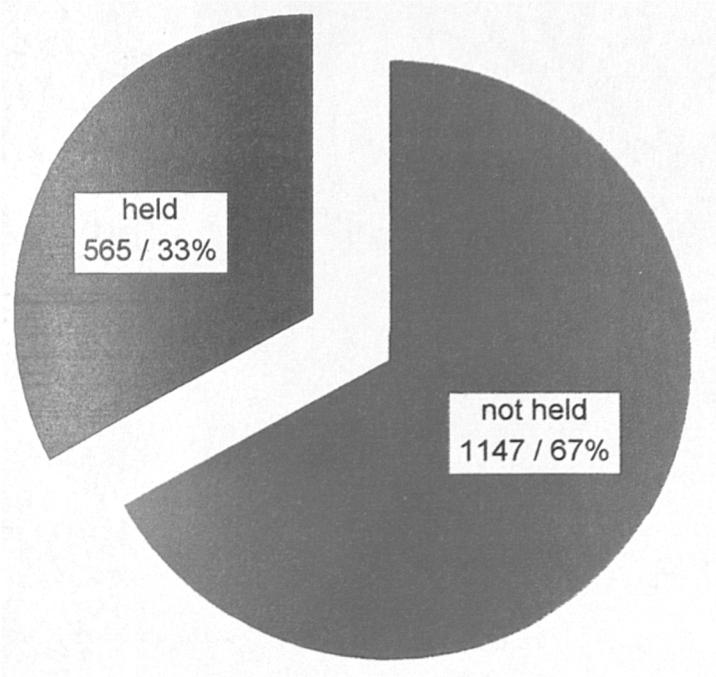
By the time the twenty-eighth week of the study had been reached, my suspicion about the CPNs not consulting with any other occupational group (or other CPNs - with whom they may be sharing an office) was growing:

> It has become obvious how little the CPN talks to any of his/her colleagues about his/her clients.
>
> (Field-notes)

The data from the Diary-interview Schedules were to confirm that for 67% (n = 1147) of the weeks reviewed in the study (n = 1712), the CPNs did not discuss the clients with anyone (Figure 4). That is, in less than one third (33%; n = 565) of the weeks covered in the research did the CPNs communicate directly with, for example a colleague, about the assessment, treatment, prognosis, or discharge of the two hundred and fifty two new clients.

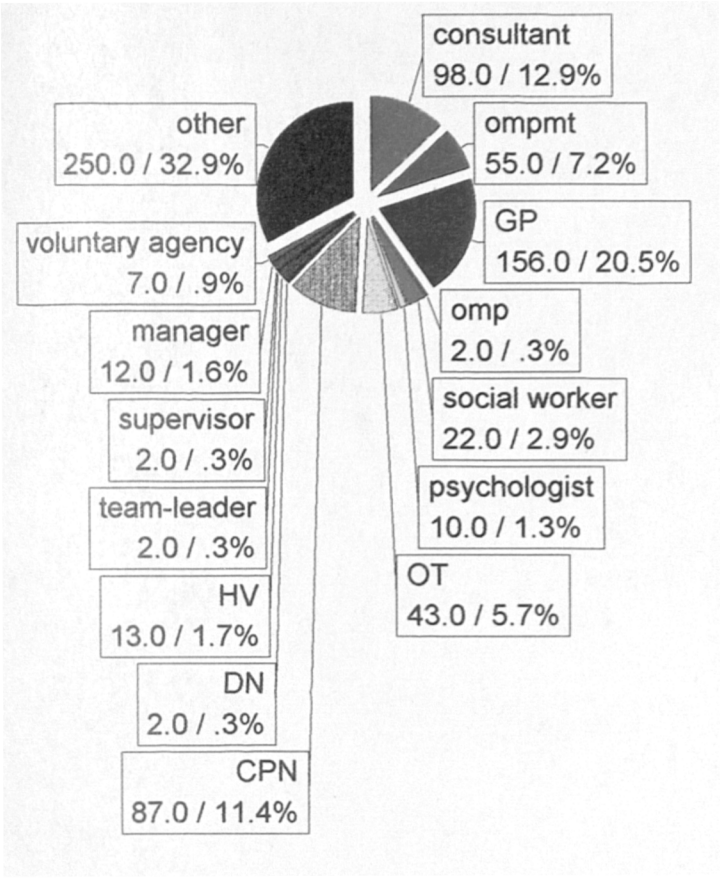
The CPNs had the most number of discussions with the general practitioners (20.5% n = 156), and then the consultant psychiatrists (12.9% n = 98). This was to be expected given that these two groups provided the majority of the referrals (Figure 5) [7] .

Figure 4



PIE CHART of WEEKS WHEN DISCUSSIONS WERE HELD / NOT HELD BY THE CPNs WITH COLLEAGUES (Q.77)

Figure 5



PIE CHART of

WHO THE CPNs HAD DISCUSSIONS WITH (Qs.77-92)

key

ompmt	=	other member of psychiatric medical team
omp	=	other medical practitioner
HV	=	health visitor
DN	=	district nurse
OT	=	occupational therapist

Referral source and diagnosis:

As Table 7 illustrates, there is a significant relationship between the referral source and whether or not discussions were held ($n = 1712$; $df = 11$; $p < 0.05$; Pearson's Chi-Square = < 0.00001; Phi < 0.00001; Cramer's V = < 0.00001). Of the number of weeks in which discussions took place ($n = 565$), the client being discussed had been referred by a general practitioner in 38.8% of the weeks ($n = 219$), and a consultant psychiatrist in 15.9% ($n = 90$) of the weeks. This therefore confirms that where the psychiatrists or general practitioners referred a client, discussions were more likely to occur. However, the ratio of weeks when discussions were held to weeks when no discussion was held for referrals made by consultant psychiatrists is 1:2.5 compared with 1:1.7 for those referrals made by general practitioners. That is, the clients who had been referred by the consultant psychiatrist were less likely to be discussed by the CPNs than those referred by the general practitioners.

The next most frequent set of discussions were with other CPNs. These were held on eighty seven (11.4.%) occasions. This, however, is a very low figure considering that all but one of the CPNs shared an office with at least one other CPN. That is, it could be assumed that informal discussions about clients would be an inevitable occurrence where CPNs met regularly in the working environment, but the data suggest that this is not the case.

TABLE 7 [e]

ANALYSIS OF THE WEEKS DISCUSSIONS WERE HELD/NOT HELD BETWEEN THE CPNs AND THEIR COLLEAGUES (Q.77) AND THE IMMEDIATE REFERRAL SOURCE OF THE CLIENTS (Q.55)

(a) Cross-tabulations of Q.77 and Q.55:

	Q.55					
Count						
Exp Val	cons	other	GP	omp	sw	
Residual	psych	psych				Row
Q.77	1	2	3	4	5	Total
1	226	79	378	16	1	1147
not held	211.7	73.0	400.0	14.1	16.7	67.0%
	14.3	6.0	-22.0	1.9	-15.7	
2	90	30	219	5	24	565
held	104.3	36.0	197.0	6.9	8.3	33.0%
	-14.3	-6.0	22.0	-1.9	15.7	
Column	316	109	597	21	25	1712
Total	18.5%	6.4%	34.9%	1.2%	1.5%	100.0%

TABLE 7 continued:

		Q.55					
	Count						
	Exp Val	p'gist	CPN	CMHT	hv	man	
	Residual						Row
Q.77		6	7	10	12	15	Total
	1	22	57	24	16	22	1147
	not held	17.4	58.3	20.1	14.1	24.1	67.0%
		4.6	-1.3	3.9	1.9	-2.1	
	2	4	30	6	5	14	565
	held	8.6	28.7	9.9	6.9	11.9	33.0%
		-4.6	1.3	-3.9	-1.9	2.1	
	Column	26	87	30	21	36	1712
	Total	1.5%	5.1%	1.8%	1.2%	2.1%	100.0%

TABLE 7 continued:

	Q.55		
Count Exp Val Residual	self- referred	other	Row
Q.77	16	18	Total
1	116	190	1147
not held	101.8	195.6	67.0%
	14.2	-5.6	
2	36	102	565
held	50.2	96.4	33.0%
	-14.2	5.6	
Column	152	292	1712
Total	8.9%	17.1%	100.0%

(b) Chi-Square of Q.77 by Q.55:

Chi-Square	Value	DF	Significance
Pearson	67.59294	11	.00000
Likelihood Ratio	69.55012	11	.00000
Mantel-Haenszel test for linear association	.24284	1	.62217

Minimum Expected Frequency - 6.930

TABLE 7 continued:

(c) Phi and Cramer's V tests of Q.77 by Q.55:

Statistic	Value	Approximate Significance
Phi	.19870	.00000 *1
Cramer's V	.19870	.00000 *1

*1 Pearson chi-square probability

Number of Missing Observations - 0

Key:

cons psych	-	consultant psychiatrist
other psych	-	other member of the psychiatric medical team
omp	-	other medical practitioner
sw	-	social worker
p'gist	-	psychologist
hv	-	health visitor
man	-	manager

Discussions with staff on the psychiatric medical team, apart from the consultant psychiatrist, were held on fifty five occasions (7.2%). They were held with occupational therapists on forty three (5.7%) occasions, with social workers on twenty two (2.9.%) and psychologists on ten (0.6%). Managers were consulted on twelve (1.6%) occasions, and supervisors on only two (0.3%) occasions (see section 4.4.3.).

A significant association is also indicated between the clients' diagnoses, as reported by the CPNs, and whether discussions were held or not held ($n = 1712$; $df = 14$; $p < 0.05$; Pearson's Chi-Square = 0.00318; Phi 0.00318; Cramer's V 0.00318; Table 8). Of the number of weeks that discussions took place ($n = 565$), 43.9% ($n = 248$) of the clients were reported as having anxiety and/or depression. The ratio of weeks when discussions were held to when discussions were not held for these clients is 1:2.5.

For those clients who were described as suffering from delusions and/or hallucinations, discussions were held on one hundred and one weeks (17.9.%). This represents a ratio of 1:2.8 when the number of weeks discussions were held are compared with the number they were not.

Discussions were held on sixty-six (11.7%) of the weeks monitored for those clients who were described by the CPNs as having 'problems with living'. However, the ratio of weeks when discussions were held to when they were not is 1:1.4.

TABLE 8

ANALYSIS OF THE PRESENTING PROBLEM/SYMPTOM/BEHAVIOUR OF THE CLIENTS (Q.68) AND WEEKS WHEN DISCUSSIONS HELD/NOT HELD BETWEEN THE CPNs AND THEIR COLLEAGUES (Q.77)

(a) Cross-tabulations of Q.68 by Q.77:

		Q.77		
	Count Exp Val Residual	not held	held	Row
Q.68		1	2	Total
	1	289	100	389
anxiety		260.6	128.4	22.7%
		28.4	-28.4	
	2	324	148	472
depression		316.2	155.8	27.6%
		7.8	-7.8	
	3	56	28	84
phobia		56.3	27.7	4.9%
		-.3	.3	
	4	52	23	75
delusions		50.2	24.8	4.4%
		1.8	-1.8	

TABLE 8 continued:

Q.68		Q.77 not held 1	held 2	Row Total
	Count			
	Exp Val			
	Residual			
	6	128	78	206
delusions &		138.0	68.0	12.0%
hallucinations		-10.0	10.0	
	7	4	1	5
confusion		3.3	1.7	.3%
		.7	-.7	
	8	20	12	32
overactivity		21.4	10.6	1.9%
		-1.4	1.4	
	9	21	18	39
aggression		26.1	12.9	2.3%
		-5.1	5.1	
	10	15	6	21
self-harm		14.1	6.9	1.2%
(actual)		.9	-.9	
	11	16	12	28
self-harm		18.8	9.2	1.6%
(intonated)		-2.8	2.8	

TABLE 8 continued:

Q.68		Q.77 not held 1	held 2	Row Total
	Count			
	Exp Val			
	Residual			
	12	35	26	61
drug/alcohol		40.9	20.1	3.6%
addiction		-5.9	5.9	
	13	90	66	156
problems with		104.5	51.5	9.1%
living		-14.5	14.5	
	14	11	12	23
sexual problems		15.4	7.6	1.3%
		-4.4	4.4	
	15	9	7	16
over/undereating		10.7	5.3	.9%
		-1.7	1.7	
	16	77	28	105
other		70.3	34.7	6.1%
		6.7	-6.7	
	Column	1147	565	1712
	Total	67.0%	33.0%	100.0%

TABLE 8 continued:

(b) Chi-Square of Q.68 by Q.77:

Chi-Square	Value	DF	Significance
Pearson	32.70386	14	.00318
Likelihood Ratio	32.35414	14	.00357
Mantel-Haenszel test for linear association	11.22083	1	.00081

Minimum Expected Frequency - 1.650

Cells with Expected Frequency < 5 - 2 OF 30 (6.7%)

(c) Phi and Cramer's V tests of Q.68 by Q.77:

Statistic	Value	Approximate Significance
Phi	.13821	.00318 *1
Cramer's V	.13821	.00318 *1

*1 Pearson chi-square probability

Number of missing observations - 0

That is, clients described by these three diagnostic categories were discussed more than clients who were classified in other ways. However, clients reported to be suffering from the non-medicalised classification of 'problems with living' were much more likely to be discussed.

Although significant relationships have been found between the client's diagnosis, and the referral agent, and whether or not discussions were held, this was not repeated with respect to the CPNs' accounts of why they accepted the referrals. That is, there appears to be no association between the reasons given by the CPNs for deciding to provide treatment for the clients who became part of their case-load, and the number of discussions that were subsequently to occur (n = 1705; missing observations = 7; df = 7; p = < 0.05; Pearson's Chi-Square = 0.9500; Phi = 0.9500; Cramer's V = 0.9500: Table 9).

Two hundred and fifty (32.9%) of the total number of discussions were held with a group of people other than the CPNs' colleagues and managers (classified under 'other' in Figure 5). This group included relatives of the client, neighbours, and student nurses on placement in the community. The latter were involved in approximately 50% of these 'other' discussions.

Whilst the CPNs were quite dismissive of the importance of these discussions (and with regard to the issue of clinical autonomy they are irrelevant), it is interesting to note that the people to whom the CPNs talk the most about their practice are student nurses.

TABLE 9

ANALYSIS OF THE REASONS GIVEN BY THE CPNs FOR ACCEPTING THE REFERRALS (Q.72) AND DISCUSSIONS HELD/NOT HELD BETWEEN THE CPNs AND THEIR COLLEAGUES (Q.77)

(a) Cross-tabulations of Q.72 by Q.77:

		Q.77		
	Count Exp Val Residual	not held	held	Row
Q.72		1	2	Total
	1	528	245	773
arbitrary		517.8	255.2	45.3%
		10.2	-10.2	
	2	28	19	47
interesting		31.5	15.5	2.8%
		-3.5	3.5	
	3	26	7	33
speciality		22.1	10.9	1.9%
		3.9	-3.9	
	4	130	76	206
delegation/		138.0	68.0	12.1%
request		-8.0	8.0	

TABLE 9 continued:

		Q.77		
	Count			
	Exp Val	not	held	
	Residual	held		Row
Q.72		1	2	Total
	5	288	165	453
appropriate		303.4	149.6	26.6%
		-15.4	15.4	
	6	39	14	53
CMHT		35.5	17.5	3.1%
		3.5	-3.5	
	9	21	5	26
other		17.4	8.6	1.5%
		3.6	-3.6	
	10	82	32	114
re-referral		76.4	37.6	6.7%
		5.6	-5.6	
	Column	1142	563	1705
	Total	67.0%	33.0%	100.0%

TABLE 9 continued:

(b) Chi-Square of Q.72 by Q.77:

Chi-Square	Value	DF	Significance
Pearson	12.17352	7	.09500
Likelihood Ratio	12.54187	7	.08409
Mantel-Haenszel test for linear association	.09331	1	.76001

Minimum Expected Frequency - 8.585

(c) Phi and Cramer's V tests of Q.72 by Q.77:

Statistic	Value	Approximate Significance
Phi	.08450	.09500 *1
Cramer's V	.08450	.09500 *1

*1 Pearson chi-square probability

Number of Missing Observations - 7

Perceptions and complaints:

The overall lack of discussion did not seem to concern the CPNs. Indeed, they appeared to have a false impression about how much contact they actually had with colleagues as they often stated that it was their normal practice to consult regularly with, for example, the consultant psychiatrists, general practitioners, or the membership of the CMHT as a whole, before accepting or discharging a client. As the data indicates (from the CPNs own accounts of what they did with each specific client) this did not happen.

However, some of the CPNs' colleagues were themselves aware that they (the CPNs) had a tendency not to discuss their clients with anyone, and were quite critical of this:

R It's not so much the autonomy, its just that sometimes they make decisions and they don't discuss it with other people. I always feel if you share it with other people you're going to get another view on it, and sometimes it's to do with the more effective way of treating people. If only they discussed it they wouldn't get stuck with someone for six months when they might have been able to move them.

I Do other members of the team do this discussing and sharing - do the CPNs stand out as a separate group and aren't doing this?

R Yes I suppose they do.....

(Occupational Therapist, Team 4)

The CPNs appeared also to be unaware of how much of their contact with other colleagues was orchestrated by circumstances that they had control over. For example, one CPN admitted openly, as the following extract from the Field-notebook recalls, that his contact with general practitioners depended upon whether or not he decided to make a "special effort" to go and see them:

> CPN 15 stated that his contact with the GPs depended upon him "coming across them in the [health] centre". That is, he talks to the GPs about the clients if he sees them. Otherwise, he has to make a "special effort to contact them".

(Field-notes)

On the other hand, the CPNs complained often about the difficulties they had in contacting some of their colleagues (particularly the consultant psychiatrists) when they did wish to hold a discussion:

> I've been trying non stop to get in touch with [the registrar] with no luck, but I did manage

to get a hold of the GP.

(CPN 8, referral 9)

The consultant psychiatrists complained also about the difficulties they had trying to contact the CPNs. As far as the CPNs were concerned, however, these problems in communication led to autonomous decisions being made. In this quotation below, the CPN explains that because he isn't always able to have a discussion with the consultant psychiatrist, he makes decisions and at a later date informs the consultant of what he has done:

I Have you contacted anyone about him [the client]?

R Well, I tried to contact the consultant, but it's very difficult, so I did leave a message with his secretary.....

I Is that a common problem not being able to get direct contact with the consultant?

R It is recently. We sometimes see him in team meetings, but it's a big problem.

I So if you want something sorted out fairly quickly?

R Sometimes we have difficulty.

I Does the logic follow then that at times you would make decisions on the basis that you can't contact the consultant?

R I think sometimes, yeh, what I've found what I am doing is making a decision, then informing them of it, rather than I'd like to discuss it with them. If the contact is difficult then the only way is to make a decision and let them know, and then see what the comeback is really.

(CPN 7, referral 2)

Autonomy here is by default. The CPN isn't being pro-active in his exercise of clinical autonomy, he is reacting to a situation in which it is difficult to do anything but act without consultation with the relevant colleague. Furthermore, the fact that the CPN wants to discuss the client with the consultant in the first place (and feels concerned when he cannot) may imply that he is seeking 'permission'.

Ritualistic communication:

The lack of direct consultation with colleagues, it can be argued, can be compensated for by other forms of indirect contact. If, for example, the CPN is expected to inform the client's general practitioner or

consultant psychiatrist in writing about her or his actions, then this could be construed as a measure that restricts the CPN's clinical autonomy. That is, even if the letter is being supplied for information purposes (as opposed to being sent to seek permission to provide treatment or discharge the client) the CPN is giving the impression that she or he is not fully autonomous.

However, although most of the CPNs stated that supplying the general practitioner or consultant psychiatrist with a letter when the client was first accepted onto her or his case-load, and again when the client was discharged from her or his care, on only fifty one occasions was this reported as happening. This low figure could have been the result of the CPNs not believing that this was an important enough occurrence to warrant mentioning during the interviews. That is, sending letters to the relevant referrer might have become a ritual which had some function in establishing medical responsibility for the client (something that the CPNs stated they still desired, even though, paradoxically, this reduced their ability to be autonomous).

The nurse manager quoted below virtually admits that informing the general practitioners or consultant psychiatrists is a requirement that is not only considered a ritual (i.e. a matter of 'courtesy'), but is also to establish medical responsibility:

> I do think that establishing who carries medical responsibility is important and I think that as a course of courtesy CPNs who

> get referrals from non-medical sources at the moment ought to make the GP or consultant or whoever aware that they're [the CPNs] involved in the patient's care.
>
> (Senior nurse manager, Team 1)

The ritualistic nature of the letter sending is amplified by the lack of response from the recipients (i.e. very rarely did the referrers initiate any direct or indirect contact on receiving a letter from the CPNs), and by the influence (a form of 'reactivity') my questions had on the CPNs. That is, the questions I posed in the interviews on a number of occasions served to remind the CPN that she or he had not sent a letter to the general practitioner or consultant psychiatrist. In effect, the sending of letters may have served also to reinforce the boundary between the 'senior' and 'junior' professional groups in the CMHT (which is discussed in section 4.4.4.).

4.3.5.Discharge and admission

The processes by which the CPNs discharge clients from their case-load is examined in this section. Reference is also made to how the CPNs organise the admission of clients to psychiatric hospitals (or psychiatric units within general hospitals). If the CPN is able to stop treating clients, and can expedite the entry of clients into in-patient facilities, without recourse to colleagues, supervisors, or managers, then he or she could be considered to have a high degree of clinical independence.

Very few of the clients in the study became in-patients during the period of data collection (n = 2 [9]). However, eighty one (32.1%) were discharged (Figure 3). A further twenty nine (11.5%) were re-referred to another professional in the field of mental health, and were subjected to a similar process to that involved in the discharge of clients.

Deference over discharge:

Of the forty clients referred by consultant psychiatrists, 30% (n = 12) were discharged or re-referred (Table 10). Where the general practitioners were the referrers, discharged or re-referred clients counted for 39.8% (n = 39) of their ninety eight referrals.

TABLE 10

ANALYSIS OF OUTCOME FOR THE CLIENT AT THE END OF THE RESEARCH (Q.71) AND IMMEDIATE SOURCE OF THE REFERRALS (Q.55)

(a) Cross-tabulations of Q.71 by Q.55:

	Q.55					
Count						
Exp Val	cons	other	GP	omp	sw	
Residual	psych	psych				Row
Q.71	1	2	3	4	5	Total
1	28	10	10	1	1	141
care continued	22.4	9.5	54.8	1.1	1.7	56.0%
	5.6	.5	3.2	-.1	-.7	
2	2	4	5	0	2	29
re-referred	4.6	2.0	11.3	.2	.3	11.5%
other MH	-2.6	2.0	-6.3	-.2	1.7	
3	10	3	34	1	0	81
discharged	12.9	5.5	31.5	.6	1.0	32.1%
	-2.9	-2.5	2.5	.4	-1.0	
4	0	0	1	0	0	1
other	.2	.1	.4	.0	.0	.4%
	-.2	-.1	.6	.0	.0	
Column	40	17	98	2	3	252
Total	15.9%	6.7%	38.9%	.8%	1.2%	100.0%

TABLE 10 continued:

	Q.55					
Count Exp Val Residual	p'gist	CPN	CMHT	hv	man	Row
Q.71	6	7	10	12	15	Total
1	3	8	2	1	3	141
care continued	1.7	9.0	1.1	3.4	2.8	56.0%
	1.3	-1.0	.9	-2.4	.2	
2	0	4	0	1	2	29
re-referred	.3	1.8	.2	.7	.6	11.5%
other MH	-.3	2.2	-.2	.3	1.4	
3	0	4	0	4	0	81
discharged	1.0	5.1	.6	1.9	1.6	32.1%
	-1.0	-1.1	-.6	2.1	-1.6	
4	0	0	0	0	0	1
other	.0	.1	.0	.0	.0	.4%
	.0	-.1	.0	.0	.0	
Column	3	16	2	6	5	252
Total	1.2%	6.3%	.8%	2.4%	2.0%	100.0%

TABLE 10 continued:

	Q.55		
Count Exp Val Residual	self- referred	other	Row Total
Q.71	16	18	
1 care continued	5 10.6 -5.6	21 22.9 -1.9	141 56.0%
2 re-referred other MH	3 2.2 .8	6 4.7 1.3	29 11.5%
3 discharged	11 6.1 4.9	14 13.2 .8	81 32.1%
4 other	0 .1 -.1	0 .2 -.2	1 .4%
Column Total	19 7.5%	41 16.3%	252 100.0%

TABLE 10 continued:

(b) Chi-Square of Q.71 by Q.55:

Chi-Square	Value	DF	Significance
Pearson	45.58643	33	.07119
Likelihood Ratio	45.34378	33	.07454
Mantel-Haenszel test for linear association	4.08526	1	.04326

Minimum Expected Frequency - .008

Cells with Expected Frequency < 5 - 35 OF 48 (72.9%)

Number of Missing Observations : 0

Key :

cons psych	-	consultant psychiatrist
other psych	-	other member of the psychiatric medical team
omp	-	other medical practitioner
sw	-	social worker
p'gist	-	psychologist
hv	-	health visitor
man	-	manager

However, much higher percentages of the clients referred by hospital and residential home staff, etc. (48%; n = 20), and of those referred by CPNs (50%; n = 8) were discharged or re-referred. Self-referrals who were discharged or re-referred during the course of the study reached a high 73.8% (n = 14).

There would seem to be a trend, therefore, for referrals made by the consultants and general practitioners to be maintained on the CPNs' case-loads for much longer periods than clients referred by other agencies (including self-referrals). This discrepancy cannot be accounted for by the type of problems these client groups were identified by the referrers and CPNs as having, by the expectations of the referrers, or by the reasons for accepting the referrals given by the CPNs.

A plausible explanation is that deference is given to the legitimacy of the referrals made by the consultant psychiatrists and general practitioners compared with that offered to other referrers. That is, the CPNs may keep referrals on their case-loads for longer because of the perceived status of these particular referrers.

Consultation:

However, a more pertinent question (in relation to clinical autonomy) is do the CPNs consult with, or ask permission from, other members of the CMHT, the general practitioners, managers, etc., before making major decisions about the careers of their clients? In

particular, do the CPNs consult with anyone before discharging a client, or before organising the admission of a client as an in-patient of a psychiatric hospital?

As we have seen in the section above, the CPNs did not discuss their clients regularly with colleagues. This lack of discussion relates also to the topic of discharge (although a different picture emerges with regard to admission).

Almost without exception, the CPNs in this study made the decision to discharge, and frequently carried out the discharge, without discussion with any other colleague:

R I've discharged her.

I What had happened this week?

R .....Things had just improved, her level of activity had improved, her worries had been put to one side, and we just explored the ways of dealing with worry instead of letting them build up. She had been referred for agoraphobia but he doesn't see that as a problem, she is quite happy to go out with her husband. She felt that she had cleared up the big obstacle, and I felt that she had and she looked certainly a lot better. So we both sort of agreed that, a discharge.

I What's the process you go through with that type of decision?

R I'll let [the consultant] know because he was the referrer.

I Is that a letter or a conversation?

R No, I'll write a letter. I mean I'll verbally tell him as well at the team meeting.

(CPN 12, referral 3)

The quotation illustrates this lack of consultation with colleagues, but points to the decision to discharge being made collaboratively with the client.
One of the CPNs (CPN 6) reported that he consistently made the decision to discharge jointly with the client concerned:

I Right, so, you've actually discharged her?

R Yes, yeh.

I Whose decision was it to discharge her?

R Both of ours.

I Both the client and yourself?

R Yes.

I Have you done anything after the discharge, have you discussed her with anyone?

R No, no. I'll write a letter to the GP.....

(CPN 6, referral 4)

It is laudable that in conjunction with the CPN's own view of what is in the best interests of the client, the CPN should discuss with the client her of his own wishes with regard to discharge. Furthermore, in many situations it may be that the client's opinion is paramount. However, there is the danger of a pooling of subjectivity when this is the only method of evaluating the effectiveness of the treatment and the client's readiness for discharge.

Invariably, as these quotations from CPN 6 and CPN 12 demonstrate, any discussion that took place happened after the decision to discharge the client had been made. Moreover, the consultant psychiatrist and general practitioner are informed of the CPN's intention to discharge the client. They are not engaged in a dialogue about the client's mental fitness to be discharged, but merely told what will happen.

These quotations also point to an interesting aspect of the researcher effect during this study. On a number of occasions the CPNs were prompted by my line of questioning in the interviews to discharge a client:

> CPN 9, when being interviewed, was stimulated into action re: discharging one of his referrals when I asked him about this referral.
>
> (Field-notes)

What happened was that during one of the interviews the CPN would state that she or he was going to discharge a certain client. When I next interviewed the CPN I would ask what action the CPN had taken over the previous week with reference to the client. This would then remind the CPN that she or he had intended to discharge the client but had forgotten to do so. Therefore, some clients had their involvement with the psychiatric services curtailed because of the intervention of a researcher.

Many of the CPNs' colleagues and managers were very critical of the lack of discussion that took place between themselves (or the team) and the CPNs, and often this was about matters concerning discharge procedures. Whilst criticising the CPNs explicitly about not conferring with him about discharging clients until after the event, one consultant psychiatrist at the same time suggested that they were under pressure to discharge clients from their case-loads from the managers.

This, he argued, might result in the CPNs' decisions not to consult with anyone. It may also lead, he suggests,

to the discharge of clients following a "tiny improvement" in their condition. The implication is that, in his opinion, clients are discharged before they should be, and that relapse is probable:

I .....What are your views about CPNs discharging clients?

R Er. If they are people who I'm responsible for then obviously I need to be informed. I'd prefer to be informed before it's done. Ideally I like to get the message, 'I think this person is ready for discharge, and I'd like to discuss it with you', rather than somebody phoning me and saying 'I've discharged Fred Bloggs'. We've had some problems. I get the impression that CPNs are under a lot of pressure to get people better and discharge them. And what happens in practice, because the referrals that come through are never as simple and straightforward, people make some tiny improvement, and then that's used as a way of perhaps getting rid of the referral, and I can't imagine that that leads to job satisfaction for the CPNs. Nor can it please the GPs terribly well.

I Pressure from ....?

R I think pressure from the nurse managers to actually show that they have a turnover, and they get people better and discharge them. In practice its not that easy. I must say that that's an impression I'm getting. I've got no figures to back that up, and I haven't had an opportunity to check it out with the CPNs, but I'd like to.....

I Right.

R .....because it can't be good for them, and I don't think its good for the patients or the Service.

(Consultant psychiatrist, Dr. S, Team 1)

However, a number of the CPNs' colleagues appeared to refrain from criticising the CPNs. In particular, some of the social workers and occupational therapists stated that the CPN had the right as a 'professional' to make these decisions:

Discharging clients - CPNs should have the same control as OTs. She said she quite often makes her own decision to discharge then informs the team rather than asking the team if she can.

(Notes from interview with occupational

therapist, Team 2)

I What about discharge? How much should CPNs be in control of discharging clients from their case-load?

R I think in accepting them as professional workers - I've been keen on supporting them. I think yes, my leaning is to say they should be able to say when they think they should be involved. I certainly don't think I or any other profession should be saying that 'I'm not happy with you doing that'.

(Social worker, Team 4)

This approach by the social workers and occupational therapists was not consistent with their overall opinion of the CPNs. It could be argued, therefore, that the support for the CPN in this context might be connected to the desire of members of these occupational groups to have their own right to clinical autonomy strengthened. That is, if they were to be disapproving of the CPNs making independent decisions about discharge, then the same criticisms could be levelled at them in turn. This could result in their clinical judgements coming under the scrutiny of their colleagues.

Arbitrary discharge:

Decisions to discharge were not only taken without any discussion with colleagues, but as I have already indicated, no formal or objective criteria was reported to have been used to evaluate the effects of the treatment or readiness of the client for discharge. That is, as with a significant proportion of the reasons given for accepting clients, decisions to discharge appeared to be very arbitrary:

I What did you do for that three-quarters of an hour?

R We reviewed what we'd done, and what had happened since I'd met him, and if there was any more to be done, and I discharged him.

(CPN 7, referral 1)

The CPN's subjective decision making over discharge, however, could be considered to work in the client's favour. If the CPN discharges the client without reference to her or his colleagues, or any bureaucratised formal procedures of evaluation, then the client is less likely to be exposed to the full effect of labelling. This is especially the case if the decision to discharge is made early in the client's psychiatric career, as I was to observe during the study:

> CPN 7 was asked to see referral 21 by the client's mother. After seeing him, CPN 7 'discharged' him. CPN 7 said that he couldn't find anything wrong with him, "He just didn't get on with his mother". CPN 7's role in 'discharging' referral 21 is an example of a client being 'de-constructed'? That is, the CPN decided to avoid labelling this client within the parameters of psychiatry.
>
> (Field-notes)

Conversely, many clients were kept on the CPN's case-load for reasons of bureaucratic convenience, rather than those concerned with the clients' mental health, as the following extract demonstrates clearly:

> As a general rule I would probably have discharged her at the end of this week, or the end of next week, but all the people I want to discharge will have to wait 'till, or formally discharge, 'till I get round to doing all the notes.
>
> (CPN 9, referral 9)

Here the length of a client's psychiatric career depended on when the CPN decided to do his paperwork, and in particular when the organisation required the

CPNs to complete statistical (computerised and/or written) accounts of their practice.

It might be suggested that as the client's treatment had stopped in this example (it had never really started), then it didn't matter when the actual discharge took place. However, I would argue strongly that it could matter, for example, to the client's self-image and future career prospects. Entering into the psychiatric system in the first place may have negative consequences for an individual (as well as potential positive ones), such as the effect of labelling and stigma. These effects will obviously be accentuated if the involvement is prolonged unnecessarily.

Discharge without consultation with other colleagues occurred even where suicide was the issue. In this next extract the CPN, after talking to the client, makes an immediate decision:

> Again, when I went there the crisis was over. The suicide attempt had come across because the boyfriend had left her, but now he had come back, so it was like more or less okay again, so I again, to form my own assessment, I got her to look at what she'd learnt from it, what she felt about the suicide attempt, to make sense of why she'd done that, what now she needed to do, what now was the direction..... At the end of the session I felt quite assured that she now knew what she needed and knew where to go for that. She

didn't particularly want any more talk/counselling, she felt she was okay. So it was like thank you.

(CPN 6, referral 6)

Organising admission:

The CPN's subjective judgement was influential also with regard to getting a client admitted as a psychiatric in-patient. The following quotations illustrate how remarkably straightforward this procedure can be, and how very influential the unqualified opinion of the CPN is:

I Did you initiate him going in to hospital?

R Yeh, yeh.

I How did you do that?

R Well I just contacted the medical staff at [the psychiatric hospital], and just discussed the situation as he's on the out-patient list. I'd spoke with [the consultant] and a bed was available, and er that was simply that.

(CPN 10, referral 1)

> .....He [the general practitioner] said to me, 'What is your opinion?'. He said, 'Just how bad do you think she is?' I said, 'Well, if I was a doctor, I would admit her to hospital'. He said 'That's all I want'. He said, 'I'll get in touch with his [the psychiatrist's] secretary', and things went from there. She was admitted the same afternoon.
>
> (CPN 11, referral 15)

If the CPN believed admission to be necessary, she or he had techniques which enabled this to happen in a way which meant that any potential obstacle could be circumvented. These obstacles, for example, may be the unavailability of the consultant psychiatrist, whose agreement for the admission of a client (in theory) is required:

> ..... If we go and see someone we ring the ward and say 'have you got a bed we are bringing someone in, can you tell the consultant', otherwise you spend hours trying to get the consultant.
>
> (CPN 9, referral 3)

CPN 9 stated that he has made decisions to admit by simply telephoning the ward nursing staff and asking if there was a bed available.

My notes made following the above interview recall that after the tape-recorder was switched off, the CPN stated, "I suppose this situation [i.e. the CPNs being able to make decisions [like this] would change if the consultants changed". He then added, "Although I don't know. Most of us are pretty headstrong in this team". The implication here is that even if the consultants demanded a certain form of action the CPNs would be able to ignore the demand.

Once again, therefore, the CPN appears to be operating with a freedom in her or his work that allows significant actions to be taken without any interference from members of the CMHT or the managers. However, as with other areas of the CPN's practice, this could be viewed not so much as a display of genuine clinical autonomy, but as an example of role-deviation (in that she or he is expected to consult with others) and a lack of rigour in the execution of care to the mentally ill.

4.4.PART 3 (Aim 2) IDEOLOGICAL AND STRUCTURAL INFLUENCES ON CPN PRACTICE

4.4.1.Content of contact

> I've got him down for Friday at 2.30, and I remember going to see him, but I haven't got a clue, I have no idea what I did. I have no recollection at all..... I have no recollection talking to him at all. Either he wasn't very interesting, or he didn't answer the door. I've got him ticked as been seen, so I presume that he wasn't a 'no entry', but I'm dammed if I can remember what happened.
>
> (CPN - unidentified)

The issue of what the CPNs stated took place when they made direct contact with clients in this study is examined in this section. Particular attention is paid to the subject of the CPN's assessment of the client's mental state, diagnostic uncertainty, and what ideological affiliations the CPN can be regarded as having.

Twelve categories relating to the content of the interaction between the CPN and the client were pre-formulated (Question 76 in the Diary-interview Schedule - see Appendix 3). Data provided by the CPNs, in response to open questioning and probing about what

happened during the sessions with the clients, were entered into these categories retrospectively. That is, data were extracted from the tape-recorded interviews. The CPNs made direct contact with the clients on seven hundred and six occasions. The CPNs reported that they had spent less than one hour with the client on 45.2% (n = 319) of these occasions, between one and two hours on 52.7% (n = 372) occasions, and two hours or more on the remaining 2.1.% (n = 15) occasions [10] .

On the majority of occasions (65.7%; n = 464) when direct contact occurred between the CPN and the client, no-one else was present (Table 11). Along with the client and the CPN, another member of the client's family, or a friend, was present on 14.5% (n = 102) of the occasions when direct contact was made. A student nurse on community placement (whilst undertaking her or his Registered Mental Nurse training) was present on seventy six (10.8%) occasions.

The venue for the meetings between the CPNs and the clients was, in the main, the client's home (83%; n = 590). The data indicates that for 22.6% (n = 158) of the occasions the CPN met face-to-face with the client, the approach taken by the CPN was one which could be described as offering reassurance and/or support (Figure 6). On 17.4% (n = 122) of the occasions, the CPN's approach appeared to have been focused on counselling the client.

TABLE 11

PARTICIPANTS WHEN DIRECT CONTACT WAS MADE BETWEEN THE CPN AND THE CLIENT (Q.75)

Value Label	Value	Frequency	Percent	Cum Percent
CPN & client	1	464	65.7	65.7
CPN & colleague & client	2	30	4.2	69.9
CPN & student & client	3	76	10.8	80.8
CPN & client & family member etc.	4	102	14.5	95.2
Other	5	34	4.8	100.0
	Total	706	100.0	

Valid cases - 706

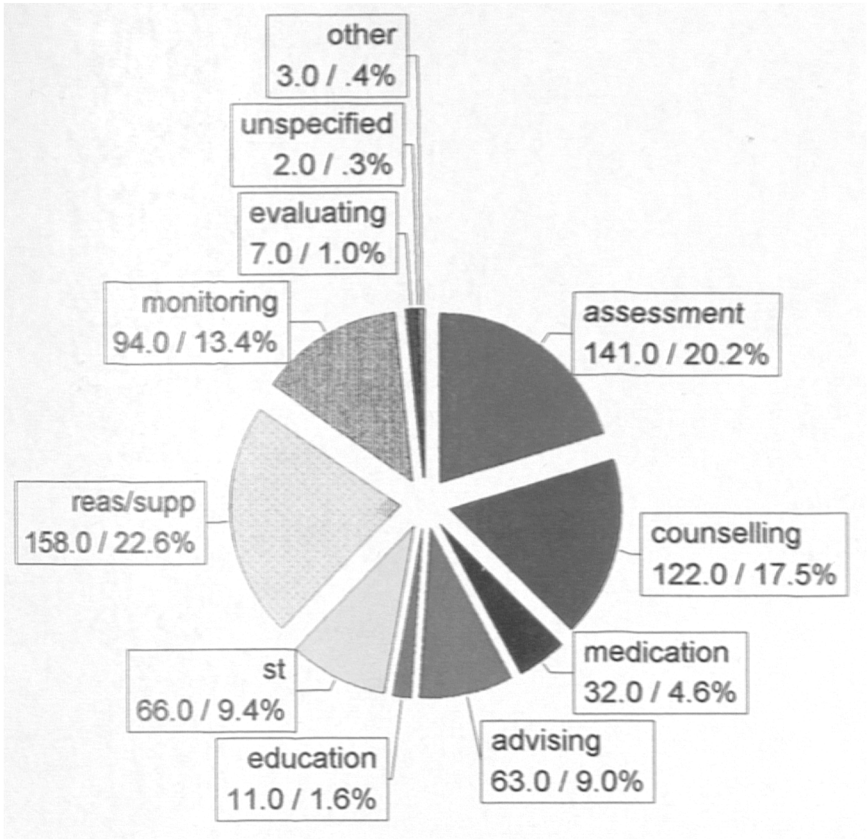
Missing cases - 0

On only thirty-two (4.6.%) of the direct contact occasions did the CPN indicate that the purpose of meeting with the client was to give her or him medication (in particular, intra-muscular injections of long-acting tranquillisers). However, the monitoring of whether or not the client was taking prescribed medication correctly, how she or he was reacting to the medication, or was suffering from side-effects, occurred on ninety-four (13.4%) occasions:

> I knew she'd changed medication, and so I was interested to see if there had been any change, she'd been on antidepressants for five weeks, and I was asking her if there had been any change in the mood, in any way at all.
>
> (CPN 9, referral 3)

The implementation of a specialist therapy (e.g. desensitization) occurred on sixty six (9.4%) occasions, and the CPN offering specific advice about the client's condition or treatment occurred on sixty three (9%) occasions. Educating the client (for example, about diet, social environment, or any relevant medical condition) accounted for eleven (1.6%) of the occasions, and the evaluation of the treatment the client had received from the CPN only seven (1%).

Figure 6



PIE CHART of THERAPEUTIC STYLE USED BY THE CPNs WHEN N D RECT CONTACT WITH THE CLIENTS (Q.76)

key

reas/supp = reassurance and/or support
st = specialist therapy

Assessment:

The CPNs stated frequently that the first time they had a session with a client (and this would possibly continue for a number of subsequent sessions) they would always assess the client's mental state, her or his suitability for continued involvement by the CPN, and what course of action to take in the future. Twenty nine (66%) of the forty-four clients who the referrers had asked specifically to be assessed by the CPN were seen in the first week following the referral being made. Of these twenty nine, twenty three (79%) were described by the CPNs as having been assessed.

However, out of the 71.2% (n = 178) of the clients monitored in the study who were seen in the first week following their referral to the CPNs, only 60% (n = 107) of these were assessed according to the CPNs' own accounts of what they did during these initial sessions. That is, although the CPNs professed to assess all clients on the first visit, the data from the first week following the referrals being given to the CPNs did not substantiate this claim.

More significantly is that on only 20.2% (n = 141) of the total number of occasions when direct contact occurred, did the CPNs indicate that they had assessed the client. If the CPNs were assessing each client then this figure should have been at the very least the same as the number of clients in the study (i.e. 252), and probably much higher given the CPNs' assertions that they at times took more than one week to complete the

task of assessment.

Moreover, when these accounts are examined in detail, the content of the interaction that is described as 'assessing' by the CPNs is worth further consideration. For example, in this following extract from an interview with CPN 7, initially it appears that the CPN is using a pre-organised schedule to aid in the assessment and planning of treatment for the client. However, when probed about what actually is being used, the CPN admits that there is nothing but a "blank piece of paper":

I What did you do?

R Took a proper history, and we worked out what he wanted to do and what we could do together, and made a kind of plan.

I When you say 'took a proper history', what type of history taking do you use?

R Well, um, I haven't actually got, it's a blank piece of paper right in front of me, um but I suppose um, with categories in the back of my mind. What I usually do is I let the individual just go for maybe twenty minutes or so, just not try and organise that particularly, depending on the individual. In this case he would have talked forever, so at the end of twenty minutes I then began to organise that into um, I suppose I always want to know

something about their previous psychiatric care, treatment. I always want to know their current situation as far as um, something about their social circumstances. If it's relevant, maybe it's not an issue here, I'd need to look at the family as well, but all this might not come out at the first visit, and also if there are any physical things that might influence that.

(CPN 7, referral 1)

Although the CPN suggests that there are a number of issues that she or he wants to review with the client on this first meeting, the explanation of what these were appears confused and unsystematic.

Instinct and intuition:

In this next extract, the CPN states quite openly that 'instinct' is the predominant quality utilised in the assessment of a new client:

Usually, I have some sort of instinct of what I will do, and get some feedback from the client about 'this is what happened' and 'this is where I'd like to go' and 'what I'd like to do', and sometimes even 'this is how I'd like you to help'. So usually there is some direction from them or I can initiate some

sort of movement, perhaps clarify some things and start moving them in certain directions.....

(CPN 9, referral 1)

Where a written assessment form is adopted, there appears to be little standardisation in its use. For example, in one team where forms are available, they are not utilised by all members of the team. The CPNs in this team gave the impression that they could be very flexible in the way they proceeded with the assessment documentation if they did decide to use it.

One of the CPNs in this team had stated initially that she was employing a particular nursing 'model' (i.e. model 'X') in her practice, but then inexplicably decided to use another model (model 'Y') on one client. Unfortunately, this latter model did not apparently have an in-built method of assessing the client's mental state. Although the original model did have an assessment technique, a new assessment form was to be produced:

I What did you do with him?

R I'd been really just finishing my assessment.

I What do you do?

R We have a sort of draft assessment form we use to give us guidelines, to gain the information we need.

I Is that part of [X] model?

R I'm not using [X] on him, but if I was using it on him I would use their assessment tool. But I've decided to use [Y Model]. So [Y] doesn't have an assessment tool laid down, so the CPNs drafted um an assessment tool to help us collect information. So I use that as the guideline to get the information. Um, really what I've been doing is just getting to know him, and building a relationship, and getting information really.

(CPN 12, referral 7)

The following extract, however, illustrates that at times the notion of pre-organising and structuring assessment procedures (or any other part of the treatment process) may be completely impracticable due to the urgency of the referral. For example, if the client is perceived by the referrer to be in danger of taking her or his own life, or the life of someone else, the CPN may have to go and see the client very quickly, and hence have little time for any preparation. Furthermore, in violent or difficult domestic situations in which the CPN may find herself or himself, common

sense, intuition, and experience may be a most useful set of assessment tools:

I You went out to see him?

R What happened was the GP rang him - this guy's got no telephone - so, I told the GP I'd go out in the morning, and he left a note to tell him to be in, so I went out in the morning - the student went with me - and there was his, I mean the reason he's suicidal is because the relationship is breaking-up. He's already divorced, but he's been living with this woman five years and she wants him out, and they were all present in the room, children on potties all running around, changing nappies.....you couldn't really get any more in the room. [both laugh]

I What did you do?

R Um, what did we do? We tried to find out what the situation was, because it was obviously very strained, and you could cut it with a knife, the atmosphere. So, it was just a matter of finding out very briefly what had happened to precipitate what had happened, to find out how he was, find out his intentions. I wanted to know whether he was still a danger to himself, basically. Find out how he felt. I

> also wanted to get some information. I talked to them both briefly for thirty seconds on their own, just to sort of confirm things. So it was purely an assessment to know what I was going to do there and then, no long term plans at all, do I do something now or can we leave it a few days and come back again.....
>
> (CPN 9, referral 15)

A problem with instinct and intuition, however, is that it isn't integrated easily into a contemporary nursing ideology which advocates the systematic and scientised formulation of nursing practice [11] . Also, instinct and intuition do not avail themselves to the scrutiny of colleagues, nor do they allow the nurse to operate very effectively as a 'reflective practitioner' (the latter being the espoused goal at present of many nurse theoreticians: Reed and Procter, 1993; Palmer et al, 1994).

Diagnostic uncertainty:

The acceptance by the CPN of these qualities in her or his practice (particularly when assessing a new client) highlights the existence of uncertainty in medical - and nursing - diagnosis (U205 Course Team, 1985). The consequence of using these subjective qualities may be to increase the likelihood of medical misdiagnosis, which may have disastrous results for a client. One such

disaster occurred in this study when a client was diagnosed by the CPN as suffering from a "text book case" of hysteria:

> .....She was referred because the GP had been called out three times on as many nights with severe chest pain, which had been diagnosed a year prior as being muscular. She had been seen by a consultant at [the general hospital], and by the anaesthetist who deals with the pain control, and she'd had an injection of [analgesia], and from then on she did actually respond to that. Anyway, it seems to have got worse, so much so that she's been screaming the house down and everything else..... So I went.....and it was a text book case, if you could have taken a student, of hysteria.....I'm sure she's going to end up needing to be referred [as a psychiatric in-patient] because I don't think it will be possible to treat in the house because of the family, they are nursing all this hysterical behaviour.
>
> (CPN - unidentified)

In this example, the CPN has been guided towards a (mis)diagnosis by the events that had preceded the client being referred to her or him. That is, a general practitioner, a consultant of general medicine, and an

anaesthetist, had all contributed to steering the diagnosis towards one involving the psychiatric services.

The CPN offered the client counselling and reassurance, and remained convinced that the problem was psychologically based. Many weeks later, the client returned to the general hospital for further investigations into her physical health, and was found to be terminally ill with not long to live.

Diagnostic uncertainty is also illustrated in the following extract from an interview in which the CPN explains that a client has all the symptoms of being "clinically depressed":

P What happened during those forty-five minutes?

C Well, once I got past mother [laughs], who seems to be somewhat over-protective, there was very little the patient could tell me, but by her presentation was sufficient to tell me how ill the girl really is. She was able to tell me - it was a question and answer situation - with mother giving her bit as well. She had all the classical symptoms of being quite depressed, clinically depressed. She hadn't been sleeping, she wasn't eating, no interests. In fact I was up there early afternoon and she was still in her night dressing gown. She was weepy, irritable, all the symptoms of being clinically

depressed.....

(CPN 11, referral 1)

However, in an interview with the CPN fourteen weeks later, what the problem is with the client remains in doubt. The CPN is no longer so certain of her original intuitive diagnosis of depression, but believes that there is still the possibility that the client is suffering from a psychosis:

P When you say she's not as well as she should be...

C I think there is an underlying psychosis. I think she is pre-occupied, she's vague, and I get the feeling that things are not right. Depression-wise there is an element of improvement in that she is not weeping all the time, she's more motivated to get bathed and dressed instead of being in her nightie and dressing gown. So that side of it, but I still, I was suspicious still of the psychotic side..... She wasn't very forthcoming at all other than she didn't want to attend the day centre. She couldn't confirm whether she was hallucinated or. I get the feeling she is still psychotic.

(CPN 11, referral 1)

Medical model:

These examples highlight that the assessment of a client is frequently based on the subjective judgement of the CPN. What these quotations also exemplify is the medical orientation of the CPNs.

Throughout the interviews, the CPNs retreated consistently into using language and values which have their roots in the medical approach to understanding human behaviour [12] . Question 68 in the Diary-interview Schedule (Appendix 3) was delivered as an open question to allow the CPNs to describe their clients in alternative ways to those which are consonant with the medical model. But as has been stated in section 4.2.2., only twenty-nine of the referrals (11.5.%) were regarded as having 'problems with living'. The remaining referrals (except for twenty which could not be classified) were categorised using medical labels:

I What would you describe as his major presenting problem, symptom.....

R Well, he's psychotic, being er like very disturbed, but probably drug induced. He admits to using cannabis in the past, but denies using it at present.

(CPN 15, referral 7)

I What would you describe as the major problem?

R Um, her problems are the anxiety, and the agoraphobia, but there's a lot of underlying things from childhood to present day really that we need to explore, so there's going to be quite a lot of counselling.....

(CPN 12, referral 18)

I What would you describe as her major presenting problem, symptom.....

R Depression, neurotic depression or reactive.

(CPN 13, referral 1)

I What was the problem with this client?

R Fixed delusional belief with violence, probably.

(CPN 7, referral 2)

I What would you describe as her major problem, or symptom?

R She's got an endogenous depression.

(CPN 9, referral 3)

The dominance of the medical model pervaded throughout the discussions that took place with each of the CPNs (i.e. in the interviews and in the backstage discussions). This was the case where the topic was related to the identification of what the client's diagnosis was, as the above quotations demonstrate, and for the other topics addressed in the Diary-interview Schedule.

There was, however, one deviation from this pattern. CPN 6 displayed what could be loosely described as 'humanistic' tendencies in that he appeared to operate deliberately from a client-centred basis. This CPN attempted to avoid using medical terminology when describing what the client was suffering from, used counselling as a therapeutic intervention more than any of the other CPNs, and when assessing a client indicated that it was important to be guided by what the client wanted:

I What did you do for that hour [with the client]?

R Well, established why I was there. Began to build a rapport. Again, tried to establish what her wants and needs were, how I could help. Also tried to get some sense of what she'd been through recently, what she was going through at the moment with problems and issues, and then got her to look at herself,

to take some responsibility for what she could do for that, what we could do or where we were going with that.....

(CPN 6, referral 3)

The approach taken by this CPN, however, was not without controversy. When I interviewed the social worker in the same CMHT, and after the tape-recorder was switched off, he suggested that when psychiatric nurses had moved from working in psychiatric hospitals to working in the community they had been perceived as a threat to his social work colleagues. That is, the CPNs gradually began to get involved with a number of therapeutic techniques (especially counselling) which the social workers presumed was their province. The social worker then criticised the CPNs for not performing counselling in a way he deemed to be correct. He argued that the CPNs remained too directive with their clients, and this he believed was antithetical to the principles of counselling. He stated that they had been 'tainted' by having worked in hospitals, and they were, unlike social workers, heavily influenced by the medical model.

I did not ask the social worker to identify any particular CPN, so I do not know if he was aiming his criticism at CPN 6 or generally at all of the CPNs in that team. The indications from the data are that this CPN was far less directive than all of the other CPNs in the study. However, other members of the same CMHT (i.e. both of the consultant psychiatrists) complained about

CPNs who refused to give injections and concentrated too much on counselling. In response to the question 'what makes a bad CPN', one of the two consultants expressed his annoyance thus:

> .....I've got a bee in my bonnet about this, but people who've had a brief training in counselling, and then set themselves up as experts, and I've had to pick up a number of clients after they've been counselled.
>
> (Consultant psychiatrist, Dr. S, Team 1)

The hostile reaction of the consultants may not be simply because of their worries about the poor quality of service the client receives, it may be due to a fear that the 'bad' CPN(s) is challenging their professional dominance by deliberately offering alternative treatments to those that traditionally belong to the medical repertoire.

Ironically, as has been demonstrated above, the majority of the CPNs in this study displayed an unfaltering allegiance to the tenets of the medical model. However, although the CPNs in this study adopted implicitly a medicalised epistemology in the delivery of their practice (and are therefore susceptible to medical dominance), this did not include any 'scientific' procedures in the assessment of the client's mental state.

4.4.2.Team membership

The CPN's membership of the CMHT is explored in detail in this section. In particular what 'meaning' was attached by the CPNs and their colleagues to being members of the CMHT is examined. The views of the managers about the CPNs' role in the CMHT are also reviewed. Furthermore, there is an analysis of how the teams operated, and what procedures were adhered to. Becoming a member of a team could be expected to change the way in which the CPN perceives her or his clinical practice, and the way in which others view what the CPN does. Specifically, the entry into the team may have an effect on how autonomous the CPN can be in making clinical decisions.

When asked the question 'What makes a good CPN', the tension between clinical autonomy and team membership is unveiled by one the occupational therapists:

R I think someone who can work in a team, which I think is the problem - I don't think a lot of CPNs do. Just from working here a lot of our people are not very good team workers - they work too autonomously.

I Too autonomously?

R Yes - they take that too far they can't seem to moderate it which is obviously perhaps about the way they trained and the way they

develop. I think if they could work better as team members and share. I think most of them are pretty good with patients - interpersonal skills are there - I think it's actually working with other members of the team.

(Occupational Therapist, Team 4)

So, for this team member, the CPNs have a problem in relinquishing some degree (if not all) of their freedom to make their own decisions. However, this does presuppose that there is a common understanding of what the CMHT as an organisational entity stands for in the fist place.

Functions of the team:

In all four teams partaking in this research there was considerable confusion and ambiguity about what the functions and status of the CMHT were, and about what the roles of its members were. For example, the CPNs were expected by their colleagues (in particular the consultant psychiatrists) to take their clients to the CMHT meetings for review by the team. This invariably did not happen, and when it did it was spoken about by the CPNs in a way that made the discussions appear to be either ritualistic (as with the letters to general practitioners) or centred around the consultant psychiatrist rather than the team as a whole.
There was even confusion about who was and who wasn't a

member of the team. In one team the social work member of the CMHT was removed by the local authority who employed him (and he was not replaced) because it was undergoing a re-organisation. The psychologists as a group seemed to have a policy of regarding themselves as consultants to the team rather than members of it.

Moreover, the psychologists appeared to deliberately avoid entering into the CMHT as a defensive occupational strategy:

> I personally would not be prepared to work full time in a community mental health team because I feel that there would be a loss of identity with my own discipline because I think that it is by working with other people in your own discipline that you keep your own skills going and you develop your own skills.
>
> (Psychologist, Team 1)

This reluctance to enter formally into the CMHT by the psychologists may be based on a fear of being subsumed by the authority of the consultant psychiatrists. This, of course, is based on the assumption that the consultant psychiatrists have already asserted their dominance over the CMHT, or are likely to do this at some later date.

With regard to who has legitimate authority to lead the team, the data demonstrate a number of major tensions

amongst its members. For example, there was different perceptions of who should be the leader of the team. A leader of the CMHT was never identified explicitly in any of the teams, although in two of the teams the term 'co-ordinator' was used to describe the person who was given the responsibility of arranging and chairing the meetings. Some members (i.e. two social workers and one occupational therapist) stated that they favoured a collegiate system, which would not encourage any one discipline to dominate the team. Other members (i.e. three of the CPNs and one social worker) at times described the operation of the team in terms that would suggest that it was in fact leaderless. But, on other occasions their accounts implied that they accepted implicitly that the consultant psychiatrist was the leader.

However, the view of one consultant psychiatrist was unambiguous when (in an informal discussion after my interview with him) he declared, "every team has a captain, and the consultant psychiatrist should be the captain". The problem here is that it would seem that this view is not understood or even known (and certainly not agreed to) by the majority of the other members of the team, or by the managers who have responsibility for the CPNs.

The confusion over roles and membership, together with a lack of commitment by members of some of the relevant occupational groups, caused a few of the CPNs to question the existence of a CMHT in reality in their areas:

The team has been a CMHT for one to two and a half years previously, but has fallen apart due to social services pulling out and the consultants not attending meetings, and for other political reasons.

(CPN 6)

CPN 11 said, when I asked her if she felt that she belonged to a CMHT, "Well, yeh, officially of course I do, but on the other hand I don't feel as though because we don't meet as a team as such. I feel as though there needs to be more putting together of the team".

(Field-notes)

The psychologist quoted above stated that she didn't believe that the CMHT, as a way of organising health care delivery in the community, had any future. This may have contributed to her lack of commitment to the CMHT:

I ..... How do you perceive the future of the community mental health team?

R I guess its my belief that they won't last.

I Why not?

R Because I think that they are too small. I think that there is too much going for personality problems and difficulties within the group for them to survive long term. I think that there will be great enthusiasts, and I can see a lot of advantages to a system like that, but I can also see a lot of disadvantages.

(Psychologist, Team 1)

Team meetings:

The lack of commitment to the CMHTs, and the ambiguity surrounding their modus operandi, was also shown with respect to the meetings of the team. The CMHT met regularly (usually every week) in each of the four areas in the study. However, the function of these meetings was, like the roles and functions of its members, not clearly defined. For example, the CPNs from one CMHT reported that although the members of the team meet each week, it was for less than an hour, and was only to discuss particular referrals that the individual members decide to mention. There is also no formalised clinical supervision of the CPNs' clients (or of any of the other members' clients) during these meetings.

Furthermore, the meetings were not always given a high priority in the CPN's working schedule in two of the other CMHTs, and at times the CPNs seemed to regard them with ambivalence:

CPN 7 made an appointment with me for a time when the team (I was told by CPN 6) has their meeting. CPN 7 looked unconcerned by the overlap.

(Field-notes)

CPN 15 attended the CMHT meeting between 9.30 am and 11 am, but CPN 13 sent his apologies and some messages for the 'team' from him (although he said these messages were in fact mainly for the consultant) with CPN 15. CPN 13 said he couldn't attend the CMHT meeting himself 'due to the pressure of work'.

(Field-notes)

The next quotation from a psychologist suggests that the team meetings could be no more than a ritual She suggests that the meetings do not serve the purpose of "checking" what the members (i.e. the CPNs) of the team are doing with their clients:

They [the CPNs] can say they are discharging a client in the team meeting, but there's not an effective check made as to whether or not this is right. CPNs do have control over this. There is an absurd kind of lip service paid to discussing it. You don't get time to discuss

> when there are ten professionals sitting around, so it's just a case of this is the way it is. Unless the psychiatrist is very involved or one of the other professionals knows the client really well there is no real checking.
>
> (Psychologist, Centre 3)

As has been discussed earlier in this chapter, the CPNs referred to in this extract could be viewed as demonstrating (de facto) autonomy in relation to the discharge of clients. The psychologists reaction to the clinical independence of the CPNs is interesting as it reinforces the notion that it is regarded as illegitimate by other members of the team.

Which team?:

Ambiguity surrounds the CPNs' identification with CMHTs. The CPNs had been selected to be part of the study on the understanding that they were all members of this type of team. This was established with the managers from the outset. However, when the individual CPNs were asked what type of teams they belonged to, only six out of the ten stated that they belonged to a CMHT (and the four remaining CPNs were not from the same area). One CPN stated that she was a member of a primary health care team (PHCT), and another that he was a member of a 'multi-disciplinary team' (MDT). At times

(subsequent to the initial interview when these responses about team identity were ascertained) the CPNs would identify themselves with the MDT when they were dissatisfied with the operation of the CMHT. Although the MDT appeared to be a fabricated entity, and the distinction between it and the CMHT was never expressed clearly, it did seem to some extent to depend upon membership:

> .....[CPN 12] was cynical about belonging to a CMHT. She saw herself belonging more to a MDT, which included colleagues not formally in the CMHT (e.g. Day Centre workers).
>
> (Field-notes)

One CPN also claimed to be a member of a primary health care team (and this was not the CPN mentioned above who had done so in the first interview), although this membership apparently was not sanctioned officially:

> CPN 15 spends two out of five days per week away from the other CPNs working from an health centre. Here he shares an office with three district nurses, a practice nurse, and a health visitor. He considers himself as part of the PHCT, although he said 'this doesn't seem to be official policy'.
>
> (Field-notes)

Structure and environment:

There was no officially endorsed, and widely understood commitment to any form of team structure (for example, either to a hierarchical or to a collegiate system) in any of the four CMHTs. In the two teams where written procedures existed these were not followed by the CPNs, or even referred to unless I asked specifically to examine them.

In general, the CPNs in the study organised their working day as they wished, decided on how many clients they would make contact with, and who else they would consult with regard to these clients. That is, for virtually all of the time these nurses spend at work, they decide for themselves the content and structure of their practice without any liaison with a supervisor, manager, or a colleague.

This freedom of action does, of course, have certain parameters. For example, where a CPN shares an office with other CPNs, and/or operates from a building with colleagues and a manager, then this will affect her or his behaviour. One of the CPNs who did not share an office complained frequently of feeling isolated, of not being able to share ideas and concerns with her colleagues, and of the difficulties in not having a mentor from whom the role of 'CPN' can be learned:

> CPN 12 talked about how vulnerable she feels working on her own. She mentioned that when working on the wards you knew what the

> boundaries of your work were, but in the community there was no framework to work within, nor was there a role model.
>
> (Field-notes)

However, what was very noticeable where CPNs did work in the same office was how much the interpersonal communication concentrated upon 'humour' - to the point where one of the CPNs commented that he would like to work on his own because the communal office was "too distracting".

It is axiomatic, however, that nurses working in the community do not come under the observation of their colleagues, or the scrutiny of their managers, to anything like the extent that they do when they work inside a hospital. A certain amount of managerial overseeing could be described as being installed in one of the centres as the CPNs were expected to record in a communal diary if they left the building, and the time of any appointments they had with their clients. In another centre the CPNs wrote on a whiteboard what their activities for the week were going to be. But, as with the computer records (which the CPNs admitted openly they did not provide with valid information [13]), the data entered would obviously depend upon the CPNs' willingness to record accurately their actions.

Notwithstanding these self-reporting records of the CPNs' movements (and the example explored below of the manager accompanying the CPN on one day every few

months), the observation of the CPN by her or his peers, colleagues, or managers only occurs for a small proportion of the working day. The CPN has the opportunity to spend most of her or his time either with clients or travelling to and from appointments, and therefore can avoid the gaze of colleagues, peers, and managers.

4.4.3.Supervision

> .....clinical supervision for CPNs has always been a big issue and one that I think has never been properly addressed.
>
> (Nurse manager, Team 1)

One of the most important influences on the clinical autonomy of any practitioner is supervision. That is, if work is supervised from within the practitioner's discipline (or not supervised at all) then it could be argued that clinical autonomy is possible. If, on the other hand, the work of the practitioner is supervised by members of another discipline (particularly if this is involuntary), then the potential for professionalisation (based on the criteria of clinical autonomy and professional dominance) is limited, if not impossible. In this section, the way in which the work of the ten CPNs in the study was supervised, and the views of the members of the CMHTs and the managers on the issue of supervision, is evaluated.

Defining supervision:

There are numerous definitions of supervision. Two of the most obvious are, firstly, the form of interaction that relates to managerial control, and secondly, the form that is associated with the reviewing of clinical

work in order to help the personal development and/or the skills of the practitioner [14] .

When talking about supervision with the CPNs, their colleagues on the CMHT, and with the nurse managers, there was a general confusion about what type of supervision was being referred to. Highlighting these definitional problems is the example of the nurse manager in one health authority who had decided to participate in the CPNs' clinical practice by accompanying each CPN on one full day every few months. Whilst this was presented by the manager as the form of supervision that is intended to help skill and personal development, it was perceived by the CPNs as more of a managerial exercise:

> The staff support officer goes with each CPN once every six months for the day as a "managerial exercise", said CPN 6. "This is not clinical supervision", he stated.
>
> (Field-notes)

Moreover, there was confusion over whether the supervision of clinical work should be inter-disciplinary or intra-disciplinary. For example, the term 'peer review' was used in connection with supervision, but some of the interviewees would use this term to describe a process whereby members of the same occupational group would review each others work, while others would use it to refer to the reviewing of

clinical work by any of the members of the CMHT.
In this extract, one of the managers of the CPNs appears to downgrade inter-disciplinary 'peer review' by claiming that nurses tend to want to be supervised by other nurses (and/or nurse managers):

I Who do I think they [the CPNs] should be supervised by?

R Certainly they should be supervised by a senior nurse with experience.

I What about the inter-disciplinary supervision?

R Again, I think, I wouldn't really call it supervision, but there is a need there to discuss case-work with the likes who are not nurses. But then you always have this sort of two-tier thing where nurses feel that they want to be supervised by nurses, nurse managers, but you can also get a great deal from just discussing with another colleague, whatever profession, if you're getting peer support, peer review. But again, I think that's different from nurses talking about the profession of nursing. Nurses feel there are issues that only affect nurses.

(Nurse manager, Team 4)

This approach by the nurse manager poses a dilemma for those concerned with teamwork. That is, if supervision remains within a discipline, it is difficult to understand how this will encourage a 'team' identity. If each discipline in the CMHT performs its own supervision, this will confirm the established demarcation of health care workers into various occupational groups, which could be considered to be antithetical to the functioning of teams. It could also be considered not to be in the best interests of the clients.

Virtually all of the CPNs, their colleagues, and the managers, however, implied that they held the supervision of clinical work to be of importance. Two managers, and two of the members of the CMHT, expressed very strongly and overtly their views about the need for practitioners to be supervised. This strength of feeling is demonstrated by an occupational therapist in this quotation:

> I personally think that it stinks that you are working on your own , you design a care package for somebody and you can go along willy nilly for six weeks, six months, and yes, if you're good at your job, you will make sure that you keep other people informed, but if there's no one else informed there's nobody evaluating the treatment that you're giving to that person and I think that's bad for you as a practitioner and I think it's not

particularly good for a client and I feel very very strongly that everybody who works independently in the community should have proper case supervision.....

(Occupational therapist, Team 1)

The vehemence of the occupational therapists opinion on this subject suggests that although she considered supervision to be essential for both the well-being of the practitioner and the client, it was not a common event. This leads to an important discussion on how often the supervision of the CPNs occurred in the four teams in the study.

Formal and informal supervision:

When interviewing the CPNs I was not only interested in discovering what type of supervision they undertook, but whether it was available on an informal or formal basis. I used the terms 'formal' and 'informal' to differentiate between regular pre-organised sessions with an identified supervisor, and ad hoc and opportunistic discussions with any available colleague.

In the initial interview with each of the CPNs (i.e. when specific details about the CPN were recorded in the first part of the Diary-interview Schedule), six of the ten informants stated that they received formal supervision from one of their colleagues in the CMHT, or

from a manager. All ten of the CPNs in the study stated that they received frequent informal supervision on demand, usually from another CPN, but occasionally from a colleague who belonged to one of the other occupational groups:

> CPN 11 stated that she received formal supervision (clinical) from the CPN manager, usually once a week. She felt she received informal supervision from her colleague (CPN 10) with whom she shared a room. This took the form of asking each other's advice if they had a problem with a client.
>
> (Field-notes)

However, in contradiction to the impression given in these first interviews, the CPNs reported during the remaining part of the study that they had consulted (formally) with a supervisor on only two occasions. This represents 0.3.% of the total number of discussions that were held by the CPNs with other colleagues, etc. (Fig. 7) [15] .

Furthermore, during the completion of the Diary-interview Schedule, and in back-stage conversations that were held following the interviews, the CPNs admitted that although supervision officially was expected to take place, it generally didn't. For example, one CPN in the study stated that he entered data about a weekly supervision session into the

computerised record of his working practices, but he confessed that this session in fact never happened. Many of the CPNs' colleagues were aware that supervision was not taking place:

> .....there isn't actually formal supervision processes at all for CPNs.....
>
> (Social worker, Team 1)

Supervision was also supposed to be given to the CPNs who were not at the 'G' level in the nursing hierarchy. As has already been discussed, there was very little difference in how the different grades operated, and in reality supervision in this context didn't occur either, or if it did it was on an informal basis:

> There was a discussion (on tape) with CPN 8 and 9 about the G and F grade roles. They both said that there was no difference except that the G grade was supposed to offer supervision. But CPN 9 implied that this didn't take place, but CPN 8 said that it was reciprocal and informal between her and CPN 7.
>
> (Field-notes)

It would appear, therefore, that the CPNs in this study did not have much formal supervision (of either the

managerial or developmental type). Consequently, this is another example from the data of how the CPNs have gained clinical autonomy by 'default'. However, the consequence of this is also that the CPNs themselves had very little opportunity for reflecting upon their practice in any structured way, and their managers gained little feedback about the quality of the CPNs' work.

It may well be, however, that much 'informal' supervision did take place, and that the under-reporting of this relates to the unspecific and unregulated manner in which it may be conducted. That is, from my observations the CPNs did talk to colleagues about their clients in a general way on many occasions, but this cannot be considered to be genuine supervision. The clients were mentioned in conversations that covered many topics concerning the work of the CPNs, aspects of the organisation to which they belonged, and their personal circumstances. The function of these conversations is related more to the requirement of individuals to communicate on a superficial level in communal situations in order to pre-empt or diffuse interpersonal tensions.

Who supervises who?:

The opinions of the other members of the CMHT differed and were often contradictory with regard to the supervision of the CPNs. For example, this consultant psychiatrist acknowledged that the CPNs had some level

of clinical autonomy, whilst at the same time arguing that the supervision of their practice is necessary:

> .....they [the CPNs] have to have a certain amount of freedom to decide about cases that they are involved with..... [T]here has to be some degree of occupational judgement. I think as far as having someone to supervise their case-loads, I think that is very important as a lot of work is done quite isolated.
>
> (Consultant psychiatrist, Team 4)

This consultant went on in the interview to explain that he had supervised CPNs in the past. Another consultant psychiatrist reinforced the notion that CPNs required supervision, and that this might come from within the CPNs' own occupational group. However, he suggested that when the CPN belonged to a CMHT, then supervision should be provided by the 'team', and in particular by the consultant psychiatrist:

> .....there should be supervision from the team, and I suppose very often that's from the consultant.
>
> (Consultant psychiatrist, Team 3)

The assumption by the consultant psychiatrist that he is the most appropriate person to supervise the work of

the CPN is linked directly to the assumption by the discipline of psychiatry that it should lead the CMHT (see Chapter 2). However, the consultant psychiatrists may be offering their services to supervise the CPNs in the face of what they consider to be the lack of effective alternatives.

For example, in the following quotation a consultant psychiatrist was openly critical of the nurse managers' abilities to supervise the CPNs. He then goes on to state, as had the psychiatrist above, that he is the most suitable person to conduct the supervision of the CPNs' clinical work:

R .....I personally am quite sceptical about nurse managers doing this because they quite often don't seem to have the necessary clinical experience. Um ....

I So who should be the supervisors of CPNs?

R I think the Consultant Psychiatrist is one obvious choice..... There was a time when I actually offered the CPNs supervision, after they had made sort of interested noises, but we only met a few times.

(Consultant psychiatrist, Dr. S, Team 1)

The criticism of the managers' ability to supervise was repeated by two other consultant psychiatrists, and

underlined by this psychologist:

I On the aspect of supervision, what do you mean by supervision and who do you think should be supervising the CPNs?

R Nurses should be supervising them until it comes to them doing therapy. I don't know if the nursing hierarchy have any experience in that either, and I think that my ideal would be that they would take on cases and they supervise them. I think they can be very helpful - it's when they take on whole cases that are quite complex and they don't know what they're doing that others should supervise them.

(Psychologist, Team 4)

Another psychologist, like the psychologist and the psychiatrists quoted above, indicated that she could offer supervision to the CPNs (and realised that this may not be popular amongst the CPNs), but was not willing to be supervised by them:

..... What I've said here is that I could be a resource, that I would provide supervision if they [the CPNs] wanted it. Some people may be uncomfortable with the idea that we were giving them supervision. I had one CPN come to

me, and she suggested that I joined in to discuss some of my cases, but I said that I didn't really want to do that. That really wasn't my agenda. I get other people to do that for me. As I say, I think a lot of people would be very uncomfortable with me supervising them.

(Psychologist, Team 2 and Team 3)

The non-reciprocal supervision of members of one occupational group by members of another accentuates a subservient-dominant relationship between the two. When the subject of supervision was discussed with the CPNs' colleagues in the Focused-interviews there was usually a response that implied that the CPNs required supervision, and that this could be done by other more 'senior' members of the CMHT (see section 4.4.4.). This view was expressed particularly (as has been illustrated in the above extracts from the interviews) by the psychologists and by the consultant psychiatrists. Furthermore, both the psychologists and the consultant psychiatrists perceived themselves as legitimate overseers of the CPNs' work, but did not avail themselves to having their work overseen by the CPNs. Moreover, the criticism of the capacity of the nurse manager to supervise the CPNs could be viewed as congruous with the psychologists' and consultant psychiatrists' self-declared role as mentors to other members of the team. That is, where managers have a

nursing background (all had in this study), they may be regarded by the psychologists and consultant psychiatrists as being in a similar (subordinate) occupational position as the CPNs.

Accountability and responsibility:

The role of the nurse manager in the supervising of CPNs who belong to a CMHT leads inevitably to a discussion on accountability. The definition of accountability I am using here refers to the formal, contractual responsibilities an individual has with an organisation (Ovretveit, 1993). Individuals are accountable to one or more representatives of an organisation for the fulfilment of those responsibilities. Practitioners may also be accountable to a professional organisation (for CPNs, this would be the United Kingdom Central Council for Nursing, Health Visiting, and Midwifery) who provide codes of conduct and/or ethical regulations.

Technically, CPNs are accountable to their line manager. However, membership of a CMHT encourages a blurring of lines of accountability because responsibilities are not (and were not in the four teams in this study) delineated precisely or formally. Moreover, although CPNs may be accountable to their line manager, when they work in a CMHT the supervision of their practice could be carried out by either a manager (who is not part of the team), the team leader (who could be the consultant psychiatrist), by another CPN, or by one of the other members of the team (e.g. an occupational therapist or

social worker). What type of supervision is provided (i.e. either managerial or developmental), will depend on what is sought by the CPN in the first place (where it is voluntary), and on who carries it out.

The problem of the relationship between responsibility and accountability, and supervision, in the CMHT was underlined by one of the nurse managers in the study. In this quotation from the manager, he indicates that although there are established channels of accountability within the health authority overall, the issue of accountability in the CMHT has not been resolved. He states that this results in some members of the team avoiding accepting the responsibility for some clients, and suggests that one solution might be to make accountability internal to the team:

> .....the thing about general management is that there are straight lines of accountability..... The only problem is when you get into peer groups. What happens then is you can get a bit of opting out, because a referral can come in, the OT or the psychologist can say that they can't take it. That's because there is no accountability. That's what we need to bring about. There's conflict there, but I don't know how it can be brought about. You could make a manager in the team. Supervision sessions could be within the mental health team. If somehow you could make the whole team accountable to the team for

their actions. At the moment everyone is working separately.

(Nurse manager, Team 2 and Team 3)

The issue of accountability, therefore, can be viewed as influencing the supervision of the members of the CMHT. However, the data from the research indicates that accountability to the team may mean that CPNs become accountable to, and succumb to supervision by, members of other disciplines (especially psychiatry).

In the following quotation the nurse manager accepts that the supervision of the work of CPNs is "inadequate", and hints at such a scenario being a possibility. That is, he implies that the medical staff could supervise CPNs because of what he describes as the traditional working relationship that exists between these two occupational groups:

I think generally the supervision of the CPNs is inadequate..... I'm conscious that CPNs, certainly in comparison to, say, social workers, have nothing like the degree of supervision. I suppose what they do have, by tradition, are fairly close working relationships with medical staff which, to some extent, compensates.....

(Nurse manager, Team 1)

Furthermore, this manager is drawing attention to a discrepancy between the organisation of intra-disciplinary supervision for social workers, and the lack of any such internal system of supervision for the CPNs in this study. Consequently, compared to the social workers, it is more probable that the CPNs will lose the autonomy they possess (and fall prey to the hegemonic tendencies of the medical profession) if and when the issue of accountability is addressed in the CMHTs.

4.4.4.Hierarchy

The clinical autonomy of mental health nurses working in the CMHTs is challenged seriously by the existence of inter-professional hierarchical structures. The hierarchical structure which permeated the four teams in this study involved the separation of the consultant psychiatrists and psychologists from the remaining disciplines, and in particular from the CPNs.

The consultant psychiatrists, as has been discussed in relation to the conflict surrounding the leadership of the team, are perceived by their colleagues as attempting to dominate the CMHTs. Furthermore, the consultant psychiatrists view themselves as the natural leaders of the CMHTs. This consultant psychiatrist differentiates his role from that of the CPNs on the basis of leadership:

I Where's the difference between say the consultant psychiatrist's..... and the CPN's role?

R Er. [pause for two seconds] I think all this is very political..... I think the consultant is the person to actually lead a team, which includes the CPNs, because he or she is likely to have had the broadest training and the longest.

(Consultant psychiatrist, Dr. S, Team 1)

However, there appears also to be a view amongst the consultant psychiatrists and the psychologists that each is in a position of seniority in the CMHT. That is, the data indicates that the consultants and psychologists are of the opinion that they belong to an occupational group which is of a higher rank compared to that of social work, occupational therapy, and especially nursing.

CPNs as support workers:

In this next quotation, the psychologist states that her role in relation to the work of the CPNs is to provide supervision. This, she suggests, is of particular importance where CPNs are treating people who are suffering from acute mental illness. She voices her concern about CPNs dealing with this group of clients as she argues they are not capable to deliver such specialist treatment as, for example, cognitive therapy. The CPNs need her supervision, she suggests, to stop them doing "crackers things", and to stop psychologists gaining a "bad name". Furthermore, she recommends that the role of the CPNs should be confined to one of providing support:

> R .....I think a lot of the work they do [i.e. the CPNs] should be done by psychologists, but there's not enough of them, and I see my role as supervising and making sure they're not doing crackers things and

giving psychological services a bad name. They always say they're doing cognitive therapy, and I don't think they know what cognitive therapy is, but I think they should. I don't have any objection at all to them seeing neurotic patients but not if they don't know what they're doing.

[later in the interview]

I You may not be that keen on giving me the details so I don't want to push to hard, what I'm interested in is how much control do you think CPNs should have in implementing treatment?

R I think ideally I would like them to have limited control, unless they were better trained. I do think a lot of the CPNs do a lot of good work, but I do think if they could stick to more supportive stuff and be ready to report back when more specialist help is needed, and avoid getting out of their depth. Having said that, just sometimes as I say they don't have the, medical wise, the training in exploring work problems, I think they give the psychologists a bad name because they call it therapy.

(Psychologist, Team 4)

In the following extract from the interview with the psychologist in Team 1, she also is concerned about the CPNs' skills, and implies that the CPNs should be confined to the supportive role. However, she recognises that the CPNs are attempting to become "prime therapists":

R Clearly there has been a big shift and now the CPNs' are arguing for status as prime therapists themselves. I don't know whether they have sufficient training or experience to justify that or not.....

I Given what you have just said, what makes a bad CPN?

R I have certainly been aware of a lack of skills and expertise, and certainly have had the odd referral from a GP where people had seen a CPN and had been angered and upset by their contact. So there obviously are some issues that need addressing.....

(Psychologist, Team 1)

Senior and junior disciplines:

The supportive role for the CPN advocated by the psychologists and consultant psychiatrists can be seen to have two aspects. The first is to provide general

help and advice (rather than more prestigious specialist therapies) to the client, and the second is offering sustenance to the 'senior' disciplines in the CMHT. Both of these functions help to fortify the distinction between mental health nursing on the one hand, and psychology and psychiatry on the other.

This separation of 'senior' from 'junior' occupational groups is accentuated by the reactions of some of the CPNs. For example, one of the CPNs had been referred a client by the psychologist. The psychologist had not discharged the client from her own case-load because (according to the CPN) she intended to see her again once the treatment provided by the CPN had been completed. In the extract below the CPN states that she views her role as delivering "down-to-earth" treatment, and the "arty-farty" therapies should be left to other members of the CMHT:

I So the psychologist is still in the background?

R Yeh. She will pick her up again as soon as the dirty work is done.

I Um. That's worth exploring. Does that happen a lot?

R To a great extent I think that is our role in a way, the basic down-to-earth stuff, going out giving support, down-to-earth sensible

advice, leaving the more in-depth arty-farty stuff to others.

(CPN 8, referral 9)

Paternalism and patronage:

If the CPNs carry out the `dirty work' (Hughes, 1971) of the psychiatric services then this would suggest that an inter-professional hierarchy does exist in the CMHT, and that their position is at the bottom. However, it may be that in undertaking low status tasks, they are awarded some degree of clinical autonomy by the senior occupational groups. That is, the pay-off for accepting the role of providing 'support' to clients could be that the CPNs are left to manage the delivery of this form of treatment without any direct interference (or 'supervision') from their colleagues. It is only when the CPNs are perceived by the psychiatrists and psychologists to be entering into the specialist areas that their work becomes scrutinised by these senior professionals. It could be argued, therefore, that the senior groups offer the CPNs a stabilised system of occupational relationships based on paternalism and patronage.

In this quotation from a consultant psychiatrist such a relationship is given tacit support. The consultant suggests that the CPNs should be viewed as professionals, but in referring to the "certain amount" of independence they should have, he is limiting their

autonomy:

> I think the community psychiatric nurse is to be regarded as a professional and they should have a certain amount of freedom to decide about cases that they are involved with.
>
> (Consultant psychiatrist, Team 4)

Although the consultant psychiatrists and psychologists form what could be described as an elite occupational caste in the field of mental health, they are also in dispute with each other. It has already been mentioned that the psychologists do not appear to want to be full members of the CMHT because (as they view it) of the danger of being subsumed by the medical profession. Indeed, one of the psychologists in this study participated in an attempted covert debacle of the consultant psychiatrist's dominant position within the CMHT (see section 4.5.2.)
Moreover, open conflict between members of these two groups did occur:

> It's a battle sometimes. We're not all working together in the team. We can work very well with the OTs and the social workers, but the psychologists and the psychiatrist, once they come in it's confrontational.
>
> (Manager, Team 2 and 3)

This extract exemplifies the 'senior-occupation' and 'junior-occupation' divide as well as illustrating how the psychologist was willing to use face-to-face confrontation (unlike the CPNs) to challenge the consultant psychiatrist's self-assumed authority. The CPNs, as we have seen, avoid open conflict, which implies that they are much less confident about the legitimacy of their challenge to medical dominance than are the psychologists.

Furthermore, the CPNs encourage the paternalistic relationship with the consultant psychiatrists by operating from within the medical model (having failed to generate their own occupational discourse), and by showing deference towards the consultants (e.g. in team meetings:

> CPN 15 and 14 stated that normally when they do discuss a client at the CMHT they are really addressing the consultant.
>
> (Field-notes)

The CPNs also show deference to the consultant psychiatrists when they categorise their role as one of providing support to the medical staff, and when they partake in the policy of each client on their case-load being linked to a 'responsible' medical practitioner (who may be either a consultant psychiatrist or a general practitioner):

> CPN 10 stated that it was either a management policy or his policy (he wasn't sure which) that every client must have a GP or a consultant psychiatrist who is "responsible for the client". He didn't have anyone on his case-load that didn't have either a consultant or a GP "taking responsibility".
>
> (Field-notes)

The identification of a responsible medical practitioner was insisted upon by the CPNs even for clients who were self-referred [16] .

As the extract above from the Field-notes indicates, it was not possible to determine at whose behest such a policy had been installed. It is at least possible that the CPNs themselves had initiated the production of such a rule, which would suggest that they were complicit in the formulation of a paternalistic relationship between themselves and the medical staff. But, whichever discipline had been instrumental in producing the regulation, the CPNs appeared not to object to its implementation.

Prerogative to diagnose:

However, the key criterion used to distinguish senior from junior disciplines in the CMHT was the perceived ability of an occupational group to perform

effectively the assessment or ('diagnosis') of a client's mental condition. Freidson has pointed to the medical profession's "prerogative to diagnose" (1970b, p.141). In this study, four of the five consultant psychiatrists, and all of the psychologists, either stated explicitly or implied that they considered this to be the fundamental element in the demarcation between the senior and the junior group.

In this quotation a consultant psychiatrist suggests that his assessment procedures, compared to those of the mental health nurses, are more complex and comprehensive:

> .....I think also that the depth and sophistication of assessment is going to be different [between] the CPN and a consultant psychiatrist, and it's better for the consultant to do it more thoroughly.
>
> (Consultant psychiatrist, Dr. S, Team 1)

For the consultant psychiatrist in this next extract, the CPN's 'primary nursing role' is one of 'monitoring'. Consequently, the CPNs are not considered to be capable of assessing fully the client's mental state. That is, once again the CPN's role is seen as one that is concerned with 'support', and that any assessment that she or he conducts is secondary to that performed by the consultant psychiatrist:

He suggested that this CPN primary nursing role was to do with monitoring the mental state of clients. He indicated later on that this - if he'd referred the clients - was after he'd done the initial assessment so that the CPN role in that case was very much a subsidiary or complementary assessment procedure.....he was worried that new referrals sent straight to CPNs actually needed a consultant psychiatrist's assessment rather than just a CPN's assessment.

(Notes taken from interview with consultant psychiatrist, Dr. L, Team 1)

The patronising tone implied in the above extract surfaces strongly in the following quotation from another consultant psychiatrist. Here the consultant suggests that although he "trusts" some CPNs to assess clients accurately, he would want to check on the performance of other CPNs:

I Where do you see the CPN's role in terms of assessing clients?

R Well, I think they do have a role in assessing clients, and usually they're fairly good at it. Ur, having said that, CPNs vary a fair amount in terms of training and experience, and yes some CPNs I would trust to give a

> pretty accurate assessment, and other CPNs I would say "yes but you know, have you checked everything through, are you quite sure?". It depends on their experience.

The consultant psychiatrist quoted below suggests that the CPN is not trained to "diagnose", and that if a general practitioner wanted a diagnosis then she or he would contact him. The interesting question arising from this consultant's observations about the general practitioners asking him to make a diagnosis is, what can be considered to be the role of the CPN with those many clients who are referred directly from the general practitioners? That is, it would seem to be unethical of the general practitioner to refer clients to a CPN if the latter is perceived not to be able to "diagnose" what their problem is.

Moreover, the term "diagnosis" here appears to be used by the consultant psychiatrist in a way that differentiates what he does with a client from what the CPN does. That is, he is implying that the medical practitioners "diagnose" (viewed as a higher order skill) whereas the CPN merely "assesses" (viewed as a lower order skill):

> As far as the difference between the role of the CPN and myself is, the CPN's role isn't essentially a diagnostical role..... [I]f the GP wants a diagnosis they would actually come to me. The CPNs are not trained in diagnostic

issues. They would usually come to a medical member if they wanted clarification on that.

(Consultant psychiatrist, Team 2)

Emphasising the rivalry between medicine and psychology, one of the psychologists criticised the CPNs for not being able to carry out appropriate assessments, but also attacked the consultant psychiatrists for their ineptitude in the assessment of clients:

> They'll say [i.e. the consultant psychiatrists] 'he needs cognitive therapy', and then you go and do an assessment and they don't need cognitive therapy, and if you ask them they don't even understand what cognitive therapy is [laughs]. It just like, it's absurd, and I think that sometimes CPNs get stuck with that. I sometimes get people [e.g. CPNs] coming to see me about what they are doing with a client, and I say 'what made you decide to do that, where's your assessment?', and they may say 'well, Dr. X told me to do it', and I say 'and that's why you did it?', and I think shit, you were stupid to do it in the first place.

(Psychologist, Team 2)

Whatever the outcome will be of the inter-disciplinary manoeuvrings between psychiatrists and psychologists, the psychiatric nurses at present are not actually involved in the battle for occupational supremacy. That is, their occupational position (as exemplified by their 'supportive' role to both the senior occupations and to the client) appears to be one that is embedded into the lower rungs of the hierarchy in the CMHT.

4.5.PART 4 (Aim 3) RELATIONSHIPS IN THE CMHT

4.5.1.Conflict and rivalry

Conflict between the various members of the CMHTs occurred in a number of different ways. As has been found in other studies (e.g. Onyett et al, 1994), much of this conflict was centred upon inter-occupational enmity surrounding the actual or potential dominance of the team by the consultant psychiatrist. The influence of the consultant psychiatrist over the CMHT, and the effects of this influence, is acknowledged by one of the members:

> .....I would say the consultant has quite a lot of control over it which is good and bad I guess.....
>
> (Social worker, Team 3)

Open system of referring:

A large area of conflict between the CPNs and the consultant psychiatrist (and other members of the CMHT) relates to the issue of the CPN operating with an 'open' referral system whereby the CPNs would accept clients from any source. In part this conflict centred upon an open system encouraging a high rate of referrals to be sent to the CPNs by the general practitioners.

It was contended frequently by the consultant psychiatrists that such a system created difficulties in identifying who had medical responsibility for the client. For example, the consultant psychiatrist from Team 4 refused to take any responsibility for the clients that the general practitioners had referred to the CPNs:

> He [the consultant psychiatrist] very much made a point of differentiating between those clients who he referred to the CPNs and those clients who were referred to the CPNs by the general practitioners. He said that GP referrals he had no responsibility for and it was up to the GP and the CPN as to what they did with those clients and they were not to expect him to take any responsibility for that.
>
> (Notes made from interview with consultant psychiatrist, Dr. L, Team 1)

One of the two consultant psychiatrists from Team 1 suggests that there are problems of "communication" when CPNs accept clients from general practitioners. He attempts to substantiate this by referring to "stories" that had been told to him, by other unidentified psychiatrists, about CPNs getting into difficulties with clients provided by general practitioners:

.....I think that if a CPN is part of a multi-disciplinary team, and is also seeing primary health care patients, then where does that CPN relate to, to the GP or to the psychiatric team, or a bit of both. You get possible communication difficulties. You do occasionally hear odd stories about CPNs taking on patients on the request of GPs, and getting all tangled-up, and the psychiatrist at the end has to pick up the pieces.....

(Consultant Psychiatrist, Dr. W, Team 3)

Antagonism between the CPNs and a consultant psychiatrist in one team, was mediated through the nurse managers. In the following quotation the consultant psychiatrist comments on the power of the nursing management to implement a policy (i.e. an open referral system for CPNs) which the psychiatric medical staff in that health authority were not in agreement with:

It's something that the CPNs [here] wanted, and something they've got. And the way things are structured [here] I don't think the psychiatric profession could have stopped it because the hierarchy, I get the impression from those involved, is very tight and very strong, and they act independently, which of course can cause problems as well. It doesn't make for a good working relationship..... What

I was concerned about was the one of medical responsibility.

(Consultant psychiatrist, Dr. S, Team 1)

One of the two nurse managers interviewed from this health authority is strident in his opinion about the type of referral system the CPNs should use:

I .....who should CPNs accept referrals from?

R Anybody.

(Senior nurse manager, Team 1)

The manager then goes on to explain that although he realised that the boundary separating medical from nursing responsibilities was a difficult one to establish:

.....I am a big believer in nursing accountability and have never believed that nurses acted on behalf of doctors.

(Senior nurse manager, Team 1)

What appears to be happening in this health authority is that the strength of the nursing management has challenged the domination of the consultant psychiatrists over the clinical practice of the CPNs.

The way in which this is achieved is through the acceptance by the CPN of clients from, for example, general practitioners. However, the CPNs have also reduced the domination of their work by the medical profession as a whole by accepting self-referred clients. The CPN does not relate to the consultant psychiatrist or the general practitioner over these clients. As has been mentioned above (see section 4.3.5.), the nursing management in this authority appears to suggest that the CPNs inform the consultant psychiatrists, or the general practitioners, about their actions only as a matter of 'courtesy'. The consultant psychiatrists' sphere of influence, therefore, is reduced considerably when a significant part of the CPNs' work does not involve them.

Double-bind:

However, the consultant psychiatrist (Dr. S) is not just expressing discomfort about the influence of the nursing management. He is also alluding to the double-bind that the CPNs (and their managers) put themselves into with respect to their clinical autonomy. On the one hand they wish to accept whichever clients they find appropriate, and from whatever source. But on the other hand the CPNs (from all of the teams) still wanted the consultant psychiatrist or the general practitioner to accept 'medical responsibility'. The responsibility referred to here by the CPNs appeared to be a euphemism for 'ultimate' responsibility. That is, in the final

analysis, the medical staff would be expected to 'carry the can' for the clients on the CPN's case-load.
This of course also puts the consultant psychiatrists into a double-bind with respect to their occupational position in relation to other disciplines in the CMHT. The consultant psychiatrists may inadvertently encourage the CPN to obtain clinical autonomy by 'default' (see Chapter 5) if they do not accept medical responsibility for all of the CPN's clients. This would contribute to the undermining of espoused claim to leadership the CMHT by psychiatry.

The team as conduit:

I have already mentioned that a majority of the social workers and occupational therapists supported the CPNs' freedom to make clinical decisions (e.g. with respect to discharge). However, there was some ambiguity from these occupational groups about the CPN's clinical autonomy in relation to accepting clients without the referral first going to the team (and then being distributed to individual practitioners).
One social worker agreed with CPNs operating an open referral system, and acknowledged that this affected the influence of the consultant psychiatrists over the team:

> .....I don't have any problem with CPNs accepting referrals from all sources as the actual advantage of that is that it makes

> the service accessible to people and then I suppose the disadvantage.....the consultants might be sometimes, there's a feeling that they're losing medical control.
>
> (Social worker, Team 1)

However, the response from another social worker indicates she believed that although the CPN could provide treatment for clients from any referral source, the referrals should first be vetted by the team:

> .....when it boils down to it if you're working together as a team they [the referrals] should all come in and we should assess them together and see who does what. So really I would think anybody, they [the CPNs] should accept them from anybody, but it should be decided amongst the team really as to who's taking what. Quite often I think it just comes from the GP and they ask for a CPN and quite often a CPN goes.
>
> (Social worker, Team 3)

Three of the four occupational therapists stated that they disagreed with the CPN being able to accept referrals independently from the team. In the following extract from the interview with one of these

occupational therapists (which I was not allowed to tape-record), criticism is levelled at the CPNs for this practise. However, the occupational therapist appears also to admit that the team's function with regard to distributing referrals is either purely ritualistic, or serving the purpose of controlling the CPNs:

> On question of CPNs and their referrals, she said CPNs should get referrals from the team. Some CPNs she said (and this was really a political point she was making, she said) get referrals directly from GPs and act on them. She said she didn't agree with this. Sometimes they don't even discuss referrals with the team, they just go ahead and treat the client without even discussing it with the team. She acknowledged that even with a system she advocated, which is to always bring the referrals back to the team after perhaps an initial assessment, the team mostly just rubber stamps the thing, but she thought the CPNs didn t even go through this process, and she didn t agree with that.
>
> (Notes made from interview with Occupational therapist, Team 2)

The consultant psychiatrist from Team 4 expresses his concern over the CPNs accepting clients from the general practitioners, arguing that the net effect is the CPN

treating more of the 'worried well' than the chronically mentally ill:

> .....there is a problem. I mean, if the GPs have total access, we would run the risk of the CPN seeing more of the worried well. Where there are limited resources you have to find where the greatest need is, and in this case it's severe mental illness.
>
> (Consultant psychiatrist, Team 4)

Another of the consultant psychiatrists also referred to the issue of the CPNs treating clients referred to them from the general practitioners in terms of available resources:

> I am always uneasy when they are taking referrals directly from GPs, ur, not because I have anything against that at all as such, but again there's a limit on resources, and er we've got to cut our coat according to our cloth. Um, if GPs want to employ CPNs out of their own budget, or buy CPN time from us, then fine because, well that would enable us to recoup our CPN time.
>
> (Consultant psychiatrist, Team 3)

It could be argued, therefore, that the CMHT should act

as a regulatory body with respect to resources and the type of clients members of the formal psychiatric services offer treatment to. That is, whether it is general practitioners, other health professionals, or members of the public who are requesting input from the state mental health industry, the CMHT could be afforded the responsibility of deciding how and to whom finite resources are distributed. However, if the CMHT was to operate in this way, and all referrals were to come to the team in the first instance, then the consequence for community psychiatric nursing in particular would be the dominance of its work by medicine.

In one of the health authorities studied in this research, the CPNs divulged that the consultant psychiatrist had indeed embarked on a policy of ensuring that all referrals (from any source) were in the future to be sent to the CMHT before being apportioned to the various members of the team. The consultant had initiated discussion on this policy by conducting a 'study day'. The content of the discussion had been about who the CPNs should be accountable to for their clinical work, and whether they should have a greater allegiance (in terms of how many clients were accepted from general practitioners compared with those from the consultant psychiatrist) to the psychiatric services than at present.

Although agreement had apparently been reached on the issue of all referrals going to the CMHT, one of the CPNs indicated that they would still have close

contact with the general practitioners:

> CPN 13 said that in reality the CPNs would still work closely with the GPs as they (the CPNs) would "go out and see them" (as they do now).
>
> (Field-notes)

The CPNs, therefore, may respond to the imposition of a process which will inhibit their clinical autonomy (and increase the dominance of the consultant psychiatrist) by collecting referrals 'informally' from the general practitioners.

'Passing-on' clients:

Unlike the situation with many of the consultant psychiatrists, the CPNs reported that in general there was little conflict between themselves and the medical staff who were attached to the psychiatric services as part of their post-basic training (but who were not formally part of the CMHT). However, there were a number of instances where conflict arose between the CPNs and these doctors. This is demonstrated in the next extract. Here the CPN is complaining that a client had been 'passed on' by the senior house officer (SHO) who had just completed her post-basic experience in psychiatry in that particular area:

I Did the SHO give you any indication as to what she or he wanted you to do?

R I saw the SHO..... Basically she'd been seeing this man over perhaps four months, during which time he wasn't responding well to medication. He's suffering from depression as a result of really multiple causes. She [SHO] was actually leaving, going to another job, so she was basically passing him on, and that's something to look at in the future so that SHO's don't just do that.

(CPN 13, referral 10)

The CPNs in this health authority explained that many of the referrals they received from these doctors (seventeen referrals in this study were received from this source) were sent to them for this reason.
The CPNs' resentment at being given clients in this manner is not confined to the medical staff. In this next extract the CPN is unhappy about being asked to accept a client who has been discharged by the psychologist. The CPN appears to be complaining that the psychologist is implying that her role is 'supportive' to that of the psychologist. However, the CPN still agreed to treat the client:

I Did the referrer [psychologist] give you any indication of want they wanted you to do with

the client?

R She's been actually known to the department on and off for a period of years, day hospital, well she suffers from chronic anxiety, and he's been seeing her [psychologist] on a one to one basis....., and he feels that he's achieved, you know, what he wanted to do, or thought he could do, but at the same time, rather than cut her off, we can probably manage her.

I Right.

R I sometimes actually question this, er not to the people, and really wonder what role we're actually playing.

(CPN 14, referral 4)

Whenever I asked the CPN about this client, her body language and her tone of voice indicated that she remained irritated with the psychologist. After about three weeks, the CPN decided to refer the client back to the psychologist. The CPN stated that she had decided to do this because she thought that the client was suffering from dementia rather than anxiety. The CPN had contacted the psychologist, who had stated that she also had suspected dementia. This, the CPN stated made her even more irritated as

she couldn't understand why the client had been referred to her in the first place if the diagnosis had not been established fully by the psychologist.

The "passing-on" of clients to CPNs by social workers was also perceived to be a problem. For example, CPN 9 suggested that individuals who had come into contact with the social services, and had a history of mental illness, would be referred to the CPNs unless a member of their staff had a special interest in mental health:

> CPN 9 stated that social workers would "pass on" potential clients to the CPNs unless a particular social worker was interested specifically in mental health. This would definitely happen (i.e. the "passing on"), he said, if the potential client had any past psychiatric history.
>
> (Field-notes)

Whilst the data from this study does not support the levels of "passing-on" of clients suggested in these accounts by the CPNs, what is important to acknowledge is the feeling of resentment the CPNs had about what they believed was the perception of them as a secondary occupational discipline in the field of mental health.

Colonising work:

In one team another cause of tension between social workers (i.e. both the social worker who was part of the CMHT and his colleagues in social services) was commented upon. According to the informant (the social worker in the CMHT), the CPNs were perceived by the social workers as having taken over areas of work that they considered belonged to them. In particular, the social workers were indignant about the CPNs treating clients with counselling. The social worker justified the antagonism felt by the social workers towards the CPNs on the basis that the CPNs (because they had originally been employed in hospitals) are influenced adversely by the medical model. This, in his view, means that the CPNs could not use this therapeutic approach effectively:

> He [the social worker] stated that the CPNs had come from the hospitals about seven years ago, and had threatened some of his colleagues. That is, the CPNs appeared (he said) to want to do "counselling" and his colleagues perceived this as their province. He also stated that although the CPNs wanted this counselling role, CPNs were much more directive/advice giving than social workers. He said that social workers believed that they were much more skilled at counselling than CPNs. There was, he said, something about the

CPNs being 'tainted' by having worked in the hospitals, and this affected how they operated in the community.

(Field-notes)

This view of the CPNs not being capable of using counselling as a form of treatment was repeated by two occupational therapists, one of whom believed that the CPNs made clients too dependent upon them, whilst the other damned their abilities through faint praise:

.....I don't think they [the CPNs] are counsellors, I think they use counselling skills every day in their day to day work but I don't think they are qualified in terms of counsellors.....

(Occupational therapist, Team 2)

Moreover, two consultant psychiatrists stated that a lot of harm had been done to clients because of the CPNs' lack of skills in this area, and suggested that they had on occasions to offer help to clients who had not been treated properly by inexperienced CPN 'counsellors'.
The psychologists, like the social workers, were of the opinion that the CPNs were "very medicalised". They were also very critical of the CPNs for not concentrating on treating the chronically mentally ill, of their competence in assessing the

client's problem, and of their ability to provide specialist therapies:

> I do see them as very medicalised, though I see them as I say as really carrying out to a certain extent reviews of patients' medication, or supervising relapses and checking up on people really. I always thought their role would be much more with the chronic, but in fact a lot of the time they get involved with the worried-well and neurotic..... Where they fall down is not doing these things like analysing the problem, they don't really know what they're doing, and they've not had the training.
>
> (Psychologist, Team 4)

> I have certainly been aware of a lack of skills and expertise [amongst CPNs], and certainly have had the odd referral from a GP where people had seen a CPN and had been angered and upset by their contact. So there obviously are some issues that need addressing.....
>
> (Psychologist, Team 2)

Ironically, while the CPNs are being criticised for indulging in counselling by the psychologists and the

social workers on the basis that they are too "medicalised", the consultant psychiatrists' censure of the CPNs could be related to this form of treatment being regarded as a threat to the dominance of the medical model.

The encroachment by the CPNs on the therapeutic territory of the social workers and the psychologists may, however, have its nemesis. This quotation from an occupational therapist indicates that mental health nurses who work in a CMHT may find eventually that other occupational groups (e.g. occupational therapy) colonise some of their activities. She suggests that the CPNs at present feel vulnerable because this potential re-adjustment to their area of work, and this has caused tension throughout the team:

> .....I think they [the CPNs] feel very threatened at the moment, and therefore that causes tension within the team because they're the most established people here.....and they feel threatened we're going to take on things that they do. There's been a lot about that in the last two years.....
>
> (Occupational therapist, Team 4)

The criticisms levelled at the CPNs may have their roots in inter-occupational rivalry. That is, where a number of disciplines (or agencies) attempt to work in a team which has no verifiable guidelines, where roles and

areas of work are not demarcated, then the scapegoating of a vulnerable group may be inevitable. However, these criticisms may be justified if the CPN is indeed not equipped to perform as a counsellor, particularly if she or he is not supervised, is making arbitrary decisions with regard to treatment, discharge, etc., and whose lines of accountability are not established clearly.

Domiciliary visits:

One other major source of enmity between the CPNs and the consultant psychiatrists, relates to the payments from the health authority for domiciliary visits. There was much cynicism from the CPNs and their manager in one area about the consultant psychiatrist being asked unnecessarily (as they saw it) by general practitioners to see clients. The CPNs in this team regarded this as an infringement on their clinical judgement, and as a way of the consultant psychiatrist making money illegitimately.

In this extract from an interview with one of the CPNs in the team in question, she describes how she had a conversation with the consultant psychiatrist about a client, and had recommended a drug to counter the side-effects of some other medication the client had been prescribed. The consultant prescribed the recommended drug, and also decided to visit the client at home, ostensibly because he had received a request to do so by the general practitioner. This is despite the

CPN's protestation that this was not needed as she had visited the client:

> I came back and discussed it with the consultant, and said in my view that most of her symptoms were extra-pyramidal..... So he agreed and prescribed her Kemedrin. But he'd also received a referral from the GP to do a DV [mimed 'money' by rolling her fingers]. I said that I didn't feel that was essential now. He said, 'well we've got to respond', and I said, 'well I've just seen her'. So of course he went, and he felt that the reason that she'd deteriorated was physical, he felt she was suffering from bronchitis. He quite often ties the two together, physical and mental deterioration. And he also felt there was an element of depression and prescribed some antidepressants. But I could still go and do the eh [laughs].
>
> (CPN, unidentified)

The CPN's impression of the consultant's motives being more acquisitive than Hippocratic is supported by the nurse manager. The manager, in this extract, suggests that the consultant psychiatrist refuses to accept a client unless he receives a request to do so from the general practitioner. Such a request entails the consultant going to see the client in her or his home, and for this he receives a fee:

.....a GP comes to me and says can I see this person, and I might go and see them and want to refer them to the consultant, but even if it's in a team meeting he'll say 'I'm not accepting that one, you tell the GP to get in touch with me'. I go back to the GP, the GP gets in touch with the consultant, the consultant goes out and gets the money. It's an abuse of the system.

(Manager, unidentified)

I do not know whether or not the CPN's and the manager's views of the consultant psychiatrist's motives for conducting domiciliary visits have any validity. However, because the CPN and the manager believe this to be the case, it doesn't matter whether or not it was true. The CPN and manager's low opinion of the consultant psychiatrist is an indication of poor relationships within the CMHT, irrespective of what 'facts' are called upon.

However, it also exemplifies the structural difference between CPNs and consultant psychiatrists. That is, the consultants' dominant position, and that of medical profession, is legitimised through this system of domiciliary visiting. It is a system which is activated by the medical profession (i.e. by general practitioners), and serviced by the medical profession (i.e. by consultant psychiatrists), to the exclusion of any other discipline in the CMHT.

4.5.2.Skulduggery

Reactions to the dominance of, or the attempts at dominance by, the profession of psychiatry differed amongst the occupational groups in the CMHT. For example, the principle strategy adopted by the psychologists, as I have mentioned already (see section 4.4.2.), was to avoid being co-opted as full participants in CMHTs. This strategy by the psychologists had the consequence of creating the impression amongst other members of the teams in the study that the psychologists were less than wholly committed to the concept of CMHTs, and produced a certain degree of disillusionment amongst some of the CPNs (particularly in Team 1) about this form of organisational structure.

As has been noted (see section 4.3.1.), the reaction of the CPNs to the consultant psychiatrists stipulating what treatment they expected to be implemented for the clients they refer is often one of hostility. In the quotation below, the CPN recalls that she had been asked by the consultant psychiatrist to visit a client who had "absconded" from hospital after having been admitted following an attempt at suicide. The CPN states that the consultant wanted her to ensure that the client was "alive and well":

I Did the consultant indicate what he wanted you to do with her?

R Just to check on her address to see whether she was alive and well.

I Is this someone you know?

R She is known to the hospital but not to me personally. She has a long history..... The reason why she was referred was that she had been admitted to [the general hospital] earlier in the week after an overdose, and she'd absconded, and I was asked to call at the address to see that she hadn't done any harm to herself, to see if there was anything I could do.

The CPN's non-verbal behaviour (i.e. her facial expression) suggested that she was not pleased at having been asked to contact the client. When probed further, she expresses her anger at what she perceives as the consultant psychiatrist asking her to carry out inappropriate tasks. The CPN, however, does attempt to contact the client (without success):

I You agreed to that, that was something you felt comfortable with?

R Well I wasn't really, but I felt that if I didn't and she had harmed herself, that I wouldn't have been able to live with. I felt I had to go and make an effort. So, I did two

visits, neither of which was answered. So, I got back to the consultant and explained the situation, and said 'I've been back twice, how many times would you like me to continue trying to trace this girl'..... It seemed to me that I was going to have to clear up someone else's inefficiency if you like. She'd been an in-patient in hospital, she'd taken an overdose, why wasn't she observed? Why wasn't she kept an eye on if she was at risk? But I was annoyed because I had to go and find out where she was and if she hadn't hung herself. That was the feeling I didn't like. But after saying that, I wasn't so annoyed that it stopped me actually responding instead of saying 'sod it, you sort it out', because if I hadn't of gone and she had hung herself or whatever, then that would have been harder for me to live with. But I was annoyed, because I felt I was being used if you like, and I also felt that it was an inappropriate referral for a CPN anyway.

I You mean anyone could have knocked on the door?

R Why didn t they ring the social worker? Why didn t they use the hospital social worker?

(CPN 11, referral 12)

As with the issue of medical responsibility (discussed in the previous section), the CPN enters into a double-bind of her own making with respect to her occupational standing. That is, whilst complaining about being used by the consultant psychiatrist to "clear up someone else's inefficiency", the CPN does not refuse the request. The CPN justifies her actions on the basis that if the client had committed suicide, and she had not attempted to make contact, she would been left with feelings of guilt. Whatever the moral argument for visiting the client in these circumstances, doing so has the effect of reinforcing the CPN's subservient role to the consultant psychiatrist.

This CPN avoided open conflict by acquiescing to the supplications of the consultant psychiatrist. However, as a number of researchers have observed (Stein, 1967; Hughes, 1988; Wright, 1985), nurses often use tactics which avoid public disagreements between medical and nursing staff, but allow the nurses considerable influence over the decision making process. Indeed, whilst not indulging in an overt power struggle with the consultant psychiatrists, the CPNs in this study executed a number of skulduggerous strategies in order to achieve their goals.

Non-compliance:

Three strategies in particular were implemented to deal with the problem of unwelcome control being exerted by

the consultant psychiatrist, the first of which was 'non-compliance'. That is, the CPN deliberately followed another course of action to the one suggested by the consultant psychiatrist as a way of asserting her or his self-adjudged right to make decisions independently.

The following extract from the Field-notebook illustrates the use of intentional non-compliance (other examples have been given in section 4.3.1.). Here the CPN does not confront the consultant psychiatrist about the prescription of a treatment regime he expects the CPN to follow. Instead, the CPN replaces the consultant's plan with his own, without informing the consultant:

> CPN 15 stated that when he had got back from holiday he had been asked to take on referral 12 by the consultant. He stated that the treatment regime had already been written out by the consultant. CPN 15 agreed to accept the client ("you don't have much choice in these circumstances", he said), but stated that he would write out his own care plans, after first assessing the client, to replace those written by the consultant.
>
> (Field-notes)

Diplomacy:

Much more commonly, however, the CPNs attempt to accomplish their own objectives (as well as avoid open conflict) through 'diplomacy'. For example, they present a negotiating stance to the consultant psychiatrists, and appear to be willing to reach a compromise by giving concessions. However, as this quotation indicates, this may only be a means to an end:

I Have you ever come to a situation where what the consultant has asked for, you have disagreed with that request?

R Yes, yes.

I What happened?

R Well, he wasn't very happy, as you can imagine. It's never gone too far down the road. It usually ends up with some element of compromise if you like. I mean I've never actually got to the stage where I've said 'I'm categorically not doing that'. I usually end up going for one or two visits or whatever.

(CPN 7)

The CPN is suggesting that when he is given an inappropriate referral, he agrees to take her or

him onto his case-load, but intends to visit the client only once or twice before discharging her or him. That is, CPN 7 is implying that in situations where conflict may arise, the consultant psychiatrist is led to believe that a compromise has been reached. The CPN then behaves as though he is carrying out the negotiated action. However, this is a facade as he is intent on eventually re-installing his own plan.

Sweeteners:

A more extreme but not uncommon type of skulduggery indulged in by the CPNs to avoid open conflict but also to get their own way is through the use of 'sweeteners'. These sweeteners take the form of deliberately accepting a limited number of 'inappropriate' clients from the consultant psychiatrist:

> CPN 12 had had a conversation with the consultant during which she had stated that she wouldn't just accept any referrals from him. She would decide which ones to accept and which ones not to. However, she admitted that she had accepted a couple of referrals from him 'just to keep him sweet at present'.
>
> (Field-notes)

The CPNs did not just use this approach on the

consultant psychiatrists. It was also utilised as a way of manipulating the general practitioners. In what appeared to be quite a widespread activity amongst the CPNs, CPN 13 explained that the primary reason for accepting one particular client onto his case-load was to encourage a "good relationship" between himself and a general practitioner:

> CPN 13 stated that he had accepted referral 25 essentially to encourage the development of a good relationship with the GP who had referred him.
>
> (Field-notes)

The result of the CPNs accepting clients who they didn't believe were appropriate referrals reduces conflict and increases the CPNs' ability to operate autonomously in other circumstances. It also has the consequence of constructing both the CPN's case-load and the psychiatric career of the clients concerned in a way which is not closely associated with the needs of these clients.

Other forms of skulduggery were also employed by the CPNs:

> .....CPN 8 said, '.....usually I don't go to them [the GPs] unless I know exactly what I want doing'..... CPN 8 described a letter she sent to one GP which was phrased (she

admitted) so that the required response (i.e. no response) was inevitable.

(Field-notes)

Here the CPN is admitting that she consciously presents an interpretation of the 'facts' in order to achieve the required (from her point of view) response from a general practitioner.

Allegiances:

A much less common strategy used by the CPNs to challenge the power of the consultant psychiatrists was the formulation of allegiances within the CMHT. Over many months of collecting data in one of the CMHTs I recorded the events surrounding one such campaign. Unfortunately for those involved in this inter-occupational axis, the consultant psychiatrist fought an effective war of attrition, and eventually returned to his old ways of dominating the team.
The saga commenced with CPN 12 complaining about how she had been treated by the consultant psychiatrist when she first joined the CMHT:

> She [CPN 12] said that when she first started the consultant had asked her to 'pop in here and pop in there'. This meant, she said, that she had been extremely busy without any time to think about what she was doing. She said

> that she is in control of this now, but very resentful about the consultant psychiatrist calling her 'his CPN'.
>
> (Field-notes)

The CPN went on to explain what happened in the CMHT meetings. In particular, she talked about the tension that existed between the consultant psychiatrist and the other members of the team. This tension related to the consultant's influence over the content and process of the team meetings. She referred to a conspiracy that emerged when the consultant psychiatrist had gone on holiday that was aimed at reducing his control over the team during these meetings:

> She said that the consultant tended to dominate the team meetings, and whilst he had been on holiday (he is at the moment) the other members of the team had arranged to meet to formulate a plan to change this. They were to meet to talk about being less 'consultant orientated'. They were to present their plan at the next team meeting when the consultant was present.
>
> (Field-notes)

When the consultant psychiatrist came back from his holiday, he was duly presented with 'some issues' by

the other members at the meeting of the CMHT. However, the CPN reported that he had been one hour late for the meeting:

> We had our [CMHT] meeting, and it was eh interesting. [laughs] I mean the meeting was for nine O'clock and we'd asked everybody to be there prompt at nine. I had a crisis with one of my clients so I couldn't be there at nine, and [the consultant] didn't turn up until ten O'clock. It just devalued it a lot really. If people can't get there for nine. I mean I couldn't help it. But anyway, we resolved some issues, and I think time will tell, and we'll review in about three months to see if anything is actually happening [i.e. about the CMHT being dominated by the consultant].
>
> (CPN 12, Team 3)

The way in which punctuality (or lack of it) is used to establish the source of power in the CMHT is also commented upon by the manager of the CPNs in this health authority. He points out that although the consultant psychiatrist is late regularly, and even though other members of the team (e.g. the psychologist) attempt to commence the meeting, it does not start until the consultant arrives:

> It's quite interesting sometimes because we are supposed to start at nine-thirty, and [the consultant] is always late, and it's a bit annoying. Then we decided it should start at nine-fifteen and then [the consultant] wanders in at twenty-to-ten, and the interesting thing is that it doesn't actually start 'till he gets there. So whereas it should be everybody's here why don't we start now, everybody starts saying 'Well let's give him another five minutes'. So the psychologist says, 'Well my time is valuable, we agreed to start at that time, therefore we *should* start', but at the end of the day we still didn't start. So there was a little bit of a battle going on.
>
> (Manager, Team 3)

The chairing of the CMHT had been a central issue. Up until the time the consultant went on holiday, according to the CPN, the consultant psychiatrist had assumed the role of chair for the meetings. Both the CPN and the nurse manager stated that the consultant chairing the meetings had the effect of turning them into 'allocation meetings'. That is, the meetings were not the coming together of equals who collaborated over the treatment of clients. Rather, they became an arena for the consultant psychiatrist to affirm himself as facile princeps through the mechanism of taking control over

the distribution of the referrals that had been sent to the CMHT:

> It was..... an allocation meeting, and that's what I meant about it being hierarchical, it was coming down to the medical staff just handing out referrals and that sort of thing.....it should be a forum for discussing cases, and deciding who is the best to do an assessment on behalf of the team and coming back and deciding who's got the skills on offer.....instead of that there was this allocation meeting.
>
> (Manager, Team 3)

Who should chair the meetings of the CMHT, and what should be the function of the meetings, were two of the issues that were discussed with the consultant psychiatrist when he returned from his holiday. The CPN reported that the consultant was a little "resistant" to the suggestion of rotating who chaired the meetings (which she predicted would also alter the purpose from 'allocation' to one which encouraged collegiality), but eventually relented. At this stage the CPN was optimistic about the possibility of change occurring. Some weeks later I asked the CPN what was happening in the meetings. She explained that while there was still room for improvement, the consultant psychiatrist had attempted to alter his approach, and that the chair was

now being rotated amongst all of the members of the team:

R I'll touch wood when I say this. Um, the team has a lot to be desired, but his [the consultant psychiatrist] attitude has improved immensely.....

I Has anything changed in terms of the structure of the team? Is there a rotating chairperson?

R Er, well I did it one week, and last week somebody else did it. We're all going to do for a month.....really he's trying. I think possibly he doesn't think it's going to change a lot, but at least he's trying, that's the important thing.

(CPN 12, Team 3)

On the last day that I collected data from CPN 12, I asked for an update about the situation with regard to the CMHT meetings. It would appear that the operation of the team had returned much to the way it had been operating previously. That is, from the CPN's account the consultant psychiatrist was orchestrating the meeting once again:

I And how is that going, just to get an update? Not very well by the look on your face?

R No comment.

I Has it slipped back to the way it was?

R There are some aspects that aren't negative, there are some aspects that are good. It's still very, if there's a referral comes in, and he's not quite sure what the referrer is asking for he sort of just tries to pass them on to anybody without really exploring who's the most appropriate person to take it, and er you know.....it still feels a bit like school where it has to be dished out, really.

I Sounds as though it's gone back to the way it was before?

R Oh, it's very medically orientated. It's such a shame really.

(CPN 12, Team 3)

Conflict over how the team meetings (and by implication other aspects of the team's activities) should be conducted is illustrated in this account supplied by CPN 12. The attempt by the other members of the CMHT to usurp the power of psychiatry, and produce a more democratic system in the team meetings, appeared to fail.

It is questionable whether any of the skulduggery the CPNs undertook was at all effective in changing the power relationship between them and the consultant psychiatrists. Their tactics were undercover, and therefore so were their successes - that is, both went unnoticed.

Moreover, the CPNs in this study were not engaged in an organised confrontation with the medical staff with the aim of asserting their occupational credentials. They played a 'game' in which their role was to act like affronted and rebellious children when directed by an omnipotent parent. As with other doctor-nurse games (see Chapter 2), the degree to which the dominance of the profession of medicine over the occupation of nursing is tempered is only marginal.

4.5.3.Policing the mad

> A lot of people are asking at the moment 'what is the role of the CPN?' I think a lot of people are starting to say 'these are expensive people, what are they doing'.
>
> (Manager, Team 4)

The role of the CPN as expressed by the CPNs in the study, by their colleagues in the CMHT, and by their managers is not without ambiguity. For example, there is a tension between the CPN's professional aspirations and what she or he does in practice. There is a further tension between these aspirations and the specific functions that other members of the team wish the CPNs to perform.

The members of the CMHT and the nurse managers were asked in the Focused-interviews what they considered the role of the CPN to be. Most of the informants were unable to provide a clear and detailed definition of the role of the CPN. Furthermore, a substantial amount of role-blurring and role-overlap was reported to exist between the various disciplines in the team:

> Um, so yes, there is a fair bit of overlap between the professions, I think.
>
> (Consultant psychiatrist, Team 3)

The blurring of roles in the CMHT affected in particular the CPNs, the social workers (see the discussion on 'counselling' in section 4.5.1.), and the occupational therapists:

> I personally think that in the community the role [of the CPN] has become very very blurred and, to a certain extent when I'm working with a client, I don't think the actual nature of the work is any different to if a CPN's doing the work.
>
> (Occupational therapist, Team 1)

> The general question about the role of the CPN - she stated that it overlaps very much with the occupational therapist.....
>
> (Notes from interview with occupational therapist, Team 2)

That is, as has been suggested in previous sections, the consultant psychiatrists and psychologists did not consider themselves to be in the same pool of occupational skills as the other disciplines. Consequently, references were not made to the over-lapping or blurring of the role of the mental health nurse with that of members of these 'senior' disciplines. The role of the CPN was perceived to be

supportive of, rather than in competition with, psychiatry and psychology.

Administering medication:

Whilst virtually all of the members of the CMHTs in the study implied that it was difficult to identify aspects of their roles that were specific to one discipline, one common theme with reference to the role of the CPN was that of the administering and monitoring of medication:

I Is there anything else in particular that the CPN is involved in that no other mental health worker is involved with? Is part of their role specific to them?

R I think giving injections probably is about the main thing.

(Social worker, Team 4)

.....I think they get lumbered with monitoring medication as one of their main roles.....

(Occupational therapist, Team 4)

She said that most of the roles link in very closely these days, i.e. there was not an enormous amount of difference between the

roles. She said that the main difference was that the CPNs were more experienced on the medication side.

(Notes from interview with Occupational therapist, Team 3)

One consultant psychiatrist, when asked the question 'What makes a bad CPN' responded that he considered 'bad' CPNs to be those who would not accept this part of their role:

.....he [the consultant psychiatrist] said bad CPNs actually were the ones.....who actually refused to give the medication when he'd asked them to give the medication.....

[Notes from interview with consultant psychiatrist, Dr. L, Team 1]

As this last quotation implies, there was amongst the CPNs some ambivalence towards been asked by consultant psychiatrists (and general practitioners) to administer medication to clients. A number of the CPNs complained that they did not wish to be used primarily by the medical staff as the 'injection nurse'. That is, there appeared to be a conscious effort being made by these nurses to rid themselves of one of the conventional components of their role - to give long-lasting injections of major tranquillisers to the chronically

mentally ill.

Those CPNs who objected to this function argued that the administering of injections could be carried out by nurses from other divisions of nursing. For example, if the client attended a day hospital, then the nurses who were employed there, they suggested, could provide the client's medication. Alternatively, the injections could be given by a district nurse, or a nurse employed by a general practitioner. That is, these CPNs appeared to regard the giving of injections to the mentally ill as a waste of their expertise (an expertise they failed consistently to define).

Anger at being expected to fulfil the role of the 'injection nurse' is expressed in this following quotation from CPN 7. However, in this instance it isn't the consultant psychiatrist or general practitioner who has asked the CPN to fulfil this role, but the nurse manager. The CPN had made an appointment with the manager to complain about being asked to do "too many" injections by the consultant psychiatrists. Ironically, the manager had then asked him to visit a client who required an injection:

I Did the [manager] give you any indication as to what he wanted you to do?

R Um, Yeh. Give him an injection.....

I How did you feel about that?

R Um,.....I suppose I felt bit angry about it because I'd actually gone to see [the manager] about me doing too many injections, then he ends up giving me another one. I'd been talking to him about the justification of CPNs doing injections, and whether I was doing too many, and I wasn't getting any guidance on that....., and we looked at the reasons for that, and then he gave me this other one. So I suppose at the time I was a bit miffed.

(CPN 7, referral 3)

However, at other times the CPNs appeared to accept willingly the aspect of their work that was associated with the giving and monitoring of medication, whether or not this was taken by injection. In this next extract, the CPN justifies accepting a client from a general practitioner because she is receiving psycho-therapeutic medication. Although he is going to use counselling as a treatment with the client, he sees part of his role very clearly as to do with monitoring the effect of her drugs:

I Why did you accept her as a referral?

R First of all, I accepted [to] provide the assessment because the information given by the GP seemed appropriate, and he said specifically a CPN because medication is

involved, so I took that as an appropriate CPN referral. I've seen her, and explored with her her current experiences of depression, and feel that she is, well, she'd benefit from counselling involvement, and a general assessment of her medication and how she's responding to her medication.

(CPN 10; referral 5)

In the following quotation, not only does the CPN appear to accept the specific task of contacting the client to administer medication (when requested to do so by the general practitioner) without equivocation, the CPN's language implies that she perceives the client's decision not to take medication as a form of deviancy. That is, the expression "defaulting in attendance" implies a normative expectation in the role of 'client' (particularly those that are "known") which is to be a passive recipient of treatments handed out by the psychiatric services:

I Why did you accept him as a referral?

R Because he is a patient known to us. I've had dealings with him before when he was defaulting in attendance [to the day hospital] for his depot injection..... He seems to be quite well managed in the community without much intervention, so when

[the general practitioner] says then you go because usually there is a reason.

(CPN 11, referral 2)

The data suggest, therefore, that the CPNs are not consistent in what they believe their function to be with reference to providing medication to clients and reviewing its effects. However, as has been illustrated above, the CPN's colleagues in the CMHT are in accord with one another about this aspect of mental health care in the community being the province of psychiatric nurses.

It could be argued that in a situation where there is perceived to be so much role blurring and role overlap that the CPNs, to protect their occupational identity, should invest more energy into this area of work. That is, if the knowledge and skills associated with this form of treatment cannot be colonised by the other 'junior' disciplines in the CMHT, then community psychiatric nursing may survive as a distinct occupational category if its members become committed to expanding their role as the sole providers of this service.

The chronically ill:

Another conventional element of the CPN's role, that some have argued is being abandoned (Weleminsky, 1989), is working with the chronically mentally ill. Much

criticism was levelled at the CPNs, especially by the consultant psychiatrists, about neglecting this area of work. That is, it was suggested that the CPNs had become too embroiled with the client group that was referred to as the 'worried well'. The clients in this group are principally those who have been diagnosed as suffering from neurotic illnesses, and who are in the main referred directly to the CPNs by the general practitioners.

The consultant psychiatrist in Team 2 suggests that the CPNs, and other members of the CMHT, were inclined to want only to provide treatment to "interesting" and "rewarding" clients, and not to those who suffer from long-term mental illness. He argues that while the 'worried well' may need input from the psychiatric services, the care of the chronically ill is more important because this group is "vulnerable":

> .....I just worry about everybody getting taken up in primary care, not because I think that's necessarily a bad thing, but because I think that there's a tendency for people to get side-tracked into interesting and not necessarily the most important things, like it's great for CPNs to do or other professionals to do support groups for married mothers and things which is fine, but here we've got a high percentage of chronic, severely mentally ill people and in my book they come first, the well people who are

> worried are in need of help but the chronically mentally ill have to come first because they're the most vulnerable basically. If we've got any time over at the end I'd like to diversify but what can happen is that all the exciting and interesting and rewarding things get done and the chronics get left to fester basically.
>
> (Consultant psychiatrist, Team 2)

This concern about the CPNs concentrating too much on primary prevention and referrals from general practitioners is echoed by the consultant psychiatrist from Team 3. He states that he wants CPNs to work with clients on his case-load (which he implies are predominantly sufferers of chronic illness). General practitioners, if they want to use CPNs, should "provide their own". Furthermore, in an implicit criticism of their occupational aspirations, he takes a sideswipe at CPNs for their attempts to become "exclusive", and suggests ownership - and therefore domination - of CPNs by referring to "his CPNs":

> I like to able to say that my, the CPN attached to my team will look to my work-load .....and if GPs want to provide their own CPNs. It's a question of resources. Um, what else. I sometimes get the feeling that CPNs see themselves as a very exclusive bunch.....

There is a trend at times to expand that into guidance for the worried well who have, I'm sure, some measure of distress, some psychological morbidity..... So yes, in an ideal world the CPN could be expected to be involved with those people, given the resources. I would also say, that CPNs, from my point of view, should be confining themselves to a secondary health care role. .....sometimes CPNs try to get themselves more involved with primary care at the expense of secondary care, perhaps unable to go and see people with chronic problems because they are too busy seeing people with minor problems.

(Consultant psychiatrist, Dr. W, Team 3)

One of the nurse managers was aware of the need for the CPN not to leave behind her or his work with the long-term mentally ill. He suggests that they are very effective in the rehabilitation and maintenance of psychiatric patients in the community. However, the manager also points to this type of work being the "bread and butter" of the CPNs' practice. That is, he is implying that treating the chronically mentally ill is an area of work that belongs exclusively to community psychiatric nursing:

.....I was reading an article just the other week, and what it was saying was that okay if

> the CPN tends, in mental health centres, to drift away from what you'd term the bread and butter stuff of long-term mental illness, then their effectiveness is questionable. But if they were to stay with the long-term enduring mental health, psychotic problem, the skills, they're invaluable, they would reduce the admission rates. So that's where, we don't need to focus on that area exclusively, but that's an area that we shouldn't leave behind because we've got skills in that area that nobody else has got, and there is more and more people with those problems being rehabilitated, resettled into the community, and that's an area that we need to keep.
>
> (Manager, Teams 2 and 3)

Surveillance:

The perceived role of the CPNs in this study, therefore, has a number of esoteric facets within the ranks of the 'junior' disciplines. The CPN is identified by her or his colleagues as being concerned with the giving and supervising of medication. Although, the CPN is viewed as having steered away from treating the chronically mentally disturbed, this is considered still to be an area of work that the CPN should commandeer. These elements to the role of the CPN suggest that much of the work of the CPN is expected to be associated with the

surveillance of the mentally ill in the community. The role of the CPN as an ancillary agent of social control was encouraged by most of the consultant psychiatrists. The CPNs were viewed as 'front-line workers' who could monitor the mental state of those people who had already come into contact with the psychiatric services, and report back to the primary agent of social control - the consultant psychiatrist:

> They're sort of an early warning system in that they're out there and they can pick up things which are going on at an early [stage].
>
> (Consultant psychiatrist, Team 2)

> .....I suppose I see the CPNs as on the front-line of the psychiatric services. They are not primary care givers, but in terms of the specialist psychiatric services I think they [are] the frontline.....
>
> (Consultant psychiatrist, Dr. S, Team 1)

Dr. S. then goes on in the interview to be more specific about the role of the CPN in the surveillance of the mentally ill in the community:

> I suppose I also like to use them as policemen, and I'm not sure, you get different views on this, not in the sinister sense, but

> in the sense of dropping in on someone who I'm concerned about just have a chat with them and see how they are, and flag-up problems if there are any, and I'm thinking particularly of the sort of patients who don't want to come to the hospital, who don't like psychiatrists, but have long-term problems.
>
> (Consultant psychiatrist, Dr. S, Team 1)

By describing the CPNs as 'policemen' (and presumably there are also 'policewomen'), he is leaving little doubt as to their social control function.

The CPNs indicated also that the general practitioners used them as surveyors of the mentally ill. In this example, the general practitioner had asked the CPN to visit an individual (who had been previously an in-patient in the local psychiatric hospital) because he had been reported to have undressed in public:

> The GP had not seen him. He was refusing to see the GP. He, well he'd been reported as stripping naked in a pub and walking through the length of the high street late one evening, and that's how he came to their [the general practitioner's] attention.
>
> (CPN 15, referral 7)

Returning to the quotation used to introduce this

section, in which a manager raises the issue of 'what are the CPNs doing', I would suggest that the data demonstrates that there is dissatisfaction about the role of the CPN at present. However, there are indications that what would be welcomed by the other disciplines in the CMHT (especially psychiatry) is an affirming of the CPN's 'supportive' function in the surveillance (or 'policing') of the severely mentally ill the community.

Far from this being a retrograde step for the occupation of community psychiatric nursing and/or for those suffering from mental distress (as is implied by, for example, Peplau, 1994), this role may serve the needs of both of these vulnerable groups. That is (as I discuss further in the concluding chapter), those with long term mental health problems living in the community do appear to require more attention from the psychiatric services, and mental health nurses may well require a change in their occupational strategy.

4.6.SUMMARY

The analysis of the data identifies a number of core themes which relate to the aims of this study (which are discussed more fully in Chapter 5). With respect to the level of autonomy the CPN exercises over the referral process (Aim 1), the CPNs in the study appear to organise their case-loads in a way that can be characterised as arbitrary. That is, the CPNs do not usually assess formally the needs of the clients, and in the main do not receive (or do not accept) guidance from the referrers about what form of treatment may be appropriate. Furthermore, the CPNs would appear to discharge clients without any objective evaluation of the readiness of the individuals concerned for this action to be taken. The CPNs also adopt specific techniques (not necessarily reflective of the requirements of the psychiatric service) to manipulate the size of their case-loads. Moreover, the CPNs do not discuss their clients on a regular basis with the person who made the referral in the first instance, with supervisors or managers, or with their colleagues in the CMHT. This is the case even when the CPN has decided to discharge a client.

With reference to the ideological and structural influences (Aim 2), the CPNs do not have a professional discourse of their own, and the content of their direct contact with clients is affected more by the medical model than any other perspective. The CPNs are influenced also by the uncertainty surrounding the

commitment of the mental health disciplines (particularly that of psychology) to the organisational structure of the CMHT. Moreover, the CPNs' membership of the CMHT is undermined by their acceptance of self-referrals and referrals from general practitioners without these clients first being reviewed collectively by the team. One other influence is the lack of supervision of the CPN's practice, either from within the discipline of community psychiatric nursing, or from other disciplines.

Relationships between the CPNs and their colleagues in the CMHT (Aim 3) are reported to be characterised at times by inter-disciplinary hostility. For example, conflict exists between members of the CMHT. This is focused in particular upon the consultant psychiatrists' attempts to attain or retain dominance, and the strategies that are adopted by the CPNs (and other members of the CMHT) to subvert these attempts. Another aspect to the relationships within the CMHT is the perception of the consultant psychiatrists and the psychologists that they are the senior professional groups within the psychiatric service, and nurses should provide a supportive role. Furthermore, although ambiguity pervades the opinions of the members of the CMHT and the managers about just what the role of the CPN is, the key elements would appear to centre around the surveillance of the chronically mentally ill living in the community.

4.7.ENDNOTES

1. Ironically, Johnstone (1989) observes that the nursing process of treatment-planning has its roots in general medicine.

2. I am using the term 'active' to indicate those clients with whom the CPN had contact on a regular basis (i.e. at least once a month), and 'dormant' refers to those clients who did not receive regular visits from the CPN (i.e. less than once a month).

3. The pre-formulated categories relating to the expectations of the referrer (Question 62 in the Diary-interview Schedule), and to the type of therapeutic style used in the CPN's direct contact with her or his clients (Question 76 in the Diary-interview Schedule), were taken from Barratt (1989).

4. These accounts of what the referrer expected were of course open to interpretation and bias by the CPN. However, on many occasions the CPN actually referred to written communications from the referrer, and these were generally consistent with the CPN's version.

5. The structure of the CPN's case-load will be affected further by the introduction of 'supervision registers' from April 1994 (NHS Management Executive, 1994), and by possible future legislation which may see the implementation of 'supervision orders' (Bean, 1993;

Eastman, 1994).

6. The figure for the number of weeks the CPNs had no direct contact with their clients varies slightly in the tables where this calculation is used. This is because of minor inconsistencies (representing a margin of error of 0.5%) made in the entering of the data into the Diary-interview Schedule and into SPSS. Whilst the different raw numbers remain both in the body of the text and in the tables, the figure expressed as a percentage has been rounded to the nearest whole number (i.e. 59%).

7. The total number of discussions is a larger figure (n = 761) than the number of weeks when discussions were held (n = 565). This is because in some weeks more than one discussion took place.

8. To help clarify the significance of the observed frequencies, the expected and residual frequencies have been included in Tables 7-10 (Norusis, 1993, p.207).

9. The clients who became in-patients were included in the 'care continued' category (Figure 3).

10. These figures for direct contact with the client refer to one occasion in any one week. When more than one direct contact in one week was made (which happened infrequently), the total number of hours involved has been collated and entered in the Diary-interview

Schedule as one visit.

11. For example, with reference to mental health nursing, Paquette et al (1991) describe procedures for nursing diagnosis and the systematic planning of treatment. Kalman and Waughfield (1993) list a number of 'standards' which they recommend for psychiatric nursing. These include:

> The nurse applies appropriate theory that is scientifically sound as a basis for decisions regarding nursing practice..... The nurse continuously collects data that are comprehensive, accurate and systematic..... The nurse utilizes nursing diagnosis.....to express conclusions supported by recorded assessment data and current scientific premises.
>
> (p.13)

12. Kelly and Field (1994) point out that it is a caricature of the medical profession to suggest that its members believe in a uni-directional and bio-chemical oriented explanation for ill-health. They argue, for example, that medicine has incorporated many social aspects in the diagnosis and treatment of illness.

13. Hunt and Mangan (1990) discuss computerised records for CPN services. They acknowledge that at present

community nurses view the information obtained through computerised records:

> .....as giving limited, if not distorted, pictures of their work.
>
> (p.95)

14. For a review of the subject of supervision in the 'helping' professions generally, see Hawkins and Shohet (1989). With reference to supervision in nursing see Butterworth and Faugier (1992). This latter text includes a chapter on the supervision of community psychiatric nurses by Wilkin.
In the report of the Mental Health Nursing Review Team (DoH, 1994, p.2), the issue of supervision for mental health nursing is addressed. Three types of supervision are described: (a) formative (which aims to help develop the skills of the practitioner); (b) restorative (this form offers support to the practitioner when dealing with stressful situations); (c) normative (which is a managerial overseeing of the quality of the practitioners work). The first two of these categories I have collapsed into one category in this section, and used the term 'developmental supervision'.

15. The CPNs did report that they had discussed their clients a further twelve times with their managers. However, the content of these discussions was not stated to be related specifically to supervision.

16. One of the CPNs stated that in the past he had refused to provide treatment to clients who did not want their general practitioner informed of their contact with the psychiatric services.

5.CHAPTER FIVE CONCLUSIONS

5.1.INTRODUCTION

The research problem which is addressed in this study is concerned with the occupational position of community psychiatric nursing in the organisational setting of the CMHT. That is, using Freidson's (1970a; 1970b) theoretical account of a 'profession', the study sets out to examine the claims of *mental health nurses* working in the community to have achieved (or are in the process of achieving) 'clinical autonomy', and to explore the effects of becoming members of the CMHT on this autonomy.

This concluding chapter has three sections. In the first section the outcomes of the data analysis are considered with respect to the three aims of the research and the working hypothesis, and an assessment of the CPN's professional status is provided. Concluding remarks are made also in this section about the effects of the CPN's clinical independence on the career pathways of the users of the psychiatric services.

In the second section the implications of the results of this research for social policy are discussed. Following Bean (1980), I am using the concept of social policy in its broadest sense:

.....as being related to an area where a social problem has been delineated and a solution is proposed.

(p.198)

The social problem in this case is the care of the mentally ill in the community in general, and the practice of community psychiatric nursing in particular. Consequently, three areas are covered in this section. Firstly, a brief account of the history of care in the community for the mentally ill is provided. Secondly, in view of recent events concerning care in the community for the mentally ill and also the results of this research, I suggest that the role and occupational goals of the CPN need to be reconsidered. Thirdly, specific recommendations are offered with regard to the practice of community psychiatric nursing, the organisation of CMHTs, and the rights of users of psychiatric services.

Finally, a review of the study is provided. This includes comments on the strengths and limits of both the research design, and Freidson's thesis in light of its application to the practice of community psychiatric nursing. Suggestions for further research are offered also in this final section.

5.2.REVIEW OF THE RESULTS AND AIMS

5.2.1.Clinical autonomy

The CPNs did not refuse any of the referrals they received during the period of this study. That is, all two hundred and fifty two new referrals became clients of the CPNs. Nearly half (48.8%; n = 123) of these referrals appeared to have been accepted for arbitrary reasons. Furthermore, the CPNs reported that they accepted all referrals either because they believed they did not have the right to refuse, or because they were 'morally' obliged to do so. With respect to this latter justification, it was suggested by the CPNs that if they did not accept a referral then neither would anyone else in the team.

However, there is some evidence that the CPNs were able to manipulate the size of their case-loads by such techniques as deciding whether or not to visit the general practitioners' surgeries. Also, 18.3% (n = 46) of the clients in the study were monitored for only one week. This implies that the CPNs may accept all referrals, but may then, within a short period of time, discharge those that they consider inappropriate.

The referrers of 40.5% (n = 102) of the referrals reviewed in the study did not specify what service they expected the CPN to provide to the client. Where the referrer did indicate what was expected, she or he was not specific, nor was there any detailed evaluation of

whether or not the request had been carried out. The data suggest also that when a referrer was directive (and this was usually the consultant psychiatrist), the CPNs would on occasions use certain 'skulduggerous' manoeuvres to avoid implementing these instructions.

Nine of the ten CPNs in the study claimed that they operated an 'open' referral system. The one remaining CPN stated that he would accept clients from any source, but that he would first obtain 'medical cover'. However, the consultant psychiatrists (and other members of the CMHTs) were critical of the CPNs for accepting referrals without these initially going to the team. The consultants stated also that they objected to the CPNs accepting clients and then assuming that they (the consultants) would be responsible ultimately for these clients. A double-bind was created by all but one of the CPNs. On the one hand they appeared to endorse an open referral system as an exemplification of their right to independent practice, but on the other hand they wanted the consultants (or the general practitioners) to be 'medically' responsible.

All nurse practitioners are responsible for their own actions, and are expected to follow their professional code of practice. However, although the CPNs in this study indicated that they wanted either the consultant psychiatrists or the general practitioners to accept 'medical responsibility', neither they nor the nurse managers offered clear definitions of 'nursing' or of 'medical' responsibility. That is, the demarcation between what nurses and what medical staff are

responsible for, with respect to the treatment of their clients, was not established.

Lines of authority were ostensibly obvious in that the CPNs had 'line managers'. However, the relationship between the CPNs and the medical practitioners, and between the CPNs and the team as a whole, overlaps such a linear bureaucratic arrangement. This lack of clarity in who has authority over who produced in this study a significant amount of dissatisfaction amongst the consultant psychiatrists in particular.

The CPNs stated that on their first contact with a client they conducted an assessment of the client's mental condition. Invariably, however, the CPNs did not use any formal and systematic assessment procedure. Instead they appeared to adopt an intuitive style, based on 'instinct' and their own experience. Nor did the CPNs appear to indulge in their expressed commitment to assess each of the new referrals, as by their own accounts only a small proportion of the content of the direct contact with the clients was stated to have been for 'assessment'. Moreover, the consultant psychiatrists appeared to regard the 'diagnosis' of a client's mental state as part of their role, and their ability to conduct assessments was stated as a major criterion which distinguished themselves from the CPNs.

The CPNs discussed their clients (and the treatment they received) very infrequently with the referrers, their colleagues on the CMHT, supervisors, or the managers. On less than a third (n = 565) of the number of weeks of practice (n =1712) that this study reviewed

did the CPNs have a conversation with anyone regarding their clients. That is, for the majority of the time the CPNs made decisions about their clients' treatment without direct discussions with anyone.

Virtually every one of the clients who were discharged by the CPNs during the study (n = 81; 32.1%) were not discussed with any other health professional or manager before this action was taken. That is, not only did the CPNs make independent decisions to discharge clients, they did not consult with any other colleague before implementing these decisions.

The CPNs reported that on only two occasions did they receive formal supervision (either developmental or normative). Informal supervision, however, did exist between the CPNs, although this was on an opportunistic and irregular basis. Moreover, there was no formalised system of reporting installed in the four teams in the study. The CPNs did, for example, send letters to the client's general practitioner (indicating that they were treating the client, or that the client would be - or had been - discharged). However, although the CPNs were expected to produce written communications, in the main their function seemed to be ritualistic. That is, these letters did not usually prompt any further discussion.

The CPNs organised their own working day with respect to how many clients they visited, how much time they gave to each client, and how much of their time they spent in the office. Data were collected (using, for example, computerised records) by the CPNs, and

supplied to their managers. However, there was some doubt about the validity of this data, and in general little direct feedback was given by managers to the CPNs from these records. Nor was there any indication as to how the data were used by management.

The CPN was not perceived by the consultant psychiatrists or the psychologists as being equal in status to themselves. Members of both of these disciplines stated that they could offer supervision to the nurses in the CMHT, but did not see this as a reciprocal arrangement. Furthermore, the consultant psychiatrists appeared to want to change the system of referring clients to one which would result in all referrals going to the team in the first instance. In doing so, they would be placed in a position of potentially regaining control over the work of the CPN, particularly as the leadership of the CMHT was regarded by the consultants as part of their role. This control could be exercised in a way which would encourage the CPNs to concentrate more on the seriously mentally ill than the 'worried well', a move that had the support of the psychologists and to some degree the social workers.

Whilst there was not a formal hierarchy in the CMHTs, the data indicates that an informal hierarchy existed. The consultant psychiatrists, in regarding themselves as the actual or prospective leaders of the CMHT, projected themselves as part of an elite group. The psychologists appeared to believe that they were co-members of this group. That is, the data from the

interviews with the consultant psychiatrists and the psychologists implies that, although to some extent in competition with each other with regard to occupational dominance in the CMHT, both regarded themselves as belonging to 'senior' disciplines. The junior disciplines were therefore perceived to be the other occupational groups in the CMHT. In particular, the CPNs were regarded by the consultant psychiatrists and psychologists as providing a 'supportive' function to the senior disciplines.

The separation of 'senior' from 'junior' *disciplines* in the CMHT by the consultant psychiatrists and the psychologists was exacerbated by the views of the CPNs about their own role and status. For example, by ensuring that each client was allocated a consultant psychiatrist or general practitioner to provide 'medical cover', the CPNs weakened their own occupational position. This was weakened further by a lack of consistency and clarity from the CPNs about what exactly they believe their role to be. Moreover, during the interviews, and in the back-stage discussions, most of the CPNs (for the majority of the time) used the language and symbols associated predominantly with a medical discourse. The absence of a distinct ideology for CPNs increases their susceptibility to medical hegemony.

Ostensibly, the CPNs in the study participated in the CMHT as members of a collegiate body. In theory, therefore, they were amongst equals and could chair or co-ordinate the meetings of the team (and in

one CMHT the co-ordinator was a CPN). However, the data indicates that the relationship between mental health nurses and the consultant psychiatrists was characterised by paternalism and patronage. The consultants regarded the CPNs as in need of being guided by the medical profession. In many instances this perspective was encouraged by the CPNs' deference to the consultants (for example, through the CPNs' inherent and persistent use of the medical model, and their avoidance of open conflict).

However, whatever the structure of the relationship between the consultant psychiatrists and the CPNs is (and the intentions of the former towards the latter are), it could be argued that the data from this study implies that the CPNs at present enjoy a significant amount of freedom in their clinical practice. Consequently, it could be reasoned that the working hypothesis cannot be verified by the data. That is, overall the data may be interpreted as supporting the notion that the CPNs are clinically autonomous when working as part of a community mental health team.

5.2.2.Autonomy by default

> Nightclub magicians and circus acrobats.....form autonomous occupations by virtue of their intensive specialisation..... Other occupations, like cab drivers or lighthouse keepers, are fairly autonomous because their work takes place in a mobile or physically segregated context that prevents others from observing, and therefore evaluating and controlling, performance. In all these cases we have autonomy by default.
>
> (Freidson, 1970b, pp.136-7)

Psychiatric nurses working in the community, by the very nature of their work, operate much of the time beyond the 'gaze' of their line managers, or members of other professional groups. That is, as has been discussed in Chapter 2, CPNs and other community health workers (for example, health visitors, community midwives, district nurses) deliver their service away from any formal organisational setting - i.e. in the home of the service user. This is in direct contrast to the nurse working within an institution. As Nolan observes, referring to psychiatric nurses operating in the community, it is ".....a very different experience for them entirely from working in mental hospitals" (1993, p.137).

Furthermore, because they are not under the direct observation of managers and colleagues, community nurses have much more opportunity to influence the content and structure of their practice compared with nurses based in institutions. In this study the CPNs appeared to exercise a high degree of independence with respect to constructing the characteristics of their case-loads. For example, they were able to determine who and when they decided to discharge, what form of treatment was offered, and how often a client received this treatment. Moreover, the CPNs did not discuss regularly or meaningfully their clients with their colleagues and/or the referrer, nor did they ask for or receive any substantial amount of formal supervision from either their peers, or their managers.

The CPNs were also able to institute certain covert strategies to avoid their work being directed by other disciplines - particularly psychiatry. The potential for the profession of psychiatry to dominate CPNs was undermined further by the latter accepting referrals from general practitioners and self-referrals.

However, this does not indicate the existence of authentic clinical autonomy. The ten CPNs in this study, as in Freidson's example of the cab driver or lighthouse keeper, have gained a substantial level of autonomy over their work 'by default'. Unlike the autonomy afforded to such occupations as medicine, it is not legitimate. That is, the CPNs have not achieved their clinical autonomy through a successful campaign of occupational advancement, which has then been

recognised and condoned by the state and/or society at large. Nor do they occupy a position of actual or potential dominance over other occupational groups within the CMHTs.

The autonomy they have exists because what they do in their practice has been left unobserved and unmanaged:

> CPNs make decisions about clinical situations that they have to deal with, often without consultation with anyone else, not necessarily by design but often because there isn't anybody else to consult with.
>
> (Senior Nurse Manager, Team 1)

CPN practice in the four teams studied in this research, far from being described as exemplifying clinical autonomy, could be characterised as being without 'rigour'. One crucial aspect to the unmanaged work of the CPNs is the effect this may have on clients. The CPNs in this study operated as pre-emptory gate-keepers to the formal psychiatric services. Consequently, the CPNs' arbitrary and unsupervised decision making processes about accepting individuals as 'clients', the length of time the clients remained within the psychiatric system, and what type of treatment they received, must be considered from the users perspective. That is, central to the evaluation of the quality of the psychiatric services must be the accounts of the users' of those services (Rogers et al, 1993; DoH, 1994;

Blom-Cooper et al, 1995).

The two most extreme examples of this lack of rigour that affected directly the service users, are firstly, on many occasions when CPNs went on holiday or were absent from work due to sickness (possibly for many weeks), no other practitioner was asked to contact their clients. Secondly, CPNs appeared to discharge clients not only without any prior discussion with colleagues, supervisors, or managers, but also without reference to any objective evaluation of the client's fitness for discharge.

This latter practice has been condemned in the Ritchie Report (1994), which *examined the circumstances that led* to the murder of Jonathon Zito by Christopher Clunis. Clunis (diagnosed as a paranoid schizophrenic) killed Jonathan Zito on an London Underground platform in December of 1992. In April 1991 a community psychiatric nurse, who had been responsible for treating Clunis with depot injections, had written to his general practitioner:

> At present there is very little I can do, so I am discharging him.
>
> (Cited in the Ritchie Report, op. cit., p.36)

The implication is that this CPN (as with the CPNs in this study) informed the general practitioner of the decision to discharge after the decision had been made, rather than conducting a discussion on the

appropriateness of this action before it was implemented.

5.3.SOCIAL POLICY AND COMMUNITY PSYCHIATRIC NURSING

5.3.1.Community care and the mentally ill

The role of the CPN and expansion of community psychiatric nursing services are inextricably linked with the policy of care in the community of the mentally ill. The existence of community psychiatric nursing is a consequence of the decarceration of the mentally ill from mental hospitals.

Government health policy has emphasised community care for the mentally ill since the 1960s (Jones, 1988; Means and Smith, 1994). However, the process of deinstitutionalisation in Britain can be regarded as occurring in the 1950s. In 1954, there were over one hundred and fifty thousand patients residing in mental hospitals (Barnes, 1990). This was the peak of psychiatric in-patient care. By 1991 there were only sixty three thousand in-patients (Hally, 1994). Many mental hospitals have now closed. Of the one hundred and thirty mental hospitals in existence in 1960, it is predicted that only twenty two will remain open by the end of the century (Health Committee, 1994).

Various explanations have been offered for the demise of institutional care (Pilgrim and Rogers, 1993; Miller and Rose, 1986). The development of pharmaceutical products in the 1950's, it is argued (particularly by the profession of psychiatry), has led to the possibility of people suffering from serious mental

illnesses to be cared for in the community. It is suggested also that a reformist movement, propagated by both sociologists and medical practitioners, assisted further the move towards community care:

> Erving Goffman published his sociological account of the effects of the 'total institution' in stripping away the personality and identity of the inmate..... John Wing demonstrated that institutionalism.....was common to long stay inmates of even well-run mental hospitals.....the solution was not to reform the institution but to do away with it.
>
> (Miller and Rose, op. cit., p.54)

However, as I have discussed in Chapter 2, Scull (1983; 1984) has suggested that with the development of the welfare state, institutional segregation of the mentally ill (as a mechanism of social control) had become too expensive. Consequently, for Scull, community care has been determined by economic considerations.

Indeed, the resourcing of care in the community remains a topical political issue. With reference to mental health, there continues to be the claim that there is insufficient funding for an effective community care policy. For example, in the House of Commons Health Committee Report (Health Committee, op. cit.) a case is presented for the Government to divert resources into inner city areas. It is suggested in this report that a

permanent Inter-departmental National Advisory Group on Mental Health is set up to oversee policy relating to care in the community to ensure that:

> .....adequate resources are made available for its recommendations.
>
> (p.xxiv)

The Audit Commission (1994) reports that although mental hospitals have closed, ninety two still remain open. The Commission observes that a serious under-resourcing of community care is occurring because most of the funding for adult mental health care in England and Wales (1.8 billion pounds a year) is spent on hospitals.

Scull's view is that the consequence of under-resourcing community care is the creation of a "nightmare existence" (1984, p.2) for discharged mentally ill people. They have become, argues Scull, neglected and homeless. However, Scull's analysis of the causes and process of decarcerating the mentally ill into the community has many deficiencies, a number of which I have described earlier (see Chapter 2). One further and fundamental problem with Scull's approach is that although he does accept that the impact of decarceration in Britain has been less severe than in the United States, in fact very few homeless people in this country are former psychiatric in-patients (Audit Commission, op. cit.).

But, the plight of mentally ill people living in the community in this country, even if they have not been 'decarcerated' from a hospital, is still stark:

> Surveys have shown that the proportions of mentally disturbed people in single homeless hostel populations have grown..... In the 1980s most surveys found that 30-40 per cent had overt psychiatric disorder..... The number of destitute people with serious mental disorder now living more or less permanently in this way is reckoned to be 60-90,000.....
>
> (Murphy, 1991, p.211)

However, unlike Pollock who concluded that the decisions of the CPNs in her study were ".....strongly influenced by the lack of resources" (1989. p.195), a lack of rigour is not necessarily occurring in the teams examined in this study because of the unavailability of appropriate funding. For example, a shortage of staff, and/or an over-subscription of numbers of clients, did not seem to be a major cause of concern for any of the informants. This was perceived also to be the case as described in the report into the killing of occupational therapist Georgina Robinson by a psychiatric patient:

> None of the professionals [including CPNs] complained to us of overwork.....
>
> (Blom-Cooper et al, op. cit., p.166)

Nor, however, would I wish to suggest that there was any wilful dereliction of duty by the practitioners involved in this research. What I argue is that the practice of the CPNs is affected detrimentally because the organisation of the CMHTs is not established clearly. That is, processes of supervision, leadership, descriptions of roles, responsibilities, and lines of authority are not delineated. Therefore, any accusation of 'role-deviation' and culpability on behalf of the individual CPN is inappropriate as neither the ideal typification of role performance nor the perceived role expectations are expressed coherently and systematically by the managers of the relevant health authority. Conversely, it could be argued that if role-deviancy exists amongst the CPNs then it is propagated by the managers because they have not installed, for example, supervisory systems.

Furthermore, although Scull's theory of economic determinism in relation to the decarceration of the mentally ill is weak, his economic perspective does raise the questions of why the CPNs have 'de facto autonomy', and why there is a 'lack of rigour'. That is, Scull's analysis may lead to the suspicion that it is financially expedient for the State and senior managers in the National Health Service to avoid ensuring

community care services are made more effective (through, for example, more stringent supervision of CPN practice) because of the consequent expense. Moreover, if mental health nurses adventure into largely uncharted territory by working with the homeless, as is advocated implicitly by the Audit Commission (op. cit.) and explicitly by the Mental Health Nursing Review team (DoH, op. cit.), then there may be massive, and therefore prohibitive, cost implications.

5.3.2.A reconstructed occupational praxis

> CPNs may be described as the 'artful dodgers' of the mental health world. They have expanded only by stealing roles previously belonging to other occupations without quite knowing what to do when they have them.
>
> (Sheppard, 1991, p.161)

In response to the criticisms of many of the CPNs' colleagues in the CMHTs examined in this study I concur with the recommendation of the mental health nursing review team, that:

> .....mental health nurses should focus on people who have serious or enduring mental illness.
>
> (DoH, 1994, p. 28).

That is, as is recommended by the Audit Commission (op. cit.), mental health nurses working in CMHTs should change their focus of attention from the 'worried well' to treating people with long-term serious mental illness. Specifically, they should provide treatment and care to those people who are described in the Ritchie Report as suffering from "schizophrenia, schizo-affective disorder, paranoid psychosis, manic-depression or a major depression" (op. cit.,

p.vii).

Furthermore, the CPNs need to re-align themselves with the consultant psychiatrists, and the bio-medical model. As I have argued in Chapter 2, both the profession of medicine and the bio-medical model are dominant in the health care arena. The medical profession (supported by bio-medicine), far from being challenged by the 'emerging professions', alternative therapies, etc., is successfully adapting to these threats and consolidating, if not improving, its occupational position. For example, the data from this study indicates that quasi-professional groups such as nursing remain susceptible to dominance from psychiatry. Moreover, the therapies in psychiatry that do not belong to the category of bio-medicine are themselves being criticised for their ineffectiveness and the non-professional behaviour of those that use them (Masson, 1990; Illman, 1993). With particular reference to CPNs, Gournay (1994) states:

> In recent years, CPNs have increasingly begun to use a wide range of therapeutic techniques. However, few.....are supported by any research-based literature.
>
> (p.40)

A strengthened allegiance with medicine for mental health nurses, however, does not preclude involvement with other therapeutic approaches (Brooker and

Butterworth, 1993; Owen, 1994). Indeed, medicine does not limit itself to physical explanations and treatments. But, as Gournay (1990) suggests, advances in such areas as molecular genetics may result in an inevitable resurgence in the status of bio-medicine and the power of medical practitioners in the decision making process. Therefore, in coming under the direct influence of psychiatry, mental health nurses working in the community are more likely to survive as a distinct discipline. That is, linking with medical practitioners may be the most appropriate occupational strategy for a discipline that appears to have lost the opportunity to become a profession, and has failed to produce a self-regulated area of practice and ideology of its own.

Under the auspices of the consultant psychiatrist, the main function of the CPN would become one which consists of administering and monitoring the effects of medication, and surveillance. The latter would entail the monitoring of the mental state of clients (e.g. observing for early signs of deterioration). It would also involve the CPNs actively participating in the implementation of supervision registers (NHS Management Executive, 1994), and in the management of 'community supervision orders' if they are introduced in the future. I agree with Hally's observation that the:

> .....supervised discharge proposals should establish the CPN in a key role in relation to clients with long term difficulties. It is

time for CPNs to embrace this group.

(Hally, 1994, p.11)

There will, therefore, be an increase in the function of the CPN as an agent of social control. However, I do not view the CPN as being complicit in an "Orwellian nightmare" (Bean, 1993) if she or he becomes more involved in these social control measures. There would appear to be a requirement for this role to be carried out in society not only to help maintain the status quo, but to prevent the increasing incidents of apparent neglect by the psychiatric services (Sims, 1993; Brindle, 1994b; Ritchie, op. cit.; O'Connor, 1994). For example, the National Schizophrenic Fellowship (1992) has claimed that people discharged from mental hospitals over a period of one year were associated with one hundred cases of suicide or murder. Boyd (1994), whilst recognising the danger of over-stating the significance of the role of the mentally ill in the rising homicide rate, concedes that during an eighteen month period, thirty four killings were committed by people who had been treated previously for mental illness.

Consequently, it could be argued that by adopting this surveillance role the occupational identity of the mental health nurse will be more secure in the CMHT, and that at the same time she or he would be serving the best interests of the mentally ill:

Maybe the pendulum swung too far: 'freedom' can be a euphemism for neglect, and neglect can be as cruel as oppression.

(Porter, 1993)

5.3.3.Specific recommendations for CPNs and CMHTs

A number of specific recommendations are made with reference to the role and practice of the CPN as a member of the CMHT. Suggestions are also offered with regard to the working of the CMHT.

Essentially, the recommendations that follow focus upon the need to protect the interests of the client. Referring in part to the psychiatric services that were involved in the treatment of Christopher Clunis, the Ritchie Report (op. cit., p.105) states that there had been "..... a catalogue of failure and missed opportunity". These recommendations, therefore, are intended to help prevent such an observation being made about any other psychiatric service:

(a) Care management: The principles of the Care Management Approach (DoH, 1990b) for all clients on the CPN's case-load (i.e. not only those who have been discharged from hospital) should be adopted. In particular, a named 'key worker' should be identified, and have the responsibility for the management and co-ordination of the client's treatment until she or he no longer needs the services provided by the CMHT. This includes consulting with referrers (and the client) about expectations with regard to treatment and prognosis. CPNs should be regarded as playing a "pivotal role" (Patients Association, 1994, p.7) as key workers in the CMHT.

(b) Discharge: No client should be discharged from the CPN's case-load, re-referred to another agency or professional, unless this is first discussed by the team, and agreed upon by the leader of the CMHT. As recommended by Blom-Cooper et al (op. cit.) "essential documentation" in the form of a written evaluation of the client's mental state and social circumstances should be produced before the client is discharged or re-referred. The notion of a "discharge contract", made between the CPN and the client, could be considered (Health Committee Report, 1994).

(c) Referral system: All referrals (from any source) should be sent in the first instance to the CMHT. If the individual who has been referred is considered to be in need of psychiatric treatment, then the most appropriately skilled practitioner should be directed by the membership of the team to accept the client. If no collegiate opinion can be reached, then the team leader should have the authority to delegate the responsibility to a named key worker.

(d) Supervision: Supervision has been identified as essential to the work of mental health nurses (DoH, 1994). The responsibility for the supervision of the clinical work of the mental health nurse working in the community should be taken over by the leader of the CMHT. The team leader could appoint another 'senior' practitioner to conduct the supervision, but should retain overall responsibility for ensuring that an

effective process is put into operation. To be effective, supervision should be mandatory (i.e. enshrined in the CPN's contract with her or his employing health authority or NHS Trust), and both normative and developmental.

(e) Assessment: A written and systematic assessment procedure should be used for all new clients. The team leader should have the responsibility for assessing a client's needs. If this is delegated to another member of the CMHT, then it is important that the results of the assessment are reviewed by the team members.

(f) Authority and responsibility: Unambiguous lines of accountability and authority should be established. For example, the CPN may be accountable to the manager for her or his general working conditions, but could be accountable to the leader of the CMHT for her or his clinical practice. Moreover, I am in agreement with the report 'Working in Partnership' into mental health nursing (DoH, 1994), that protocols defining the roles, and responsibilities of each member, discipline or agency, should be produced.

(f) Holidays and sickness: A temporary 'key worker' should be appointed by the CPN where she or he is absent from work. If this is due to sickness, then the leader of the CMHT must accept the responsibility for appointing a replacement.

(g) Twenty four hour availability; Although this was not a primary concern of this study, a connected issue to that of holidays and sickness is the round the clock availability of the CPN service. Two consultant psychiatrists interviewed in this study stated that they would like to see the CPNs extend their hours to cover weekends and twenty-four hours a day. The Health Committee Report (op. cit., p.xiv) states, "The general picture is of inadequate emergency and crisis services, particularly out of office hours". I would suggest, therefore, that the CMHTs may wish to consider a system of emergency cover.

(h) Quality of service: The Ritchie Report (op. cit.) comments that in the services they reviewed it was noticeable how little attention was paid to the measurement of outcomes or of quality, whether for individual staff or for teams:

> There seem to have been no consequence whether work was done well or done badly.
>
> (Ritchie, op. cit., p.123)

I am aware that in most of the teams that were part of this study, measurements of quality and/or outcomes (e.g. 'Clinical Audit') have been installed. This to be applauded and should be expanded to include all CMHTs. Furthermore, the assessment of quality should include the views of the service users, and the construction of

tools for measuring quality could be carried out in partnership with groups representing clients.

(i) Team leadership: Health authorities and NHS Trusts should provide legitimate authority to the consultant psychiatrists to serve as unequivocal leaders of the CMHTs.

5.4. REVIEW OF THE STUDY

5.4.1.Strengths and limits

This research study has three major strengths. Firstly, methodological and data triangulation has been used in the research design. This has provided data which has high internal validity. Secondly, the study of ten CPNs working in four CMHTs provides an in-depth case study of professional practice in the field of mental health. Thirdly, not only has the research merit because it is applied to a substantive area, it has been driven by an established theoretical perspective. This theoretical perspective, I have argued in Chapter 2, remains robust and has maintained its validity as an analytical tool for examining the process of professionalisation. Moreover, the application of Freidson's 'professional dominance' thesis to the practice of community psychiatric nursing has, I believe, substantiated further the claim made above that this approach is the most appropriate to comprehend the nature of the professions in both industrial and post-industrial society. In this study, Freidson's model has demonstrated that psychiatric nurses working in the community are not and will not become a profession because they do not possess de jure autonomy, and because they remain susceptible to dominance by psychiatrists.

However, the results from a case study such as this

cannot be generalised as the data has a relatively low level of external reliability (see Chapter 3). That is, the study can provide useful insights into the practice of mental health nursing in the community, but no general inferences can be made.

Consequently, whilst the specific recommendations made above have an immediate relevance to the mental health nurses, their colleagues and their managers who were involved in this study, the suggestion of a 'reconstructed occupational praxis' requires careful consideration. It is feasible that in the four teams studied in this research, the mental health nurses could be offered role descriptions by their employing authorities that reflect the modifications in their work advocated here. However, a change in role and occupational goals for all CPNs requires a national debate, and further research.

5.4.2.Further research

More in-depth case studies into the work of psychiatric nurses who are members of community based multi-disciplinary teams needs to be undertaken in order to either confirm or challenge the results from this research. Team work is changing due to the implementation of post-Griffiths community care legislation (DoH, 1989a; DoH, 1990a; DoH, 1990b), the resurgence of the dominance of the medical profession, and the corresponding diminution in the status of such occupational groups as nursing. Therefore, future research must take into account these changes which affect the practice and dynamics of the relationships between members of the multi-disciplinary team.

Moreover, further research needs to be conducted into the direction community psychiatric nursing intends (or is allowed) to go in terms of its occupational position. This is of particular importance now as the occupational category of community psychiatric nursing is not only in danger of being displaced (unless, for example, it reconstructs its identity along the lines suggested above), it may in the future be encompassed within mental health nursing as a whole and disappear as a speciality if the following recommendation of the Mental Health Nursing Review Team is accepted:

We recommend that the title 'mental health nurse' be used both for nurses who work in the community and for those who work in hospital and day services.

(DoH, op. cit., p.50)

6.APPENDICES

6.1.APPENDIX 1

DIARY-INTERVIEW (1st draft)

Each CPN will have a 'Dairy-interview' booklet (retained and completed by the researcher) which will contain a number of referrals)

COMMUNITY PSYCHIATRIC NURSE PROFILE

Date completed:

1. CPN No.: .....

2. CPN TEAM No. .....

3. AGE: (1) 20-29 years [ ]
(2) 30-39 years [ ]
(3) 40-49 years [ ]
(4) 50-59 years [ ]
(5) 60 + years [ ]

4. GENDER: (1) Female
(2) Male

5. ETHNICITY (Self-described): (1) Caucasian/White [ ]
(2) Afro-carribean [ ]
(3) Asian [ ]
(4) Oriental [ ]
(5) Other [ ]

NOTES: .....
.....

6. PROFESSIONAL QUALIFICATIONS (Excluding RMN):

(1) RGN [ ]
(2) RNMH [ ]
(3) RSCN [ ]
(4) SEN [ ]
(5) EN (M) [ ]
(6) CPN Cert/Diploma ENB 810 [ ]
(7) CPN Cert/Diploma ENB 811 [ ]
(8) Counselling Cert/Diploma [ ]
(9) Psychotherapy Cert/Diploma [ ]
(10) Behaviour Therapy Cert/Diploma [ ]
(11) Dip. in Nursing (old regs) [ ]
(12) Dip. in Nursing (new regs) [ ]
(13) Other [ ]

NOTES: .....
.....
.....

7. ACADEMIC BACKGROUND:

(1) Ordinary Degree (BA or BSc) [ ]
Subject.....
(2) Honours Degree (BA or BSc) [ ]
Subject.....
(3) Higher Degree (MA/MSc/MPh) [ ]
Subject.....

NOTES: .....
.....

8. PRESENT EMPLOYMENT TITLE:

(1)	Grade D	[ ]
(2)	Grade E	[ ]
(3)	Grade F	[ ]
(4)	Grade G	[ ]
(5)	Grade H	[ ]
(6)	Grade I	[ ]
(7)	Other	[ ]

DETAILS OF RESPONSIBILITIES: .....
.....
.....
.....
.....

9. LENGTH OF TIME IN PRESENT POST:

(1)	Under 1 year	[ ]
(2)	Between 1 and two years	[ ]
(3)	Between 2 and three years	[ ]
(4)	Between 3 and four years	[ ]
(5)	Over four years	[ ]

10. OTHER RELATED PROFESSIONAL RESPONSIBILITIES

(1)	Member of psychiatric MDT	[ ]
(2)	Are serving or have served as Chairperson/coordinator of MDT	[ ]
(3)	Member of PHCT	[ ]
(4)	Other	[ ]

NOTES: .....
.....
.....

11. SIZE OF CASE LOAD IN TOTAL:

(1)	Below 10	[ ]
(2)	Between 10 and 20	[ ]
(3)	Between 21 and 30	[ ]
(4)	Between 31 and 40	[ ]
(5)	More than 41	[ ]

12. SIZE OF ACTIVE CASE LOAD:

(1)	Below 10	[ ]
(2)	Between 10 and 20	[ ]
(3)	Between 21 and 30	[ ]
(4)	Between 31 and 40	[ ]
(5)	More than 41	[ ]

13. REFERRAL SOURCES:

(1)	Consultant psychiatrist only	[ ]
(2)	Any member of the psychiatric medical team	[ ]
(3)	GPs only	[ ]
(4)	Any medical practitioner	[ ]
(5)	Any member of the MDT	[ ]
(6)	Any referral source	[ ]
(7)	Only those referrals that are selected for me by my manager/ supervisor	[ ]
(8)	Other	[ ]

NOTES: .....
.....
.....

14. OPERATIONAL SITE(S):

(1)	Grounds of psychiatric hospital	[ ]
(2)	CMHC/Resource centre	[ ]
(3)	GP surgery	[ ]
(4)	DGH	[ ]
(5)	Mixture of above	[ ]
(6)	Other	[ ]

NOTES: .....
.....
.....

15. ACCEPTANCE OF REFERRALS:

(1)	I have to accept all referrals made to me	[ ]
(2)	I have to accept referrals only from some sources	[ ]
(3)	I can negotiate over which referrals I accept	[ ]
(4)	I have total control over which referrals I accept	[ ]

NOTES: .....
.....
.....

16. CLINICAL SUPERVISION:

(1)	I receive no formal or informal supervision	[ ]
(2)	I receive only informal supervision	[ ]
(3)	I receive formal supervision	[ ]
(4)	Other	[ ]

NOTES: .....
.....
.....

17. CONTROL OVER THE STRUCTURE OF THE WORKING DAY:

(i.e. when the working day starts and finishes, when meals breaks are taken, and when clients are visited)

(1) There is a set structure to my working day which is pre-organised for me [ ]
(2) I negotiate with colleagues, my manager or supervisor over the structure of my working day [ ]
(3) I have large amount of control over the structure of my working day [ ]
(4) I have complete control over the structure of my working day [ ]

NOTES: .....
.....
.....

18. OTHER RELEVANT INFORMATION:

.....
.....
.....
.....
.....
.....

REFERRAL PROFILE

Date completed: .....

1. CPN NO.: .....

2. REFERRAL NO.: .....

3. DATE REFERRED TO CPN: .....

4. REFERRAL SOURCE:

(1)	GP	[ ]
(2)	Consultant psychiatrist	[ ]
(3)	Other member of the psychiatric medical team	[ ]
(4)	MDT	[ ]
(5)	Self-referred	[ ]
(6)	Social worker	[ ]
(7)	Psychologist	[ ]
(8)	CPN	[ ]
(9)	District Nurse	[ ]
(10)	Health Visitor	[ ]
(11)	PHCT	[ ]
(12)	Other	[ ]

NOTES: .....
.....

5. AGE:

(1)	Below 20 years	[ ]
(2)	20-29 years	[ ]
(3)	30-39 years	[ ]
(4)	40-49 years	[ ]
(5)	50-59 years	[ ]
(6)	60 + years	[ ]

6. GENDER:

(1)	Female	[ ]
(2)	Male	[ ]

7. ETHNICITY:

(1)	Caucasian/White	[ ]
(2)	Afro-carribean	[ ]
(3)	Asian	[ ]
(4)	Oriental	[ ]
(5)	Other	[ ]

NOTES: .....
.....

8. MARITAL STATUS:

(1)	Single	[ ]
(2)	Married	[ ]
(3)	Separated	[ ]
(4)	Divorced	[ ]
(5)	Cohabiting	[ ]
(6)	Single	[ ]
(7)	Other	[ ]

9. EMPLOYMENT STATUS:

(1)	Full-time Reg Gen Category	(i)	[ ]
(2)		(ii)	[ ]
(3)		(iii)	[ ]
(4)		(iv)	[ ]
(5)		(v)	[ ]
(6)	Part-time Reg Gen Category	(i)	[ ]
		(ii)	[ ]
		(iii)	[ ]
		(iv)	[ ]
		(v)	[ ]
(7)	Full-time housewife/husband		[ ]
(8)	Unemployed		[ ]
(9)	Full-time student		[ ]
(10)	Other		[ ]

NOTES: .....
.....

10. INDICATION OF INITIAL REFERRER'S EXPECTATIONS:
(REF. BARRATT, 1989)

(1)	Assessment	[ ]
(2)	Counselling	[ ]
(3)	Giving medication	[ ]
(4)	Other physical care	[ ]
(5)	Advising	[ ]
(6)	Education	[ ]
(7)	Specialist therapy	[ ]
(8)	Reassurance/Support	[ ]
(9)	Monitoring	[ ]
(10)	Evaluating	[ ]
(11)	Other	[ ]
(12)	Unspecified	[ ]

NOTES: .....
.....
.....
.....

11. CLIENT'S PSYCHIATRIC HISTORY:

(1)	Previous in-patient care	[ ]
(2)	Previous out-patient care	[ ]
(3)	Previous in-patient and out-patient care	[ ]
(4)	Previously treated by GP	[ ]
(5)	No previous psychiatric history	[ ]

12. PREVIOUS CPN INVOLVEMENT:

(1)	Yes	[ ]
(2)	No	[ ]
(3)	Unknown	[ ]

13. DIAGNOSTIC CATEGORY (ICD):

(1)	Psychosis	[ ]
(2)	Neurotic disorders	[ ]
(3)	Personality disorders/psychopathy	[ ]
(4)	Alcohol/Drug dependence	[ ]
(5)	Anorexia Nervosa/Bulimia	[ ]
(6)	Other	[ ]
(7)	Unclassified	[ ]

NOTES: .....
.....

14. MAJOR PRESENTING SYMPTOM/BEHAVIOUR:

(1)	Anxiety	[ ]
(2)	Depression	[ ]
(3)	Phobia	[ ]
(4)	Delusions	[ ]
(5)	Hallucinations	[ ]
(6)	Delusions and hallucinations	[ ]
(7)	Confusion	[ ]
(8)	Overactivity (hypomania/mania)	[ ]
(9)	Aggression	[ ]
(10)	Self-harm (actual)	[ ]
(11)	Self-harm (intonated)	[ ]
(12)	Drug/Alcohol addiction	[ ]
(13)	'Problems with living'	[ ]
(14)	Sexual problems	[ ]
(15)	Over eating/Under eating	[ ]
(16)	Other	[ ]

NOTES: .....
.....

15. KEY WORKER ATTACHED TO CLIENT:

(1)	Above named CPN	[ ]
(2)	No Key Worker identified	[ ]
(3)	Other MDT member	[ ]
(4)	Non-MDT Health Care Professional	[ ]

NOTES: .....
.....

16. DIRECT INVOLVEMENT OF HEALTH CARE PROFESSIONALS (OTHER THAN ABOVE NAMED CPN):

(1)	No-one else	[ ]
(2)	Other MDT member	[ ]
(3)	Non-MDT Health Care Professional	[ ]

NOTES: .....
.....
.....

17. REASON FOR REFERRAL BEING ACCEPTED BY THE CPN:

(1) It was delegated to the CPN [ ]
(2) CPN accepted the refferal following negotiations with colleagues [ ]
(3) CPN consciously chose to accept referral [ ]

NOTES: .....
.....
.....

18. OTHER RELEVANT INFORMATION: .....
.....
.....
.....
.....
.....

N.B. INFORMATION FOR THIS SECTION WILL BE GATHERED VIA INTERVIEWS AND DOCUMENTARY ANALYSIS

CPN-REFERRAL 'ACTION'

Date Completed: .....Covering period from.....
to.....

1. CPN NO.: .....

2. REFERRAL NO.: .....

3. WEEK NO.: .....

4. HAVE YOU HAD 'FACE TO FACE' INTERACTION/CONTACT WITH THE CLIENT DURING THIS WEEK?

(1)	Yes	[ ]
(2)	No	[ ]

(If yes then ask question 5 to 10}
(If no then ask questions 10)

5. HOW MUCH TIME DID YOU SPEND WITH THE CLIENT (ALTOGETHER)?

(1)	Less than half an hour	[ ]
(2)	More than half an hour but less than one hour	[ ]
(3)	More than one hour but less than two hours	[ ]
(4)	Two hours or more	[ ]

6. WHERE DID THIS INTERACTION TAKE PLACE (REF. PARNELL, 1978)?

(1)	Client's home	[ ]
(2)	CPN office	[ ]
(3)	Day centre	[ ]
(4)	Day hospital	[ ]
(5)	Out-patient clinic	[ ]
(6)	Client's place of work	[ ]
(7)	Social club	[ ]
(8)	Hostel	[ ]
(9)	Residential accommodation (private)	[ ]
(10)	Residential accommodation (local authority)	[ ]
(11)	Hospital ward/unit	[ ]
(12)	Other	[ ]

7. WHO WAS WITH YOU?

(1)	the client	[ ]
(2)	the client and a student	[ ]
(3)	the client and a colleague	[ ]
(4)	Other	[ ]

NOTES: .....
.....

8. WHICH OF THE FOLLOWING MOST ACCURATELY DESCRIBES THE FUNCTION OF THE INTERACTION YOU HAD WITH THE CLIENT (REF. BARRATT, 1989)?

(1)	Assessment	[ ]
(2)	Counselling	[ ]
(3)	Giving medication	[ ]
(4)	Other physical care	[ ]
(5)	Advising	[ ]
(6)	Education	[ ]
(7)	Specialist therapy	[ ]
(8)	Reassurance/Support	[ ]
(9)	Monitoring	[ ]
(10)	Evaluating	[ ]
(11)	Other	[ ]

NOTES: .....
.....

9. DETAILED EXPLANATION OF INTERACTION:
(TAPE-RECORDED FOR SUBSEQUENT QUALITATIVE ANALYSIS)

PROBES:

Could you please describe exactly WHAT you did?

WHY did you do what you did?

WHY did you do this rather than an alternative course of action?

WHOse idea was it to do this?

WHAT/WHO influenced you to take this course of action?

Did you decide on your own to do this?

Was it discussed with a colleague?

Did you do this following any negotiation with a colleague?

Was it discussed with the client?

10. HAVE YOU HAD ANY INDIRECT INVOLVEMENT WITH THE CLIENT
THIS WEEK?

(1)	Yes	[ ]
(2)	No	[ ]

(If yes then ask questions 11 to 13)
(If no then ask question 14)

11. HOW MUCH TIME DID YOU SPEND ON THIS INDIRECT INVOLVEMENT (ALTOGETHER)?

(1)	Less than half an hour	[ ]
(2)	More than half an hour but less than one hour	[ ]
(3)	More than one hour but less than two hours	[ ]
(4)	Two hours or more	[ ]

12. WHAT FORM DID THIS INDIRECT INVOLVEMENT TAKE?

(1)	Telephone conversation with client	[ ]
(2)	Discussion with colleagues	[ ]
(3)	Case conference	[ ]
(4)	Writing notes	[ ]
(5)	Planning care	[ ]
(6)	Other	[ ]

NOTES: .....
.....

13. DETAILED EXPLANATION OF INDIRECT INVOLVEMENT (TAPE-RECORDED FOR SUBSEQUENT QUALITATIVE ANALYSIS):

PROBES:

Could you please describe exactly WHAT you did?

WHY did you do what you did?

WHY did you do this rather than an alternative course of action?

WHOse idea was it to do this?

WHAT/WHO influenced you to take this course of action?

Did you decide on your own to do this?

Was it delegated to you?

Did you do this following any negotiation with a colleague?

14. IF YOU HAVE HAD NO DIRECT OR INDIRECT INVOLVEMENT WITH THIS CLIENT, COULD YOU EXPLAIN WHY? (TAPE-RECORDED FOR SUBSEQUENT QUALITATIVE ANALYSIS)

TRANSCRIPTIONS OF OPEN QUESTIONS 9, 13, 14 (TAPE-RECORDED)

REFERRAL NO.: CPN NO.: DATE:

REF: DIPNS/MORRALL/DIARY

6.2.APPENDIX 2

DIARY-INTERVIEW (2nd draft)

1. CPN NO. [ ][ ]

2. TEAM NO. [ ]

DATE RESEARCH COMMENCED: .....

DATE RESEARCH COMPLETED: .....

10/4/90

COMMUNITY PSYCHIATRIC NURSE PROFILE

3. AGE: (1) 20-29 years [ ]
(2) 30-39 years [ ]
(3) 40-49 years [ ]
(4) 50-59 years [ ] [ ]
(5) 60 + years [ ]

4. GENDER: (1) Female [ ] [ ]
(2) Male [ ]

5. ETHNICITY: (1) Caucasian/White [ ]
(2) Afro-carribean [ ]
(3) Asian [ ] [ ]
(4) Oriental [ ]
(5) Other [ ]

QUALIFICATIONS COMPLETED/BEING UNDERTAKEN(Excluding RMN):

6. RGN [ ]
7. RNMH [ ]
8. RSCN [ ]
9. SEN [ ]
10. EN (M) [ ]
11. CPN Cert./Diploma ENB 810 [ ]
12. CPN Cert./Diploma ENB 811 [ ]
13. Counselling Cert./Diploma [ ]
14. Psychotherapy Cert./Diploma [ ]
15. Behaviour Therpay Cert./Dip [ ]
16. Dip. in Nursing (old regs.) [ ]
17. Dip. in Nursing (new regs.) [ ]
18. Degree (e.g. BSc/BA/BEd/MA) [ ]
19. Other [ ]

NOTES: .....

20. DATE RMN OBTAINED: (1) Before 1980 [ ]
(2) 1980-1985 [ ] [ ]
(3) 1986 or later [ ]

21. TRAINED ON THE '1982' SYLLABUS? [ ]

22. PRESENT EMPLOYMENT GRADE: (1) E [ ]
(2) F [ ] [ ]
(3) G [ ]
(4) H [ ]

23. LENGTH OF TIME SPENT AS A CPN:

(1) Under 1 year [ ]
(2) One year or more but less than two [ ]
(3) Two years or more but less than three [ ][ ]
(4) Three years or more but less than four [ ]
(5) Five years or more [ ]

NOTES: .....

TEAM MEMBERSHIP:

24.Member of a psychiatric MDT	[ ]
25.Member of a CMHT	[ ]
26.Member of PHCT	[ ]
27.Other	[ ]

NOTES: .....

28. SIZE OF CASE LOAD IN TOTAL:

(1) Below 10	[ ]	
(2) Between 10 and 20	[ ]	
(3) Between 21 and 30	[ ]	[ ]
(4) Between 31 and 40	[ ]	
(5) More than 41	[ ]	

REFERRAL SOURCES:

29.Any referral source (including all of those below)	[ ]
30.Consultant psychiatrist	[ ]
31.Any member of the psychiatric medical team	[ ]
32.GPs	[ ]
33.Any medical practitioner	[ ]
34.Social Workers/Social Services	[ ]
35.Psychologists	[ ]
36.CPNs	[ ]
37.Any member of the MDT	[ ]
38.Any member of the PHCT	[ ]
39.Any member of the CMHT	[ ]
40.Team-leader	[ ]
41.Supervisor	[ ]
42.Manager	[ ]
43.Clients (self-referrals)	[ ]
44.Voluntary Agencies	[ ]
45.Other	[ ]

NOTES: .....

OPERATIONAL SITE(S):

46.Grounds of psychiatric hospital	[ ]
47.CMHC/Resource centre	[ ]
48.GP surgery	[ ]
49.DGH	[ ]
50.Other	[ ]

NOTES: .....

CLINICAL SUPERVISION:

51.CPN receives formal clinical supervision	[ ]
52.CPN receives informal clinical supervision	[ ]

NOTES: .....

REFERRAL PROFILE

1.CPN NO. [ ][ ]
2.TEAM NO. [ ]
53.REFERRAL NO. [ ][ ]
54.WEEK NO.(1-15) [ ][ ]

55.IMMEDIATE REFERRAL SOURCE:

(1) Consultant Psychiatrist	[ ]	
(2) Other member of the psychiatric medical team	[ ]	
(3) GP	[ ]	
(4) Medical practitioner other than above	[ ]	
(5) Social Worker	[ ]	
(6) Psychologist	[ ]	
(7) CPN	[ ]	
(8) MDT	[ ]	[ ][ ]
(9) PHCT	[ ]	
(10)CMHT	[ ]	
(11)District Nurse	[ ]	
(12)Health Visitor	[ ]	
(13)Team-leader	[ ]	
(14)Supervisor	[ ]	
(15)Manager	[ ]	
(16)Self-referred	[ ]	
(17)Voluntary Agency	[ ]	
(18)Other	[ ]	

NOTES: .....

56.ORIGINAL REFERRAL SOURCE:

(1) Same as immediate referral source	[ ]	
(2) Consultant Psychiatrist	[ ]	
(3) Other member of the psychiatric medical team	[ ]	
(4) GP	[ ]	
(5) Medical practitioner other above	[ ]	
(6) Social Worker	[ ]	
(7) Psychologist	[ ]	
(8) CPN	[ ]	
(9) MDT	[ ]	[ ][ ]
(10)PHCT	[ ]	
(11)CMHT	[ ]	
(12)District Nurse	[ ]	
(13)Health Visitor	[ ]	
(14)Team-leader	[ ]	
(15)Supervisor	[ ]	
(16)Manager	[ ]	
(17)Self-referred	[ ]	
(18)Voluntary Agency	[ ]	
(19)Other	[ ]	

NOTES: .....

57. AGE: (1) Below 20 years [ ]
(2) 20-29 years [ ]
(3) 30-39 years [ ] [ ]
(4) 40-49 years [ ]
(5) 50-59 years [ ]
(6) 60+ [ ]

58.GENDER: (1) Female [ ] [ ]
(2) Male [ ]

59.ETHNICITY: (1) Caucasian/White [ ]
(2) Afro-carribean [ ]
(3) Asian [ ] [ ]
(4) Oriental [ ]
(5) Other [ ]

60.MARITAL STATUS: (1) Single [ ]
(2) Married [ ]
(3) Separated [ ]
(4) Divorced [ ] [ ]
(5) Cohabiting [ ]
(6) Single [ ]
(7) Widowed [ ]
(8) Other [ ]

61 EMPLOYMENT STATUS:
(1) Full-time Reg. Gen. Category {i} [ ]
(2) {ii} [ ]
(3) {iii} [ ]
(4) {iv} [ ]
(5) {v} [ ]
(6) Part-time Reg. Gen. Category {i} [ ][ ][ ]
{ii} [ ]
{iii} [ ]
{iv} [ ]
{v} [ ]
(7) Full-time housewife/husband [ ]
(8) Unemployed [ ]
(9) Full-time student [ ]
(10)Other [ ]

NOTES: .....

62.INDICATION OF REFERRER'S EXPECTATIONS:
(REF. BARRATT, 1989)
(1) Assessment [ ]
(2) Counselling [ ]
(3) Giving medication [ ]
(4) Other physical care [ ]
(5) Advising [ ]
(6) Education [ ] [ ][ ]
(7) Specialist therapy [ ]
(8) Reassurance/Support [ ]
(9) Monitoring [ ]
(10)Evaluating [ ]
(11)Unspecified [ ]
(12)Other [ ]

NOTES: .....

CLIENT'S PSYCHIATRIC HISTORY:

63.Previous in-patient care [ ]
64.Previous out-patient care [ ]
65.Previously treated by GP for
a/this 'psychiatric' problem [ ]
66.Previous CPN involvement [ ]
67.No known previous psychiatric history [ ]

NOTES: .....

68.MAJOR PRESENTING SYMPTOM/BEHAVIOUR:

(1) Anxiety [ ]
(2) Depression [ ]
(3) Phobia [ ]
(4) Delusions [ ]
(5) Hallucinations [ ]
(6) Delusions and hallucinations [ ]
(7) Confusion [ ]
(8) Overactivity (hypomania/mania) [ ] [ ][ ]
(9) Aggression [ ]
(10)Self-harm (actual) [ ]
(11)Self-harm (intonated) [ ]
(12)Drug/Alcohol addiction [ ]
(13)'Problems with living' [ ]
(14)Sexual problems [ ]
(15)Over eating/Under eating [ ]
(16)Other [ ]

NOTES: .....

69.KEY WORKER ATTACHED TO CLIENT:

(1) Above named CPN [ ]
(2) Other CPN [ ]
(2) Other MDT member (not a CPN) [ ] [ ]
(3) Other CMHT member (not a CPN) [ ]
(4) Other PHCT member (not a CPN) [ ]
(5) No key worker identified [ ]

NOTES: .....

70.LENGTH OF TIME MONITORED (BY RESEARCHER)

(1) One week only [ ]
(2) two to four weeks [ ]
(3) five to seven weeks [ ] [ ]
(4) eight to ten weeks [ ]
(5) eleven or more weeks [ ]

71.CLIENT OUTCOME: (1) Care continued [ ]
(2) Re-referred to
other MH professional [ ] [ ]
(3) Discharged [ ]
(4) Other [ ]

NOTES: .....

72.WHY DID YOU ACCEPT THIS PARTICULAR REFERRAL?

[PROBES:Was it delegated to you? If so by whom?
Did it follow from negotiations with colleagues?
If so, who with?
Did you accept it because you felt that you [ ][ ]
had the appropriate skills?
Do accept all referrals?
What would have happenned if you hadn't accepted
this referral?]

CPN-REFERRAL 'ACTION' PROBE SHEET
(TAPE-RECORDED)

CAN YOU TELL ME ABOUT ANY 'FACE-TO-FACE CONTACT YOU HAVE HAD WITH THE CLIENT DURING THIS WEEK?

[PROBES:How much time did you spend with the client?
Where were you?
Who else was there?
What happenned?
Why did you do what you did?
Who made the decisions?
What were you trying to achieve?
What are you going to do next?]

CAN YOU TELL ME ABOUT ANY DISCUSSIONS YOU HAVE HAD WITH ANYONE THIS WEEK ABOUT THE CLIENT?

[PROBES:How much time did you spend on this?
Where did it take place?
Was it by telephone?
Who was involved?
What happenned?
Why did you have this discussion(s)?
Who made the decisions?
What were you (or others) trying to achieve?
What did you do/are you going to do
as a result of the discussion(s)?]

CAN YOU TELL ME ABOUT ANY OTHER DIRECT OR INDIRECT INVOLVEMENT YOU HAVE HAD WITH THIS CLIENT DURING THIS WEEK?

[PROBES:How much time did you spend on this?
Where did it take place?
Who was involved?
What happenned?
Why did this happen?
Who made the decisions?
What were you (or others) trying to achieve?
What did you do/are you going to do
as a result of this?]

IF YOU HAVE HAD NO DIRECT OR INDIRECT INVOLVEMENT WITH THE CLIENT DURING THIS WEEK, COULD YOU TELL ME WHY?

[PROBES:Why did this happen?
Who made the decision not to have any
involvement?
What were you trying to achieve?]

CPN-REFERRAL 'ACTION' DATA
(DATA EXTRACTED FROM TAPE-RECORDINGS)

1.CPN NO.: [ ][ ]
2.TEAM NO.: [ ]
53.REFERRAL NO.: [ ][ ]
54.WEEK NO.(1-15): [ ][ ]

73.TIME SPENT ON ANY DIRECT CONTACT:
(1) None [ ]
(2) Less than one hour [ ]
(3) One hour or more but less than two [ ] [ ]
(4) Two hours or more [ ]

74.LOCATION OF ANY DIRECT CONTACT:
(1) Clients home [ ]
(2) CPN centre [ ]
(3) Day centre [ ]
(4) Ward [ ]
(5) Day centre [ ][ ]
(6) Hostel [ ]
(7) Out-pts.clinic [ ]
(8) Other [ ]

NOTES: .....

75.PARTICIPANTS IN ANY DIRECT CONTACT:

(1) CPN and client only [ ]
(2) CPN, colleague, and client [ ]
(3) CPN, student, and client [ ][ ]
(4) CPN, client, & member of family/friend [ ]
(5) Other [ ]

NOTES: .....

76.THERAPEUTIC STYLE USED IN ANY DIRECT CONTACT:

(1) Assessment [ ]
(2) Counselling [ ]
(3) Giving medication [ ]
(4) Other physical care [ ]
(5) Advising [ ]
(6) Education [ ] [ ][ ]
(7) Specialist therapy [ ]
(8) Reassurance/Support [ ]
(9) Monitoring [ ]
(10)Evaluating [ ]
(11)Unspecified [ ]
(12)Other [ ]

NOTES: .....

DISCUSSIONS HELD WITH:

77.No-one [ ]
78.Consultant Psychiatrist [ ]
79.Other member of the
psychiatric medical team [ ]
80.GP [ ]
81.Medical practitioner other
above [ ]
82.Social Worker [ ]
83.Psychologist [ ]
84.Occupational Therapist [ ]
85.CPN [ ]
86.District Nurse [ ]
87.Health Visitor [ ]
88.Team-leader [ ]
89.Supervisor [ ]
90.Manager [ ]
91.Voluntary Agency [ ]
92.Other [ ]

NOTES: .....

93.DISCUSSION STYLE (IF HELD):

(1) Advice seeking	[ ]	
(2) Advice receiving	[ ]	
(3) Informaton giving	[ ]	
(4) Information receiving	[ ]	
(5) Receiving supervision	[ ]	[ ][ ]
(6) Team discussion	[ ]	
(7)	[ ]	
(8)	[ ]	
(9)	[ ]	
(10)	[ ]	
(11)	[ ]	
(12) Other	[ ]	

94.OTHER INVOLVEMENT:

(1) None	[ ]	
(2)	[ ]	
(3)	[ ]	[ ][ ]
(4)	[ ]	
(5)	[ ]	

95.IDEOLOGICAL FRAMEWORK:

(1)	[ ]	
(2)	[ ]	
(3)	[ ]	[ ]
(4)	[ ]	
(5)	[ ]	

96.LEVEL OF NEGOTIATION:

(1)	[ ]	
(2)	[ ]	
(3)	[ ]	[ ][ ]
(4)	[ ]	
(5)	[ ]	

97.LEVEL OF COLLEGIALITY:

(1)	[ ]	
(2)	[ ]	
(3)	[ ]	[ ][ ]
(4)	[ ]	
(5)	[ ]	

98.DECISION-MAKING:

(1)	[ ]	
(2)	[ ]	
(3)	[ ]	[ ][ ]
(4)	[ ]	
(5)	[ ]	

6.3.APPENDIX 3

DIARY-INTERVIEW (final draft)

1. CPN NO. [ ][ ]

2. CENTRE NUMBER: [ ]

DATE RESEARCH COMMENCED: .....

DATE RESEARCH COMPLETED: .....

Sept 10 1992

COMMUNITY PSYCHIATRIC NURSE PROFILE

3. AGE: (1) 20-29 years [ ]
(2) 30-39 years [ ]
(3) 40-49 years [ ]
(4) 50-59 years [ ] [ ]
(5) 60 + years [ ]

4. GENDER: (1) Female [ ] [ ]
(2) Male [ ]

5. ETHNICITY: (1) Caucasian/White [ ]
(2) Afro-carribean [ ]
(3) Asian [ ] [ ]
(4) Oriental [ ]
(5) Other [ ]

QUALIFICATIONS COMPLETED/BEING UNDERTAKEN(Excluding RMN):

6. RGN [ ]
7. RNMH [ ]
8. RSCN [ ]
9. SEN [ ]
10. EN (M) [ ]
11. CPN Cert./Diploma ENB 810 [ ]
12. CPN Cert./Diploma ENB 811 [ ]
13. Counselling Cert./Diploma [ ]
14. Psychotherapy Cert./Diploma [ ]
15. Behaviour Therapy Cert./Dip [ ]
16. Dip. in Nursing (old regs.) [ ]
17. Dip. in Nursing (new regs.) [ ]
18. Degree (e.g. BSc/BA/BEd/MA) [ ]
19. Other [ ]

NOTES: .....

20. DATE RMN OBTAINED: (1) Before 1980 [ ]
(2) 1980-1985 [ ] [ ]
(3) 1986 or later [ ]

21. TRAINED ON THE '1982' SYLLABUS? [ ]

22. PRESENT EMPLOYMENT GRADE: (1) E [ ]
(2) F [ ] [ ]
(3) G [ ]
(4) H [ ]

23. LENGTH OF TIME SPENT AS A CPN:

(1) Under 1 year [ ]
(2) One year or more but less than two [ ]
(3) Two years or more but less than three [ ][ ]
(4) Three years or more but less than four [ ]
(5) Five years or more [ ]

NOTES: .....

TEAM MEMBERSHIP:

24.Member of a psychiatric MDT [ ]
25.Member of a CMHT [ ]
26.Member of PHCT [ ]
27.Other [ ]

NOTES: .....

28. SIZE OF CASE-LOAD IN TOTAL:

(1) Below 10 [ ]
(2) Between 10 and 20 [ ]
(3) Between 21 and 30 [ ] [ ]
(4) Between 31 and 40 [ ]
(5) More than 41 [ ]

REFERRAL SOURCES:

29.Any referral source (including all of those below) [ ]
30.Consultant psychiatrist [ ]
31.Any member of the psychiatric medical team [ ]
32.GPs [ ]
33.Any medical practitioner [ ]
34.Social Workers/Social Services [ ]
35.Psychologists [ ]
36.CPNs [ ]
37.Any member of the MDT [ ]
38.Any member of the PHCT [ ]
39.Any member of the CMHT [ ]
40.Team-leader [ ]
41.Supervisor [ ]
42.Manager [ ]
43.Clients (self-referrals) [ ]
44.Voluntary Agencies [ ]
45.Other [ ]

NOTES: .....

OPERATIONAL SITE(S):

46.Grounds of psychiatric hospital [ ]
47.CMHC/Resource centre [ ]
48.GP surgery [ ]
49.DGH [ ]
50.Other [ ]

NOTES: .....

CLINICAL SUPERVISION:

51.CPN receives formal clinical supervision [ ]
52.CPN receives informal clinical supervision [ ]

NOTES: .....

REFERRAL PROFILE

1.CPN NO. [ ][ ]
2.TEAM NO. [ ]
53.REFERRAL NO. [ ][ ]
54.WEEK NO.(1-15) [ ][ ]

55.IMMEDIATE REFERRAL SOURCE:

(1) Consultant Psychiatrist	[ ]	
(2) Other member of the psychiatric medical team	[ ]	
(3) GP	[ ]	
(4) Medical practitioner other than above	[ ]	
(5) Social Worker	[ ]	
(6) Psychologist	[ ]	
(7) CPN	[ ]	
(8) MDT	[ ]	[ ][ ]
(9) PHCT	[ ]	
(10)CMHT	[ ]	
(11)District Nurse	[ ]	
(12)Health Visitor	[ ]	
(13)Team-leader	[ ]	
(14)Supervisor	[ ]	
(15)Manager	[ ]	
(16)Self-referred	[ ]	
(17)Voluntary Agency	[ ]	
(18)Other	[ ]	

NOTES: .....

56.ORIGINAL REFERRAL SOURCE:

(1) Same as immediate referral source	[ ]	
(2) Consultant Psychiatrist	[ ]	
(3) Other member of the psychiatric medical team	[ ]	
(4) GP	[ ]	
(5) Medical practitioner other than above	[ ]	
(6) Social Worker	[ ]	
(7) Psychologist	[ ]	
(8) CPN	[ ]	
(9) MDT	[ ]	[ ][ ]
(10)PHCT	[ ]	
(11)CMHT	[ ]	
(12)District Nurse	[ ]	
(13)Health Visitor	[ ]	
(14)Team-leader	[ ]	
(15)Supervisor	[ ]	
(16)Manager	[ ]	
(17)Self-referred	[ ]	
(18)Voluntary Agency	[ ]	
(19)Other	[ ]	

NOTES: .....

57. AGE: (1) Below 20 years [ ]
(2) 20-29 years [ ]
(3) 30-39 years [ ] [ ]
(4) 40-49 years [ ]
(5) 50-59 years [ ]
(6) 60+ [ ]

58.GENDER: (1) Female [ ] [ ]
(2) Male [ ]

59.ETHNICITY: (1) Caucasian/White [ ]
(2) Afro-carribean [ ]
(3) Asian [ ] [ ]
(4) Oriental [ ]
(5) Other [ ]

60.MARITAL STATUS: (1) Single [ ]
(2) Married [ ]
(3) Separated [ ]
(4) Divorced [ ] [ ]
(5) Cohabiting [ ]
(7) Widowed [ ]
(8) Other [ ]

61 EMPLOYMENT STATUS:
(1) Full-time Reg. Gen. Category {i} [ ]
(2) {ii} [ ]
(3) {iii} [ ]
(4) {iv} [ ]
(5) {v} [ ]
(6) Part-time [ ] [ ][ ]
(7) Full-time housewife/husband [ ]
(8) Unemployed [ ]
(9) Full-time student [ ]
(10)Other (e.g. retired) [ ]

NOTES: .....

62.INDICATION OF REFERRER'S EXPECTATIONS:
(REF. BARRATT, 1989)
(1) Assessment [ ]
(2) Counselling [ ]
(3) Giving medication [ ]
(4) Other physical care [ ]
(5) Advising [ ]
(6) Education [ ] [ ][ ]
(7) Specialist therapy [ ]
(8) Reassurance/Support [ ]
(9) Monitoring [ ]
(10)Evaluating [ ]
(11)Unspecified [ ]
(12)Other [ ]

NOTES: .....

CLIENT'S PSYCHIATRIC HISTORY:

63.Previous in-patient care [ ]
64.Previous out-patient care [ ]
65.Previously treated by GP for
a/this 'psychiatric' problem [ ]
66.Previous CPN involvement [ ]
67.No known previous psychiatric history [ ]

NOTES: .....

68.MAJOR PRESENTING SYMPTOM/BEHAVIOUR:

(1) Anxiety [ ]
(2) Depression [ ]
(3) Phobia [ ]
(4) Delusions [ ]
(5) Hallucinations [ ]
(6) Delusions and hallucinations [ ]
(7) Confusion [ ]
(8) Overactivity (hypomania/mania) [ ] [ ][ ]
(9) Aggression [ ]
(10)Self-harm (actual) [ ]
(11)Self-harm (intonated) [ ]
(12)Drug/Alcohol addiction [ ]
(13)'Problems with living' [ ]
(14)Sexual problems [ ]
(15)Over eating/Under eating [ ]
(16)Other [ ]

NOTES: .....

69.KEY WORKER ATTACHED TO CLIENT:

(1) Above named CPN [ ]
(2) Other CPN [ ]
(3) Other MDT member (not a CPN) [ ] [ ]
(4) Other CMHT member (not a CPN) [ ]
(5) Other PHCT member (not a CPN) [ ]
(6) No key worker identified [ ]
(7) Above CPN with other colleague [ ]

NOTES: .....

70.LENGTH OF TIME MONITORED (BY RESEARCHER)

(1) One week only [ ]
(2) two to four weeks [ ]
(3) five to seven weeks [ ] [ ]
(4) eight to ten weeks [ ]
(5) eleven or more weeks [ ]

71.CLIENT OUTCOME: (1) Care continued [ ]
(2) Re-referred to
other MH professional [ ] [ ]
(3) Discharged [ ]
(4) Other [ ]

NOTES: .....

72.WHY DID YOU ACCEPT THIS PARTICULAR REFERRAL?

[PROBES:Was it delegated to you? If so by whom?
Did it follow from negotiations with colleagues?
If so, who with?
Did you accept it because you felt that you [ ][ ]
had the appropriate skills?
Do you accept all referrals?
What would have happened if you hadn't accepted
this referral?]

(1) ARBITARY ('Because I answered the phone'; 'I had space on my case-load'; 'Nobody else available')

(2) INTERESTING ('I found this client's details interesting')

(3) SPECIALITY ('My skills appear to meet the client's needs')

(4) DELEGATION/REQUEST ('I was asked specifically to deal with this client' [e.g. by GP]; 'I was delegated this client' [e.g. by manager/consultant/supervisor/superior]; 'I was asked to see the client by a colleague')

(5) APPROPRIATE ('Because the referral seemed appropriate'; 'It was urgent')

(6) CMHT (The team generally)

(7) OBJECTIVE (The use of an agreed upon assessment format)

(8) UNSPECIFIED

(9) OTHER

(10)RE-REFERRAL (CPN had previously dealt with client)

CPN-REFERRAL 'ACTION' PROBE SHEET
(TAPE-RECORDED)

CAN YOU TELL ME ABOUT ANY 'FACE-TO-FACE CONTACT YOU HAVE HAD WITH THE CLIENT DURING THIS WEEK?

[PROBES:How much time did you spend with the client?
Where were you?
Who else was there?
What happened?
Why did you do what you did?
Who made the decisions?
What were you trying to achieve?
What are you going to do next?]

CAN YOU TELL ME ABOUT ANY DISCUSSIONS YOU HAVE HAD WITH ANYONE THIS WEEK ABOUT THE CLIENT?

[PROBES:How much time did you spend on this?
Where did it take place?
Was it by telephone?
Who was involved?
What happened?
Why did you have this discussion(s)?
Who made the decisions?
What were you (or others) trying to achieve?
What did you do/are you going to do
as a result of the discussion(s)?]

CAN YOU TELL ME ABOUT ANY OTHER DIRECT OR INDIRECT INVOLVEMENT YOU HAVE HAD WITH THIS CLIENT DURING THIS WEEK?

[PROBES:How much time did you spend on this?
Where did it take place?
Who was involved?
What happened?
Why did this happen?
Who made the decisions?
What were you (or others) trying to achieve?
What did you do/are you going to do
as a result of this?]

IF YOU HAVE HAD NO DIRECT OR INDIRECT INVOLVEMENT WITH THE CLIENT DURING THIS WEEK, COULD YOU TELL ME WHY?

[PROBES:Why did this happen?
Who made the decision not to have any involvement?
What were you trying to achieve?]

CPN-REFERRAL 'ACTION' DATA
(DATA EXTRACTED FROM TAPE-RECORDINGS)

1.CPN NO.: [ ][ ]
2.TEAM NO.: [ ]
53.REFERRAL NO.: [ ][ ]
54.WEEK NO.(1-15): [ ][ ]

73.TIME SPENT ON ANY DIRECT CONTACT:
(1) None [ ]
(2) Less than one hour [ ]
(3) One hour or more but less than two [ ] [ ]
(4) Two hours or more [ ]

74.LOCATION OF ANY DIRECT CONTACT:
(1) Client's home [ ]
(2) CPN centre [ ]
(3) Day centre [ ]
(4) Ward [ ]
(5) Relative's home [ ] [ ]
(6) Hostel [ ]
(7) Out-pts. clinic [ ]
(8) Other [ ]

NOTES: .....

75.PARTICIPANTS IN ANY DIRECT CONTACT:

(1) CPN and client only [ ]
(2) CPN, colleague, and client [ ]
(3) CPN, student, and client [ ] [ ]
(4) CPN, client, & member of family/friend [ ]
(5) Other [ ]

NOTES: .....

76.THERAPEUTIC STYLE USED IN ANY DIRECT CONTACT:

(1) Assessment [ ]
(2) Counselling [ ]
(3) Giving medication [ ]
(4) Other physical care [ ]
(5) Advising [ ]
(6) Education [ ] [ ][ ]
(7) Specialist therapy [ ]
(8) Reassurance/Support [ ]
(9) Monitoring [ ]
(10)Evaluating [ ]
(11)Unspecified [ ]
(12)Other [ ]

NOTES: .....

DISCUSSIONS HELD WITH:

77.No-one [ ]
78.Consultant Psychiatrist [ ]
79.Other member of the
psychiatric medical team [ ]
80.GP [ ]
81.Medical practitioner other
than above [ ]
82.Social Worker [ ]
83.Psychologist [ ]
84.Occupational Therapist [ ]
85.CPN [ ]
86.District Nurse [ ]
87.Health Visitor [ ]
88.Team-leader [ ]
89.Supervisor [ ]
90.Manager [ ]
91.Voluntary Agency [ ]
92.Other (e.g. student/relatives) [ ]

NOTES: .....

94.OTHER INVOLVEMENT:

(1) None [ ]
(2) Client not in/not turn up [ ]
(3) Tel.con.with client/letter [ ] [ ][ ]
(4) CPN on holiday [ ]
(5) Discharged/transferred etc.[ ]
(6) Letter to consultant/GP [ ]
(7) Visit by student/colleague [ ]
(8) Discussed with CMHT [ ]
(9) CPN sick [ ]
(10)CPN sick but client visited
by student/colleague [ ]

6.4.APPENDIX 4

FOCUSED-INTERVIEW SCHEDULE (1st draft)

NAME:-

DATE:-

AREA:-

NOTES:-

(January 1990)

KEY PROBE HEADINGS	PROBE CATEGORIES
What	CPN Role
Where	Role comparisons
How	Referrals - CPN autonomy
When	Hierarchical/Supervisory structures
Why	Organisational Structure
Who	Ideal types

1. CPN ROLE (GENERAL AND COMPARATIVE)

What do you consider the role of the CPN to be?

How does that role differ from your own? (attitudes; skills; knowledge; status; levels of autonomy legal elements; codes of conduct etc).

In what way does the role of the CPN differ from that of other mental health workers (eg social worker; psychiatrist; psychologist; occupational therapist).

2. CPNs AND THE REFERRAL PROCESS

Who should CPNs accept referrals from? (why?)

How much control should CPNs have over who they accept as a referral?

What do you consider the role of the CPN to be in assessing clients?

What are your views about CPNs independently carrying-out the initial assessment of clients?

What are your views about CPNs independently organising treatment or care programmes for clients?

What happens in the area in which you work?

What are your views about CPNs independently implementing treatment or care programmes for clients?

How much control should CPNs have over discharging clients from their case-load?

What happens in the area in which you work?

3. HIERARCHICAL/SUPERVISORY STRUCTURES

What are your views on the 'supervision of CPNS'?

What do you mean by 'supervision'?

Who do you feel should supervise CPNs?

How should CPNs be supervised?

Why should CPNs be supervised?

Who should CPNs be responsible to, and for what?

4. ORGANISATIONAL STRUCTURES

Where do you feel it is best to have CPNs located (eg PHCTs; CMHTS; hospital based)?

What are your reasons for this?

5. IDEAL TYPES

What makes a 'good' CPN?

What makes a 'bad' CPN?

What needs to happen to improve CPN practice?

6.5.APPENDIX 5

FOCUSED-INTERVIEW SCHEDULE (2nd draft)

INTERVIEWEE:-

DATE:-

AREA:-

NOTES:-

(May 1990)

AIMS

1. To assess the professional 'status' of the CPN as viewed by her/his mental health colleagues.

2. To evaluate the role of the CPN as perceived by her/his mental health colleagues.

3. To establish the degree of collegiality, conflict, and rivalry that exists between the CPN and her/his mental health colleagues.

4. To monitor any 'ideological' incompatibility between the CPN and her/his mental health colleagues, and identify the existence of possible 'hegemonisation'.

5. To evaluate the level of supervisory/managerial control and/or the existence of overt/covert hierarchies affecting the role of the CPN.

6. To assess the level of concordance between the CPNs and her/his mental health, legal status etc or interpretation of such.

KEY PROBE HEADINGS	PROBE CATEGORIES
What	CPN Role
Where	Role comparisons
How	Referrals - CPN autonomy
When	Hierarchical/Supervisory structures
Why	Organisational Structure
Who	Ideal types

1. CPN ROLE (GENERAL AND COMPARATIVE)

a. What do you consider the role of the CPN to be?

b. How does that role differ from your own? (attitudes; skills; knowledge; status; levels of autonomy; legal elements; codes of conduct etc).

c. In what way does the role of the CPN differ from that of other mental health workers (eg social worker; psychiatrist; psychologist; occupational therapist).

2. CPNs AND THE REFERRAL PROCESS

a. Who should CPNs accept referrals from? (why?)

b. How much control should CPNs have over who they accept as a referral?

c. Who do CPNs accept referrals from in the area in which you work?

d. What are your views about the role of the CPN in assessing clients?

e. What are your views about CPNs independently carrying-out the initial assessment of clients?

f. What happens in the area in which you work?

g. What are your views about CPNs independently organising treatment or care programmes for clients?

h. What happens in the area in which you work?

i. What are your views about CPNs independently implementing treatment or care programmes for clients?

j. What happens in the area in which you work?

k. How much control should CPNs have over discharging clients from their case-load?

l. What happens in the area in which you work?

3. HIERARCHICAL/SUPERVISORY STRUCTURES

a. What are your views on the 'supervision of CPNS'?

b. What do you mean by 'supervision'?

c. Who do you feel should supervise CPNs?

d. How should CPNs be supervised?

e. Why should CPNs be supervised?

f. Who should CPNs be responsible to, and for what? clinically; managerially.

g. What happens in the area in which you work?

4. ORGANISATIONAL STRUCTURES

a. Where do you feel it is best to have CPNs located (eg PHCTs; CMHTS; hospital based)?

b. What are your reasons for this?

c. What happens in the area in which you work?

5. IDEAL TYPES

a. What makes a 'good' CPN?

b. What makes a 'bad' CPN?

c. What needs to happen to improve CPN practice?

6.6.APPENDIX 6

FOCUSED-INTERVIEW SCHEDULE (final draft)

INTERVIEWEE:-

DATE:-

AREA:-

NOTES:-

(October 1990)

AIMS

1. To assess the professional 'status' of the CPN as viewed by her/his mental health colleagues.

2. To evaluate the role of the CPN as perceived by her/his mental health colleagues.

3. To establish the degree of collegiality, conflict, and rivalry that exists between the CPN and her/his mental health colleagues.

4. To monitor any 'ideological' incompatibility between the CPN and her/his mental health colleagues, and identify the existence of possible 'hegemonisation'.

5. To evaluate the level of supervisory/managerial control and/or the existence of overt/covert hierarchies affecting the role of the CPN.

6. To assess the level of concordance between the CPNs and her/his mental health, legal status etc. or interpretation of such.

KEY PROBE HEADINGS	PROBE CATEGORIES
What	CPN Role
Where	Role comparisons
How	Referrals - CPN autonomy
When	Hierarchical/Supervisory structures
Why	Organisational Structure
Who	Ideal types

1. CPN ROLE (GENERAL AND COMPARATIVE)

a. What do you consider the role of the CPN to be?

b. How does that role differ from your own? (attitudes; skills; knowledge; status; levels of autonomy; legal elements; codes of conduct etc.).

c. In what way does the role of the CPN differ from that of other mental health workers (eg social worker; psychiatrist; psychologist; occupational therapist).

2. CPNs AND THE REFERRAL PROCESS

a. Who should CPNs accept referrals from? (why?)

b. How much control should CPNs have over who they accept as a referral?

c. What are your views about the role of the CPN in assessing clients?

d. What are your views about CPNs independently carrying out the initial assessment of clients?

e. What are your views about CPNs independently organising treatment or care programmes for clients?

f. What are your views about CPNs independently implementing treatment or care programmes for clients?

g. How much control should CPNs have over discharging clients from their case-load?

3. HIERARCHICAL/SUPERVISORY STRUCTURES

a. What are your views on the 'supervision of CPNS'?

b. What do you mean by 'supervision'?

c. Who do you feel should supervise CPNs?

d. How should CPNs be supervised?

e. Why should CPNs be supervised?

f. Who should CPNs be responsible to, and for what? clinically; managerially.

4. ORGANISATIONAL STRUCTURES

a. Where do you feel it is best to have CPNs located (eg PHCTs; CMHTS; hospital based)?

b. What are your reasons for this?

5. IDEAL TYPES

a. What makes a 'good' CPN?

b. What makes a 'bad' CPN?

c. What needs to happen to improve CPN practice?

d. Is there anything you would like to add?

6.7.APPENDIX 7

FIELD-NOTEBOOK

TEAM:

RESEARCH WEEK:

DATE:

TIME:

SUBSTANTIVE OBSERVATIONS

METHODOLOGICAL OBSERVATIONS

ANALYTICAL COMMENTS

6.8.APPENDIX 8

TRANSCRIPTION OF INTERVIEW WITH PILOT STUDY SOCIAL WORKER

I What do you consider the CPN role to be?

R There has obviously been a lot of talk about this, particularly as the social worker has come into the team, because I think that the CPNs have historically seen themselves as a sort of a, an adjunct to the consultant. They've sort of tended to do his bidding, the emphasis now is moving towards them being key workers/case managers, taking on a lot more skills if you like or community skills.

I So is that something that has happened in this team - has the shift been noticeable in this team?

R I think it has, yeah, it's happened historically, um in this town, but it's happened nationally as well there has been so many more emphasis on the community nurse helping people, supporting people with their environment if you like, the bigger problems rather than just targeting their neuroses or whatever you want to call them. So there was a certain amount of negotiation when I came in, I wouldn't be the person that took all the referrals relating to benefits or I wouldn't be the person who took all the referrals relating to

accommodation, etc, etc. I think there was an acknowledgement that maybe I've got a lot more knowledge and experience of those things and that I would make those things available but that I wouldn't actually intercede if they were key-working somebody, I wouldn't then be called in if it got sticky in terms of their knowledge base.

I So who was that negotiation between?

R Well, it was at the level of me going in, but I mean it was a middle management level as well in terms of social services middle-management saying, I think the best example is part-three or domiciliary care where the management was saying `well, right, you've got a social worker going in, then the CPNs are going to be allowed to access those resources direct'. If they want to raise a part-three bed now, they can actually go to the meeting and ask for the bed and negotiate with whoever has to be negotiated with, and similarly with domiciliary care.

I The difference between your role and the CPN role, are there any significant differences?

R I think the major one is that which is laid out through the legislation really in terms of I'm still deemed to be a member of Joe Public looking in on what people are doing with mentally ill

people. That's a very sort of caricature way of looking at it but it's a good way to feel how I'm called upon sometimes to assess what is going on. I suppose the bottom line is there is more ingrained in me than the immediate thought when you get involved in a situation like can we maintain this person in the community, what is the least restrictive alternative apart from lifting them to hospital.....

I So in that sense do you feel that, certainly for a part of your role, you are the client's advocate in the sense of protecting him or her from the excesses of psychiatric intervention?

R Well I think that's how the legislation puts you, that's the role that you're given to oversign medical recomendations, to ensure that the legislation is not being overstepped or being misused. Quite clearly that is easier to do when you're outside the team than when you actually become a member of the team because one has to develop working practices with yourself and CPNs and yourself and the consultant, and those clearly break down the barriers in terms of being that lay person, one tends to start becoming a little schizophrenic about it in that one wants to please the nurses and the members of your team, but you recognise that there are going to be times when you do cross because I think sometimes you've got to be

more willing to take a risk.

I By taking a risk you mean?

R Well in terms of when you're talking about do you maintain this person at home or do you take them into hospital, there is always that thin dividing line where one feels that maybe you've got to take a risk in terms of saying `well maybe they would be better off treated at home, although there is a risk that they might commit suicide or whatever'.

I So, I get the feeling that there is some kind of worry about duplicity in the sense of being part of the team, and that somehow interfering with the.....?

R It's not a worry [stated emphatically]. It's just that I think that you've got to recognise that that is an ever present thing that the influences on your role are different if you are within the team than if you are coming in from outside of the team to do a particular piece of work.....

I Would it be fair to say that the CPN and the psychiatrist traditionally had one particular approach to psychiatry and social services, were in the business of modifying that, and that coming in to the team means that it is more difficult to see that division between those two groups?

R [long pause] No. I don't know how to put this. It's part of the dispute between the two elements is to do with orientation, is coming from the more social model, and the other side is the medical model. I mean what is easy to do when you're outside of the team is to see that dichotomy very much in black and white. What tends to happen as you come closer is that those boundaries do grey over, there are grey areas. But that doesn't mean you don't lose your part of the spectrum in terms of saying, there are times when you've got to take the social factors more into consideration than sometimes people do. I mean, the medical side is taking that on by having community teams per se. The fact that they are saying `well right CPNs have got to do much more than just ensure that people take their medication'. They [CPNs] have to learn how to take social histories and they have to learn how people are networked and what the social pressures are on people as well as a recognition that what that pressure from social services has been saying for a number of years.

I Do you see the CPNs as actually having shifted from their more medical background? Has that actually worked here, because of being in the team?

R Yeah, I mean I think it has, but I mean I find it difficult to say that exactly because the strong

CPNs, if you like, when I came into this team had already taken that model on board. Yeah, there are others who would still prefer to see in terms of we can treat particular presenting problems and who won't look beyond those who feel safer doing that. But I think that just by the training, it appears to me as though their training is much wider much less specific.

I What I want to move onto is the referral process itself, as far as the CPNs are concerned. From your point of view, who should CPNs accept referrals from?

R From my point of view?

I Yes.....

R Well, I mean, initially I think we as a team should accept referrals from anywhere, and then there's a second level, in terms of referrals coming from the team. Once you get the referrals in the team that ideally should be very much a group process, so it shouldn't be that the consultant says `well right, I want so and so to do this or this is the CPN's role'. It may be the CPN's role, or somebody may have particular skills but that should be agreed, as far as possible, in an ideal world, with the rest of the team.

I You mentioned `maybe a CPN's role' and there is obviously some link in there to what skills that particular person's got. Where would the role divisions be?

R From my experience so far, obviously they've got skills in terms of phobias and whatever which I haven't, so the CPNs tend to take those type of referrals on. That isn't to say that I'm not picking up some of those fringe skills, but whether the twain will ever meet exactly [and we] will all become as one I don't know, but I think that even amongst the CPNs obviously they have different skills as well, some are stronger in anxiety management and some are stronger in phobias and some are stronger in different parts of phobias to others. Whether that's a personality thing, I would guess it is.

I How much control should CPNs have over who they accept as a referral?

R [pause] I don't know is the answer to that because if one looks at the old model then, in an ideal situation, one would expect that the consultant would only filter down the work which was appropriate, that's in the ideal model. Them having a say in it I would guess depends to a large extent on their relationship with the consultant. I don't honestly know enough about nurses, the management

side, how CPNs are managed if you like, to say `well the decision is a nurse's or the decision is a consultant's.....'.

I Should they, for example, in this community mental health team, should they have the same level of control as you have in your role as a social worker, in accepting a referral?

R [short pause] Yes, yes, but that again comes back to their confidence in dealing with a particular type of situation that they are being asked to do. One would hope that if they are being asked to do something for a particular reason where they haven't got quite all the skills then they would be supported in taking something on.

I Supported by whom?

R Well, by the team. Or the team identifies somebody who can give them that support.

I What would happen, in this set-up, if a CPN refused to accept a referral?

R It depends why there is a refusal, doesn't it? The team can refuse to accept a referral in terms of the team saying `we don't feel this is appropriate', and one would hope that everybody's perception of what is appropriate is virtually OK ,

is levelled out, so that in an ideal situation that shouldn't arise because it is the team that takes the referral, and then it's the team's responsibility to work out who takes it, and there are various reasons why people won't. It's very rare that anybody would refuse point blank without giving a reason. If the people have a good reason such as they know the person or live in the same street or whatever or they've attempted to do some work with them previously and they felt that, either there was a personality clash or they didn't feel that *they could get anywhere and I* think that is quite a valid reason to ask the rest of the team whether there's somebody else in that team who can address that problem.

I Have any situations like that arisen, is that something that has happened in the team?

R Not really, no. I don't feel it has. Not to the point where somebody has dug their heels in, it's probably happened through silence. It's probably happened through the person who either feels threatened or who doesn't want to take on a particular assessment or whatever has opted out through not volunteering, or opted out by not actually putting their four-penny-worth in and allowing somebody else to come forward and say `well, I'll take that on'. So, I can't remember it really being a great problem in terms of somebody

saying `no I'm not going to do it'.

I Should CPNs be able to assess clients on their own?

R [long pause and a cough] I think the ideal model is yes. I think they should, yes I think they should be able to have enough knowledge of all the skills, to assess somebody and come back to the team and say `well, this is what I feel needs to be done'. What we are trying to do [i.e. the team] is help each other by doing joint assessments which, it isn't one specific learning situation but one does learn from seeing that people do assess in subtly different ways. Nobody is saying one way is right or wrong, and people use their own personalities in assessments in any case, and come to the same conclusion or come to a conclusion. So, I mean it is very much a matter of looking at it in terms of ideals then looking at it in terms of how can you practically get people to that level of having the confidence to take on assessments for themselves.

I You mentioned earlier on that CPNs should be able to develop the ability to take social histories. Do you feel that there is a lot to learn from say your approach to, in this case, assessment as far as the CPNs are concerned?

R I think there is, because I've been trained in a

societal way. I've been trained through sociology, through looking at culture, etc, etc, which is a much broader canvas, and something which some CPNs have got through a lot of skills, but not always got through training, I still feel that side is extremely important because you've got to know why you're treating someone, why you're maintaining somebody in the position that you think you *are* maintaining them. If you do it merely by drugs and say `well right, you know, you'll stop hearing these voices' and just leave it at that then actually all you're doing is stopping the voices. You're not helping people to live within the context that they're actually trying to live. I think that's the important thing to start understanding and facilitating that living.

I How much do you think the CPN should be responsible for their own actions in the preparation of treatment/care programmes?

R [pause] I mean they are responsible for them in any case. What tends to happen is that they put together their care ideas and when they say `well I would quite like to take on, to do this particular type of work' then that gives other disciplines the opportunity of saying `well have you considered this might help or that might help'. But I mean there is no one grand way of dealing with a client in any case I don't think. It's this thing that I

see more and more of, whether you help people to cope with their immediate circumstances in a - I don't want to say sticking plaster job because that sounds derogatory and I don't mean it that way because it's sometimes very useful just to see people within their own context, to help them to cope with that particular problem they've hit at that particular time and actually let them get on with their lives, but there are times when the sticking plaster job comes apart, and I think that's the time when you need to give it a broader look.

I What would happen if there was something patently wrong with what the CPN was doing with a client, how would the team or you react to that?

R [long pause] If it's patently and obviously wrong then the team would say something. If there was a danger to life or limb or whatever. But further down the scale, I think to a certain extent you can voice your concern, but you've got to give people the opportunity to learn from their mistakes if you like. I know that sounds dreadful because you're talking about people learning on other human beings, but I mean people do have to have to learn. We all learn every day. When you do this type of work you don't stop learning. Quite often each situation, if you've got a fresh mind, should actually be a new situation. What does concern me

sometimes is I think the medical model actually tends to be quite quick to stereotype and say `we have got a particular type of situation'. I know there is pressure on for it to do that, there is pressure on for it to do that in the legislation in any case.....You've got to have a diagnosis after twenty-eight days [when a client has been sectioned under the 1983 MH Act].....so there is pressure on to say that we are dealing with a particular type of problem.

I Do you feel that CPNs on their own are able to evaluate care plans, and how much does supervision come in to that, and where would that supervision come from?

R Nobody oversights each other's cases. There is supervision built in, and it develops at different levels, and there is no pressure on anybody to go through every case and say `well, this is what happened and this is how I've resolved it'. What tends to happen is that what comes to those supervision sessions are those which people don't feel they are resolving. So therefore you've got to have a climate of honesty in terms of saying `I don't think I'm resolving a particular type of problem'. That doesn't always happen I'm sure. But, that again, without actually having one person or a group of people assessing each case and how it's been resolved, I think you're talking about

professional responsibility in a way, you've got to be able to trust the people if they do get into problems of if they do get into trouble they've got the confidence to come back and say `I'm in trouble, I've got problems'. And that again leads back to trust really.

I From the outside, it might be suggested that the basis of the trust might be at the expense of some kind of difficulty with a client not being uncovered. Is that something that the team addresses or you feel needs addressing?

R I don't think the team have addressed it. I come from a situation where there's line management supervision, and where, the more experienced one gets the more trust is given in terms of your individual assessment and closing cases, etc, etc, so that you get to the point where you don't flog every case to death, but that's because the supervisor knows your strengths and weaknesses. In a way I suppose in an ideal situation with us should be is that we all do occasionally just pull out at random closures and say `well let's not feel threatened but let's actually talk about what we've done with this particular client. It sounds worse than it is in terms of you haven't got anything set up within the system because people don't work in that much isolation in reality. Often the consultant is involved, often I'm involved. In one

way or another we all talk about things. We all know who people are having difficulties with because we tend to come back and moan about them. So it's not as though, well I hope it isn't as though, we've got people who are doing bad work and it's continuing to be bad work. If people are doing bad work I think that would be showing in terms of re-referral in any case. I know that there will always be an element of it if there is bad work going on then people will actually then refuse to use the service, but again, you come back to trust.

I How do you perceive the role of the CPN in terms of the CPN being able to discharge clients?

R Well, they do [both of us laugh].

I How do you feel about that?

R I'm relatively happy about that. It's like the previous problem, ideally you can set up a situation where you can do oversight, where the team oversights, but I don't think [pauses, and says `where can I go' implying that he's not sure how to phrase his answer]. Again, it's this assumption that CPNs are working in total isolation, in glorious isolation, when one discharges one writes to the GP and tells him one is discharging and normally the reasons why and normally what resolution if any resolution has

actually occurred. So it's not as though they're doing all of this in isolation, they're not sort of running out and seeing somebody behind closed doors/closed windows, doing it, closing it, and then nobody knows about it.....

I There is some kind of informal or hidden supervision process that stops these things going unnoticed?

R Yeah.

I Okay.....

R I'm not saying that's ideal, I'm saying that's how it works at the moment. I'm not saying that maybe it couldn't be improved. Again in terms of pulling out a sample of discharged clients.

I Do you feel that CPNs should be directly responsible to any particular individual, either for supervision or other types of monitoring?

R [pause] Technically they are aren't they? Technically I assume they are responsible to their nursing managers.

I But in this situation they are three steps removed from management.....

R That's right, so I mean in that sense they are then responsible to the team, and then you come back full circle to how well is the team supervising itself, etc.

I You could say that team responsibility can in practice be a cop-out in terms of responsibility. Is that a concern?

R A cop-out for who, the team or the individual?

I You could argue that if you don't have a leader of a team taking final responsibility, then everybody is avoiding that responsibility.

R The bottom line is ensuring that the basis of the team, where you come from in terms of the values, the operational policy, actually are good values and that they're on the whole shared by the rest of the team you're talking about the team taking responsibility for it's own action in a way, although individuals in that team at the end of the day have got to be responsible for their individual bit of work, um so yeah it can be a cop-out.

I What makes a good CPN, what makes a bad CPN?

R I think number one, and I think it applies to all caring professionals, is that you've got to be non-judgemental, and you've got to be open in terms

of taking on information.....it's often easier to look at what makes a bad CPN, and what makes a bad social worker, it's somebody who comes in with all their own values, who comes in and has already decided what's happening, and is absolutely stacked full of stereotypes, I'm not saying that stereotypes aren't useful, but there are different ways of using them. So, it's a flexibility isn't it, really. you're talking about somebody who cares, somebody who's open, and somebody who's flexible.

I What would need to happen to improve CPN practice?

R I suppose it's a need to possibly take people who have got a broader experience of life, which how, social work solved that problem, mature students, they need a good intellect, need a good overall balanced view, and can actually understand a place like this town, in terms of it's historical context, it's economic context, it's social history because that's what you're talking about when you're dealing with people you then need a good understanding of the human psyche.

I You've talked about what could make a good CPN, are there bad CPNs around?

R Yeah, but I wouldn't say they were bad CPNs, you can't blame people for their training, you can't

blame people for the institutions that they've worked through, there are some who are worse than others because they find it more difficult to accept the change, but even then one wouldn't necessarily say they were bad CPNs, one would say that they are people in a situation due to an historical accident or whatever. They may have been very good CPNs in the model of doing as they were told, checking on what they needed to check on, etc, etc. So, there are people who will struggle to take on that broader thing, because it is a lot to ask of people, it's a lot to say `well what we want is well balanced, mature, rounded, intelligent people, every bloody organisation would like that.....[both of us laugh].....

I Have you anything else to add?

R In our situation, what has given us a lot to work on is the fact that the traditional centre of power has actually taken a step backwards.....removed himself one step, and has allowed other people the opportunity to accept responsibility for certain things and to some that has been quite a hard process of not being able to run to that centre of power and say `please sir I'm stuck sir, what can I do', and some people have found that easier than others.

I When you say some people, you are talking about

some CPNs?

R Well, some people, you know, because we all, like it cut and dried, to give the decision to somebody else, you've got to say `hurrah' to both sides, to have actually taken that change, and I don't think that the team has acknowledged how great a change that has been, there is still some of the old tensions there, but the position of power is actually confident enough to be able to ride those tensions and to accept the bric-a-brac, when people get frustrated. Have I put that in a coded enough way?

6.9.APPENDIX 9

INTERVIEW WITH CONSULTANT PSYCHIATRIST (PILOT STUDY)

I What do you consider the role of the CPN to be?

R I think the first thing that comes into my mind is that it's not so much to write the actual clinical work that's happening within the team as the changes that we've all gone through and a different style of working, I've found the support extremely helpful from the CPNs in the changes that I've gone through in the last 12 - 18 months. Changes that have gone on in the team, losing the hierarchy, support from them in doing that.
Clinical roles, very different from how it was. I was trying to describe it to the medical student - that phrase that came to mind was one, it was like "first amongst equals" - that seems to be how the medical nursing bit seems to be blending, that for 99.9% of the time it's equal amongst equals, but when there needs to be a first usually I'm turned to rather than saying `I'm here'. That seems to be how it works out.

I So with the changes that have happened within the team, the move from a hierarchical system to a team system, given that you are a consultant psychiatrist and that other people in the team have role titles, what do you see the difference to be between your role and the CPN's role?

R For the vast majority of the time the role is irrelevant because the stuff that we are dealing with doesn't actively demand a specialist role or discipline. It's more demanding of someone that is used to and enjoys treating particular problems so it depends to be more `what's your speciality?', `what do you like doing?', `what are you good at?'. The other bits are, from the doctor's point of view, are when do you need the doctor - when you look at medicines. From the nursing side the only thing we've come up with is injections, we can't persuade the social worker to give them (both laugh). Those two dichotomies are the only times you need a particular discipline and if you need a section for hospital or drugs or giving a treatment that nobody else is able to give, it is all just mixed in and you take out what you want. If you end up with something that you feel you can't do you ask for help from whomever can help you.

I Who should CPNs accept referrals from?

R From anybody.

I Is that something you're happy with?

R If the CPNs are acting in their team member role that's OK - any member of the team can be approached with a referral so long as it's brought

through to the team, or unless it's specifically, if somebody is asking the CPN `can you see this person', that's fine and then just mention it to the team.

I Does that actually occur?

R It occurs certainly with myself with the outpatients role but a lot of the outpatients has more or less died a death but I still get approached `could you do such and such?' Some of the CPNs it still happens with and I think usually the CPN in these circumstances would say `yes, I will pass it on to the team'. If the referrer, particularly a GP referrer said, `No, I want you to do this one', if they've got room on their case load they'll do it but mention it to the team so that the team is aware that that person is being seen. If they haven't got room on their case-load the CPN has done in the past, said `I can't, if you want me you'll have to wait three or four weeks'.

I How much control should CPNs have over who they accept as a referral?

R There's the control from outside and then from them. Certainly they should be able to say if they feel they have the skills, it's an open market really, whichever referrals come, all that they feel they can deal with they should be entitled to

bid for. There is outside control from the rest of the team saying - it sounds from the assessment you've done that this other person is perhaps the better or the more appropriate person. So I think the controls tend to come more from outside - I think it's really an open house for the individual. If you've got the space on your case-load, if you've got the interest and knowledge in that treatment then put in a bid for it.

I What would happen if a CPN didn't accept a referrals, refused to accept a referral, and it was felt that that referral should go to the CPN?

R The nearest we got to it was last week. The person I had seen with the social worker, who ought to be in hospital but refuses, what we'd agreed, myself and the social worker, was to be given support at home and both of us our first reaction was to ask one of the CPNs.

It went through the referral system and the CPNs said `well, why do you need a CPN?'. And we said to ourselves `why do we need a CPN?'. If it was just contained within disciplines, if how it would resolve itself. I would find it hard to see it actually arising, but if it was actually somebody, a CPN, saying no and the whole team itself said yes, I think somebody else would step in, one of the other CPNs, rather than going through to a

management level. In the team policy it would be line management issue, for the co-ordinator of the team to go to the line manager, but in practice I think it would be another CPN saying `well, I can do that'.

I What do you consider the role of the CPN to be in the assessing of referred clients?

R I suppose again the CPN is going in with some idea, you're trying to find out what the problem is going to be. You want them to assess for that particular problem but also the much broader thing of what is actually happening here. So they're not just asking questions related to what the referrer is letting you know is the problem, they are asking the right questions to get the broader issues, to formulate some idea about what is necessary, not what are they, the CPNs, going to do about it, what is necessary, and from that to bring it back to the team and say `this is necessary and I can or can't do it'.

I Assessing is obviously a pretty crucial initial step in the life of any referral. Do you feel that CPNs are equipped to assess?

R I think from knowledge of problems they are but I don't think any of us actually get any training as to how to assess.

I think it's more to do with knowledge and experience of mental health problems and life in general and trying to cobble that together in somebody's house to say `what are the problems here' and `have I got the skills to cope with it', rather that going in to it with a set proforma and saying `this is how I'm going to assess this person'. I'm saying nobody gets training, perhaps I just talk about doctors (both laugh). Generally we'd go for a joint assessment anyway. About half the joint assessments are between, eg a CPN and another discipline, either a doctor or a social worker, and about half the joint.

I Who do you think that the CPN should be clinically responsible to?

R I suppose the obvious answer is the whole team - it doesn't, i.e. the responsibility, come through to me. I feel quite happy in saying that there is a cut off and that as a nurse you are doing such and such and that's fine, but you've got the responsibility within yourself for what you're doing and doesn't infringe in mine, whether or not I have medical responsibility for that action.

I What is your approach to CPNs discharging clients?

R I think the decision is something, is something

again to be brought back to the team for information purposes. If it's someone I'm seeing in outpatients it would be something I'd care to know, I'd hope that they'd tell me. If it's a client that I have no knowledge or dealings with anyway, it's useless information, it's really just if I'm involved but not in a permission asking sense, it's more just passing on information.

I What should be the system that operates as far as supervision is concerned with regards to CPNs?

R It should be there! Which is a problem in some parts of the district health authority. It should be disciplinary and regular and it should be wanted. It's not a sort of supervised, an imposed supervision, not a hierarchical process, very much a forum for, a multi-disciplinary forum, that feels safe for people to say `I don't know what the hell I'm doing here', very much a voluntary system that allows you to be very honest.

I It occurs to me that it may not be your problem in terms of wanting to have a multi-disciplinary team with shared responsibilities but may be that some CPNs have difficulty in taking up that challenge?

R Yeah, I think for some people in the team, some people who were CPNs before the team began, I think it's OK because it fits into their model of how

they would have liked to have worked in the old days as with CPNs with a degree of autonomy but not hierarchical links and being told to do something. I think the folk who've moved from hospital to community, it's a big change.

I In what way does a good CPN differ from a bad CPN?

R The obvious one would be the initiative to actually act on what they've got would make the good one. I always remember that a consultant I worked with being offered a CPN saying `what the hell do I want a CPN for - do I need somebody else to go out and find problems'. That to me would be a bad CPN, who finds difficulties and brings them back as opposed to dealing with them. There's less chance of that happening with a team.

I Some people might say that it's a strategy that you could use to defer problems and not necessarily a strategy to engender good practice?

R I've been accused of that. GPs have said, `he's relinquishing his responsibilities'. For the first 12 months it actually felt like I'd actually got more responsibilities because I had to keep looking over my shoulder to find out what was happening because, in some way, you still feel responsible because you are now letting go but I feel more comfortable about letting go now and saying `well

people are responsible for what they are doing'.

I What needs to happen to the CPN service or CPNs themselves in order for them to change for the better?

R One of the problems that our system has at the moment is the management of it. It's messy, it's still run through the management. We don't really want to be management but as individuals within the team, we have half a dozen different bosses so I think some relinquishing of management responsibilities but I don't know how we are going to approach the whole idea of management locally. But that is where a lot of the grumbles are at the moment.

I Thank you very much.

6.10.APPENDIX 10

TRANSCRIPTION OF SELECTED PARTS OF DIARY (PILOT STUDY)

CPN 1

REFERRAL NO 1

I So, you've had indirect contact via his mother. There was a telephone call, was that to you direct?

R Dr [SHO], he was the other one who was [going] to do the assessment.

I So, you're not quite sure what you're going to do about that now?

R No, I'll have to make contact with him [the client] or his mother to say when when can we come and see you.

I There are two of you going to do the assessment, and it sounds like you are going to do the chasing up of it in terms of re-contacting him. Was that something you discussed with the SHO?

R I suppose it's more a question of being really here more, because we are here all the time.

I So, that would be a natural thing to occur, it's something that would just fall into place?

R Yes.

I Is there any sort of policy or any particular thing written down whereby if the situation arises somebody actually is responsible for taking it further?

R I think the fact that we were to do a joint assessment makes us both responsible to make sure something is done about it. The other thing is it came up every Tuesday [at the team meeting] until it is dealt with. If you haven't seen them you'll be able to say why, if you have seen them you'll give feedback to the team as to whether you are going to be a key worker or whether somebody else should be, so there is a pretty safe system.

I So in that case do you regard the team as a sort of, has a responsibility as a team to monitor what is going on with referrals? Is it in the final result the team who has to take responsibility for, say, this particular type of situation?

R Yes, I would have said so. I've worked in some groups and teams in the past, you've always felt as though you were responsible for whoever else was with you as well. Being part of the team, they were able to keep an eye on you and, say `hey, have you forgotten this?' It's a pretty good thing in that way. It goes back to the team, if things are going wrong, it isn't just up to the co-ordinator to get

it right, it's up to whoever is thinking in that way to put their 'oar in' and say so.

I What would happen if something disastrous went wrong with this particular client and the 'team' was taking responsibility for it, is there somebody on the team who would take a final decision, responsibility?

R I think, on that one, in our policy we are all clinically responsible for our own work but we should also get the support of the team. We should also get the support of management in that they've accepted our team policy. So it's a pretty safe system if you're doing your job.

I Has that ever been tested out in the history of the team?

R I don't think to any extent, only maybe when a GP has got a bit uptight and said ` I want this, this, and this doing' then we put it right - it's usually Mike [the consultant: name changed] as it's medical to medical. There's odd things where they've [GPs] come in with little 'digs' or comments and they have been sorted out by saying, `right this is maybe what you want' but our policy is this, it's the policy we told you about, hard luck!

I It sounds like there is quite a list of commitment

to the policy that was arranged in the team from individual members, and they won't be "carved up".

R We put a lot into it.

I Have the GPs, as they seem to be one of the major referring agencies, have they now accepted the idea of referring to a team that has this particular policy? And again I know that you have direct referrals as well.

R Yes, they're pretty well accepted. This.....

I There is some kind of agreement to tell them [the GPs] what you are up to?

R Yes.

I If it's a referral to the team that may not be necessary [to tell the GPs what you are doing], but if it's a direct referral, that is an agreement?

R If it's a referral to the team we usually write a summary after assessment. This lad [i.e. the referral No. 1], the GP had rung saying `what is happening?' And I said hadn't seen him. And he said `look this is important', but he wouldn't go so far as to say, `do it today'. In the past they used to say `would you go and have a look at such and such'. It may have been to sort out a

house, well what the hell do they think we are? We have to be careful not to slip into roles that are not appropriate.

I Let's say they [the GPs] do refer to the team but they may well want a doctor rather than a nurse, is there any notion of their putting pressure on the team, or members of the team to give them who they [the GPs] perceive is the 'right person'?

R We made that understanding that if they actually asked for a particular person that person could refuse and give it back to the team, CPN 2 used to get a lot, it was always `CPN 2 could you do this, do that', He said, `I'll put it back to the team'. A lot of the requests came to the consultant from other doctors, asking `would you see the client or will you get one of your domiciliary care staff to look after the clients'. For a while it was `Mike, will one of your team', which used to get us quite angry, because we weren't `his' team, he was part of `the' team.

I In some teams you do get to apparent co-operation between members and there not being a hierarchy. It seems like from what you're saying is that you went through that process. Have you arrived?

R I think we are probably there now.

I So what did you do?

R We [SHO and the CPN] started off by asking him what he saw the problem as, discussing things that were going on. We knew at an early stage that he was looking for something very different from what we were wanting to offer. This guy was, he'd changed his GP because he hadn't been able to from the first one. He was looking for something to make him sleep, and everything was resolving around this sleep pattern. He didn't sleep so he didn't get up, so couldn't get a job, so if he couldn't get a job he hasn't a decent income to have a girlfriend and all the other things in life. So, he'd get to bed late at night, wouldn't sleep yet again, wouldn't get up to mid-day. So all he needed was a handful of Temazepam which works when he can scrounge it. The GP had said no, his girlfriend had split with him, this had made matters a hundred times worse, he had made this sort of suicide gesture. He had taken some tablets first before he'd cut his wrists and had been conveniently found unconscious.

I He'd meant to be found?

R He'd got it all planned. As I say, very much into what he wanted. When we went through all the suggestions, working out these patterns, and say `right, don't go to bed tonight at three o'clock in

the morning, don't go 'till nine o'clock the following night. You'll find you'll have a good night's sleep then, he'd drunk a fair bit of coffee, he smoked quite heavy and he did it at night, that's a stimulant and I said to him `that smacks of keeping you awake' and he said to me `that's the only way I can get to sleep'. He was getting quite aggressive, he said `what you should do is take me back to childhood, why can't I be analysed'. So we pointed out quite strongly that that wasn't going to help him and that we weren't offering it anyway. I remember on the last occasion he was quite aggressive on interview, we kept our cool this time pretty good, and at the end of it he came round to doing a bit of listening, [to the SHO]. The SHO said `You're not mentally ill'. `Really' said the client, and he [the client] was quite pleased to think that he wasn't. It looks as though most of the things that happened in his life were things that he could resolve if we could help him to do this. Then he got into saying that he felt that he hadn't had much of an education, he ought to have stayed on at school. I think he said that he'd spent most of his school times running away and avoiding lessons, and now could see the significance of it and he said `I know I'm quite intelligent, I ought to develop it' and I'd say well it's in your hands, why don't you, and then come back to us when you've started doing something and we'll help you along the way.

I So you contracted with him that if he was to do something then you would.....

R We said, that it was very much in his hands, we weren't going to take all his troubles away, he wasn't mentally ill, his problems were such that he needed to make an effort and could be helped along the way, but not in actual fact somebody carrying him or leading him, so we left it very much like that. I spotted him in the road a couple of days after, and he went to greet me, you know, shunting from across the road and I thought, hey this guy avoided me the last time I'd seen him, so had we actually gone beyond his aggression because he'd absolutely moved from `you're not helping me, why can't I have a few tablets, my stupid GP '. We did point it out to him that he wasn't getting anywhere with the aggression, he needed to actually get stuck in and sort it out. I'm waiting now for him to come back and say that he's started doing something.

I It was a good sign then, by recognising you on the street.

R That was just a though, you know, a glimmer because I went very much into the thinking `here's another one wants it sorting out but doesn't want to do anything'. I just felt as though there was a

glimmer of hope.

I You say talk about what you did [in the session] and you said that `we', as in the SHO and yourself, did this?

R It's pretty close to fifty-per-cent shared between us. One of the things that was said before we went in was because I knew him, the SHO said look `you be the hard guy and I'll be Mister Nice, but it worked out to be exactly the opposite. The SHO was getting quite annoyed, but this guy [the client] was getting all defensive, so it was quite an interesting little session really. From one plan we changed over to another.

I So, after you'd had the session, did you and the SHO have a chat about what you were going to do?

R Mostly, just looking at what had been discussed and into what was happening in the future. He [the SHO] was good enough to do the write-up which was quite nice.

I That's unusual, is it?

R I think er, I'd say its unusual, it's only a matter of form really, he'd put something on the dictaphone whereas I'd be sitting down and writing it out, it's making it hard work.

I So you contacted the GP?

R We wrote to the GP because he'd referred him, in fact the SHO did it I think.

I You talk about feedback to the team as a way of telling them what you'd done. Did you receive any suggestions or any advice or comments from the team?

R The feedback was mostly, `carry on that way', `that sounds good', `are you prepared to take it on?' and I was. I think if they had picked up anything that was adverse they would have come down pretty quick.

6.11.APPENDIX 11

TRANSCRIPTIONS (EXTRACTS) OF FIELD NOTES

Total amount of observation time: 150 hours

The notes were completed during the observation session, immediately following, or later the same day. Frequently verbal notes were made using a tape-recorder after the session. These were then transcribed and entered into the Field-notebook.

TEAM 1

RESEARCH WEEK 2

Substantive Observations:

A comment was made by CPN 9 to CPN 6 and 7 about supervision being arranged by the staff support officer for every two weeks. The tone of the interchange suggested that they believed this should have been going on but hadn't. CPN 7 remarked that they had better admit that it hadn't been going on because he always entered a time-location in his computerised records.

Methodological Observations:

I was much more organised. Checked the equipment before use and all was working well.

Analysis of Observations:

The referrals examined so far appear to be dealt with quite autonomously by the CPNs as far as treatment is concerned. The CPNs (particularly CPN 6) seem to judge for themselves when to discharge their clients - often in negotiation with the client but not colleagues. CPN 6 appears also to discharge clients but then keep them on his books until the end of the month. Is this done to massage the computerised statistics?

RESEARCH WEEK 3

Substantive Observations:

CPN 9 raised the issue of him and CPN 6 having such a high turnover of clients. He said that they seemed to be "getting through" them very quickly, and as they weren't receiving many new referrals their respective case-loads were actually going down.

Methodological Observations:

I am feeling much more relaxed about asking my questions

and listening attentively to the replies. I am now able to go through the list of questions and probes without constantly looking at my schedule. I have a lot more faith in this diary method compared to observation as the latter would increase the likelihood of the Hawthorne Effect.

Analysis of Observations:

CPNs here display a large degree of freedom in organising their working programme (within certain 'time' parameters).
There is an issue from CPN 8 about being used as an 'injection nurse', whereas CPN 9 operates with a humanistic/client-centred philosophy.

RESEARCH WEEK 4

Substantive Observations:

With reference to part of the interview dealing with referral 3 and the process of admission, CPN 9 stated that he has made decisions to admit by simply telephoning the ward nursing staff and asking if there was a bed available. After the tape was switched off he said, "I suppose this situation [i.e. the CPNs being able to make decisions like this] would change if the consultants changed". He then added, "Although I don't know. Most of us are pretty headstrong in this team",

indicating that even if the consultants demanded a certain form of action the CPNs might/would be able to ignore the demand.

CPN 9 remarked that they were going through a dry spell with regards to incoming referrals.

CPN 9 commented that "three new referrals had come" in, and that he and the others would be "fighting over them".

CPN 7 made an appointment with me for a time when the team (I was told by CPN 6) has their meeting. CPN 7 looked unconcerned by the overlap.

Methodological Observations:

I'm worried about how long it's going to take me to collect twenty-five referrals from CPN 9 and CPN 7.

Analysis of Observations:

My impression is that there is not much going on today. No-one supervises the CPNs or asks questions about what the CPNs are doing?

'Bare-foot Therapists' might be a useful phrase to describe how CPNs appear to be operating. There is a mixture of 'autonomy' to practice (and to make decisions over admission) with 'doing the dirty work' for other more prestigious mental health groups (e.g. the medical staff and the psychologists).

There is an issue best summarised by CPN 9 who stated, ".....sometimes I'm making a decision and then

informing them [the consultants] of it because the contact is difficult....." De facto autonomy? Furthermore, CPN 8 said, ".....usually I don't go to them [the GPs] unless I know exactly what I want doing."

RESEARCH WEEK 20

Analysis of Observations:

The second consultant interviewed today made the point today that CPNs often discharge clients after a very short period of time when there had been only a small amount of change in the client's condition. He also said that CPNs assumed that they know a lot about counselling and other therapeutic techniques following short courses. CPNs, he believed did a lot of harm to clients by practicing these techniques on them. Although he said that he didn't have any "hard data" to back up these claims, he did feel very strongly about them. The analytical point here is that these views (if valid) indicate the 'autonomy' of the CPN to operate in this way.

RESEARCH WEEK 25

Substantive Observations:

CPN 8 said that she had three categories of clients

within her case-load:

(a) the 'active' clients receiving continuous input on a regular basis

(b) those on the health authority's computerised 'monitor' system, whereby a reminder would be sent to the CPN to visit certain vulnerable clients (who were not formally on the CPN's case-load)

(c) a number of 'inactive' clients who might be re-referred at some time in the future.

Methodological Observations (and substantive):

When I was interviewing CPN 8 (and this had happened before) I said, ".....so you're thinking of discharging her?", and she answered with, "I've just thought about it now - she's discharged! [i.e. she decided to do it then and there]. What would I do without you keeping me numbers down!".

The tape-recorder broke down this morning, so I have decided to use a small dictaphone (using ordinary sized tapes to keep costs down) instead from now on.

I've decided to stop monitoring the referrals already collected from CPN 7 and just monitor future new referrals. I have monitored these present ones for up to twenty-five weeks.

TEAM 2 and TEAM 3

RESEARCH WEEK 1 AND 2

Substantive Observations:

There are three CPNs in this CMHT (which technically is two teams, with CPN 10 and 11 in one team, and CPN 12 in the other, although they are all housed in the same building).

CPN 10 and 11 talked about the seasonal variation in the amount of new referrals they got. They said that referrals tended to 'dry-up' in the summer, and would pick-up again near and during the Christmas period. CPN 11 said, "....it's the stress of Christmas....." that resulted in a higher amount of new referrals. She also stated that at the end of all of the school holidays the referral rate went up because of the effect of children being at home "stressing parents".

CPN 12 talked about how vulnerable she feels working on her own. She mentioned that when working on the wards you knew what the boundaries of your work were, but in the community there was no framework to work within, nor was there a role model. She said that she found herself "working too hard in the beginning". She now realises that she wasn't doing the clients any good doing this, and that she needed to slow down to be more effective.

CPN 11 stated that she received formal supervision (clinical) from the CPN manager, usually once a week.

She felt she received informal supervision from her colleague (CPN 10) with whom she shared a room. This took the form of asking each other's advice if they had a problem with a client.

CPN 11 said, when I asked her if she felt that she belonged to a CMHT, "Well, yeh, officially of course I do, but on the other hand I don't feel as though because we don't meet as a team as such..... I feel as though there needs to be more putting together of the team...." [transcribed from my verbal notes on the dictaphone, made immediately after the session].

CPN 10 didn't turn up for his appointment with me. The receptionist tried to find out where he was by looking in the 'notebook-diary' which records where the CPNs are. That is they write in here where they are going to be if they leave the building as well as writing in here their appointments within the centre.

There are weekly team meeting for both 'teams', which CPN 10 described as "referral review sessions".

Methodological Observations:

Talked to CPN 12 about the research. She asked questions about what the information was going to be used for, and who would have access to the information. I reassured her that the CPNs would be anonymous, and that I would make every attempt to disguise the location of the data. As frequently happens with the CPNs and with the significant others, CPN 11 made some interesting

comments after the dictaphone was switched off (see above). What I do is to record these comments immediately afterwards on tape, and later make notes in the Field Note book.

Interviewees not turning up is quite a waste of my time, but I have to try not to appear irritated as this may stop the CPN from participating.

I feel very tired this afternoon. Does this affect the type of data I obtain?

Analysis of Observations:

CPNs (e.g. CPN 11 and 12) have some confusion over their team membership. That is, they are not sure whether to predominantly identify with the CPN team, MDT or with the CMHT.

RESEARCH WEEKS 3 AND 4

Substantive Observations:

CPN 12 non-verbal behaviour (e.g. rolling her eyes) indicated that she was cynical about the supervision she received. The CPN manager, she stated, is always willing to listen but she wanted a more active approach to supervision. She was also (non-verbally) negative about her consultants medical model approach, and she was cynical about belonging to a CMHT. She saw herself belonging more to a MDT, which included colleagues not

formally in the CMHT (e.g. Day Centre workers). She pointed out that she rarely had any contact with any of her colleagues from the CMHT on a day-to-day basis.
She said that when she first started the consultant had asked her to "pop in here and pop in there". This meant, she said, that she had been extremely busy without any time to think about what she was doing. She said that she is in control of this now, but very resentful about the consultant psychiatrist calling her "his CPN". She said that the consultant tended to dominate the team meetings, and whilst he had been on holiday (he is at the moment) the other members of the team had arranged to meet to formulate a plan to change this. They were to meet to talk about being less "consultant orientated". They were to present their plan at the next team meeting when the consultant was present.

Methodological Observations:

I forgot to bring a spare tape with me, so I had to borrow one from CPN 10 in the middle of an interview. Also, the red light on the dictaphone which indicates that the batteries are working went out, but the interview was still recorded.
There is a problem in not being able to record the non-verbal behaviour accurately, as with CPN 12 (see above) and CPN 10 who said that he had written to referral 2's GP but his non-verbal behaviour was incongruous.

Analysis of Observations:

The CPNs seem very isolated by not having a communal room (as with team 2).
CPN 12 wants to challenge the dominance of the consultant, but doesn't explicitly challenge the modes of treatment and 'language' associated with that model.

RESEARCH WEEK 5

Substantive Observations:

Talked obliquely about autonomy with CPN 10 (after the tape was switched of). He was against the idea of attempting to "objectify" his practice, and felt that in the end he had to rely on his "intuition and skills" to make decisions. He was against the idea of CPNs specialising in acute or chronic work as he thought these types of categories were very arbitrary. He did believe that there was a case for a specialist "rehabilitation" team, but then all other work could be done by the remaining CPN (he had worked previously in rehabilitation himself).

Methodological Observations:

My role as researcher is often contaminated by my role with some of the CPNs as lecturer to them in the past and present on various courses. This means that

sometimes I have to switch from being relatively passive and open (researcher) to being more active and directive (lecturer). On the positive side, if my lecturer relationship with the CPN is good, trusting, etc., then this can encourage co-operation. It also means that I can identify areas to probe further as I know the field, and can challenge the CPNs on inconsistencies in their presentation of 'facts'. However, being a lecturer may make the CPN more guarded than if I was a 'straight' researcher.

I find there is a tension between 'holding a conversation' and a more formal interview. I try not to let the diary become the focus of attention, which would encourage a much more structured set of responses than I want. What seems to happen is if I put the diary down and still use the questions (from memory), we slip quite easily into a 'conversation'. This does encourage the interviewee to talk more openly. It's as if putting the diary down is the same as switching the dictaphone off. In these circumstances the interview becomes much more like a conversation between two people who have a common agenda (e.g. mental health). This means that there is a lot more of a dialogue, and that closed questions, leading questions, and my opinions are much more prevalent.

TEAM 4

RESEARCH WEEK 1 AND 2

Substantive Observations:

I asked CPN 15 about the rate at which new referrals would come in. He said it was cyclical as the more he attended GP surgeries the more the referrals he got, but the more referrals he got the less he could attend the GP surgeries. CPN 14 added that she knew which GPs to go to if she wanted some new referrals, and that some GPs didn't refer at all to the CPNs.

CPN 13 stated that although they operated with an open referral system, the consultant organised a study day to "thrash out" the idea of changing to having all referrals going through the consultant. I clarified this with CPN 13 and it transpired that what was being proposed was that all referrals should go through the CMHT. The discussion on the study day, stated CPN 13, had also been about who the CPNs should be responsible to. That is, should GPs have what is now 50% of the CPN's case-load (and which they refer directly to the CPN), or should the CPNs identify more with the "psychiatric services" through the CMHT. CPN 13 said that he didn't mind the proposed changes, but CPN 14 said that she did. CPN 13 said that in reality the CPNs would still work closely with the GPs as they (the CPNs) would "go out and see them" (as they do now).

Methodological Observations:

I visited the CMHC to talk to the three CPNs about my research, and to make appointments with them for the interviews. CPN 13 asked about what would happen to the data on the tapes. He was concerned who would have access to these tapes.
I was careful not to demand too much information from the CPNs in this session, and to make it as informal as possible. This was because this would allow my 'entry' into the research arena to be more successful.
Both CPN 14 and 15 have cancelled one appointment due to sickness.

Analysis of Observations:

The changes proposed by the consultant in this centre is what originally got me interested in this research.

RESEARCH WEEK 5

Substantive Observations:

CPN 15 spends two out of five days per week away from the other CPNs working from a health centre. Here he shares an office with three district nurses, a practice nurse, and a health visitor. He considers himself as part of the PHCT, although he said "this doesn't seem to be official policy".

CPN 15 stated that he doesn't accept clients without the GP's or the CMHT's agreement first. He then specified that it would be either the consultant or the psychologist on the CMHT whose agreement would be sought. Does the diary data support this?

CPN 14 was not sure whether or not she could accept self-referrals. She asked CPN 13, who went and checked in the referral policy document. This stated that the CPN would have to check with the GP first, except in exceptional circumstances.

Comment by CPN 14 [on tape] about being left alone to do what they (the CPNs) wanted to do. The implication is that nobody checks on what the CPNs are doing.

Methodological Observations:

Keeping going collecting the data over what has now been one-and-a-half years is becoming very tiring, and boring!

It takes a lot of my time travelling to and from the centre, particularly now that I sometimes have to meet CPN 15 at the health centre (there is about fifteen miles between the CMHC and the health centre). Also, at the health centre the room where I interview CPN 15 (the only room available) is very noisy with so many people in it. This causes recording problems.

Analysis of Observations:

Some of the CPNs' views about what they do (e.g. about contacting GPs) are not held up by the diary data. The 'construction of mental illness' is a very pertinent area to look at when I analyse the data.

RESEARCH WEEK 7

Substantive Observations:

CPN 15 stated that he was reluctant to confirm that he was 'the key worker' for referral 5, who was at risk from self-harm. He explained [on tape] that his colleagues were also avoiding being nominated as 'key worker'. Nobody wanted to held responsible if this client committed suicide. CPN 15 stated that there was a real risk of the client doing this, which he said was "very sad".

CPN 14 talked about how the consultant "left the CPNs to get on with things", but she said that this indicated a lack of interest on his behalf. She also complained that he didn't turn up for certain meetings (e.g. the day hospital meeting, which involves the CPNs). Again, she stated that this suggested a lack of interest on behalf of the consultant, and was a lost opportunity for the consultant to talk to the CPNs.

CPN 14 asked my advice (which I didn't offer) about the CPNs not being asked to be involved with a client before

she/he was 'discharged' by the consultant from his case-load, and then referred on to the CPNs. She indicated that she didn't agree with this practice.
CPN 14 felt that she was "abused sometimes" by being used to collect medicines that the GPs prescribe for patients who do not need CPN involvement.

Methodological Observations:

Once again I appear to have created a good rapport with the CPNs. As with the other teams, this rapport has led to the CPNs providing me with 'backstage' data. For example, during our interview CPN 14 asked me to switch the dictaphone off, and then provided me with "gossip" about one of the clients.

Analysis of Observations:

Are the CPNs asking for a paternalistic 'overseer' (in the form of the consultant), rather than accepting professional responsibility?

RESEARCH WEEK 8

Substantive Observations:

CPN 15 attended the CMHT meeting between 9.30 am and 11 am, but CPN 13 sent his apologies and some messages for the "team" from him (although he said these messages

were in fact mainly for the consultant) with CPN 15. CPN 13 said he couldn't attend the CMHT meeting himself "due to the pressure of work".

Methodological Observations:

CPN 14 was not there for her interview with me as she had taken a day off. There is a continuing problem of cancelled appointments with CPN 14. There is also, as with team 2 and 3, the problem of getting the twenty-five referrals from each of the CPN taking much longer than anticipated.

Analysis of Observations:

I get the impression of a 'Peter's Law' operating. That is, the amount of referrals 'picked up' by the CPNs (e.g. from the GPs) vary depending upon the time the CPN feel they have available, and such things as the weather (i.e. going out to the GP surgeries will be restricted during bad weather?).

6.12.APPENDIX 12

TRANSCRIPTIONS (EXTRACTS) OF INTERVIEWS WITH CPNs

TEAM 1 CPN 6

Referral 4 Week 1

I Apart from, if I can classify it this way, exploring the problems, was there anything else that you did?

C6 Um, I did some relaxation with her, got her to look at how she could more able [to] ground herself. I noticed with her that she was quite tense, breathing fast when she was talking to me. At times she was weepy, she was shuffling a lot, so I got her to look at how her body worked, and I got her to actually put both feet on the ground, and I got her quite often during the session just to slow down, and to tell her to breathe, and to remind her to breathe. I also helped her to make connections with her anxiety, and her body.

I What happened on the next visit?

C6 She'd done a lot of the work we'd mentioned in our first session, what she needed to do, how she could do it, the relaxation, some more assertiveness, more control on her emotions, let go of other peoples responsibilities, and things are beginning to change for her. So what I did was to get her to re-cap that, also

to get her to look at now she can keep the momentum going for herself, what now she needed, what now was the direction, how she could fail herself, how she could slip back, would she recognise if she was doing that, what then would she need to do, what were her resources, and we left it there really. We both felt at the end that okay there was nothing more we needed to work on at the moment, and I gave her the opportunity to call me again in the future.

I Right, so, you've actually discharged her?

C6 Yes, yeh.

I Whose decision was it to discharge her?

C6 Both of ours.

I Both the client and yourself?

C6 Yes.

I Have you done anything after the discharge, have you discussed her with anyone?

C6 No, no. I'll write a letter to the GP.....

Referral 1 Week 1

I Did the referrer indicate what he wanted you to do?

C7 It was an acute problem. This chap has had a long standing marital problem. He got to the state where he was going to walk out and leave his wife, and he had got nowhere to go, and he just wanted a hand firstly coping with the practical side of that, but also the emotional things around it because he gets quite depressed.

[gap]

I Why did you accept that particular referral?

C7 Because it seemed appropriate. Besides, there was much more to it than I've said. He's just been treated for cancer, he's got a chronic problem with lots of acute stresses at the moment, so I accepted him because I thought it was appropriate for I wouldn't keep him on my books too long.

[gap]

I What did you do?

C7 Took a proper history, and we worked out what he wanted to do and what we could do together, and made a kind

of plan.

I When you say 'took a proper history', what type of history taking do you use?

C7 Well, um, I haven't actually got, it's a blank piece of paper right in front of me, um but I suppose um, with categories in the back of my mind. What I usually do is I let the individual just go for maybe twenty minutes or so, just not try and organise that particularly, depending on the individual. In this case he would have talked forever, so at the end of twenty minutes I then begin to organise that into um, I suppose I always want to know something about their previous psychiatric care, treatment. I always want to know their current situation as far as um, something about their social circumstances. If it's relevant, maybe its not an issue here, I'd need to look at the family as well, but all this might not come out at the first visit, and also if there are any physical things that might influence that.

I So you did that. What else did you do on the second time?

C7 So I got some kind of information as to what was going on at the moment, and then I asked him what he wanted to do about all that, and where I fit in I suppose, and then we made some kind of plan from there.

I You did the plan together?

C7 Yeh.

I What does that plan imply?

C7 It's a very simple plan, basically, as I've said, one of the major stresses and his wife didn't listen to him, and he wanted to get something off his chest and have someone to talk to who understood those things. So I said I'd give him some time for that. There was a practical side as he wanted to get out of the situation, and I suggested to him that there might be more implications to that than he'd realised, and said shall we save those till the next time and look at what the implications of moving out might be, or and I gave him some ideas as to what the options might be for him.....

Referral 2 Week 4

I Have you contacted anyone about him?

C7 Well, I tried to contact the consultant, but it's very difficult, so I did leave a message with his secretary.....

I Is that a common problem not being able to get direct contact with the consultant?

C7 It is recently. We sometimes see him in team meetings,

but it's a big problem.

I So if you want something sorted out fairly quickly?

C7 Sometimes we have difficulty.

I Does the logic follow then that at times you would make decisions on the basis that you can't contact the consultant?

C7 I think sometimes, yeh, what I've found what I am doing is making a decision, then informing them of it, rather than I'd like to discuss it with them. If the contact is difficult then the only way is to make a decision and them know, and then see what the comeback is really.

TEAM 1 CPN 8

Referral 6 Week 3

I Why did you accept the referral?

C8 Um [5 sec. pause] I tend to take ladies with depression and anxiety problems.

Week 4 Referral 2

I What was the content of the conversation?

C8 It's quite funny really. When he sees me he stands up because he thinks he's going to get his depot, and I was going to give someone else a depot, so he's like, I walked into the bedroom and he's standing there with his trousers down [both laugh].

Referral 9 Week 4

I Was the psychologist still involved?

C8 No. Temporarily they'd stopped. Basically [the psychologist] had thought that she was suicidal and was worried about her, and the registrar went out to see her and asked me to see her rather than the psychologist.

I So the psychologist is still in the background?

C8 Yeh. He will pick her up again as soon as the dirty work is done.

I Um. That's worth exploring. Does that happen a lot?

C8 To a great extent I think that is our role in a way, the basic down-to-earth stuff, going out giving support, down-to-earth sensible advice, leaving the more in-depth arty-farty stuff to others.

Week 5 Referral 9

C8 I've been trying non stop to get in touch with [the registrar] with no luck, but I did manage to get a hold of the GP.

Week 5 Referral 10

I What would happen if you didn't think a referral was appropriate from the consultant?

C8 I'd go and see them and tell them.

I And the consultant would accept that?

C8 It depends on the case. One of them I'd rung up and said 'there's nothing I can do', and he said 'well, because she's a suicide risk can you keep going in'.

TEAM 1 CPN 9

Referral 1 Week 3

C9 Usually, I have some sort of instinct of what I will do, and get some feedback from the client about 'this is what happened' and 'this is where I'd like to go' and 'what I'd like to do', and sometimes even 'this is how I'd like you to help'. So usually there is some direction from them or I can initiate some sort of

movement, perhaps clarify some things and start moving them in certain directions, but with her [the consultant] is sort of saying 'she ain't gong to move' I'm not really sure how to treat her, or whether I can.

Referral 3 Week 3

I What would you describe as her major problem, or symptom?

C9 She's got an endogenous depression.

[gap]

I Why did you take on this particular referral?

C9 Every referral we get we've got to do an assessment. When this referral came in, I took the telephone call from [the GP].....[the other CPN] took one, [the O.T.] took this one, but she was going on a course this week so she wasn't going to be able to see her, so I said I'd take it.

[gap]

I What happened on the second visit?

C9 I knew she'd changed medication, and so I was interested to see if there had been any change, she'd been on antidepressants for five weeks, and I was asking her if

there had been any change in the mood, in any way at all.

Referral 9 Week 7

C9 She's that person who needs the relaxation. I rang the physios, and went to see them, and they do out-patients, so they'll send her an appointment.

[gap]

C9 As a general rule I would probably have discharged her at the end of this week, or the end of next week, but all the people I want to discharge will have to wait 'till, or formally discharge, 'till I get round to doing all the notes.

TEAM 2 CPN 10

Referral 2 Week 2

I Why did you accept her as a referral?

C10 Well, the initial information I had, the referral appeared appropriate, it was brought up in the team meeting, and in a sense because, when a referral is brought to the team meeting it's not a foregone, it should not be a foregone conclusion that the person who brings it takes it, but never-the-less I took him. So I

just accepted it as being appropriate for my skills. So I provided the assessment. The assessment showed that she was experiencing significant depressive features, and that that would be amenable to counselling involvement. She was already on anti-depressant medication from the GP, so I felt to complement that.

Referral 5 Week 4

I Why did you accept her as a referral?

C10 First of all, I accepted to provide the assessment because the information given by the GP seemed appropriate, and he said specifically a CPN because medication is involved, so I took that as an appropriate CPN referral. I've seen her, and explored with her her current experiences of depression, and feel that she is, well, she'd benefit from counselling involvement, and a general assessment of her medication and how she's responding to her medication.

Referral 7 Week 5

C10 She [the client] came into the drop-in facility, and spoke to one of the members of staff who got the details, and I took the referral as it was brought in to the team meeting.

I Why did you take the referral, I mean why you rather than anybody else?

C10 I suppose, I mean apart from the informal thing of just generally knowing whether you feel, there's that kind of like unsaid thing of whether you know where you are with your case-load. There is some discrepancy as to his presentation. When he was in hospital it was seen that there was no symptoms of mental illness as such. In the letter he doesn't appear to be experiencing mental illness. But his mother says is that his behaviour sounds quite disturbed. There is some hint that it may be part of a mental health *problem, and* you [the CPN] is being asked *because they are probably* better versed in the psychopathology.

New referrals *Week 10*

I Any other new referrals?

C10 All new referrals have been snatched up by other member of the team.

Referral 4 Week 15

C10 He's like not formally on my case-load, and I don't know if I highlighted that? Although I saw him, I assessed him, and I've written to his GP, I was due to go out and see him but I haven't put him formally on my case-load. I've told the GP what my opinion was, and I've referred him for group involvement to [the day centre], but I'm not intending to provide individual

counselling at this time. So he's not really on my case-load, I haven't taken him on. After having said that, I will be visiting him. Kind-of-like formally he's not on my case-load, but informally he is.

I Why has that situation arisen, why is he informal rather than formal?

C10 Right. It goes back to, he was on my case-load some time ago, and we did some work and he responded fairly well to it, but in the end he became very dependent, and he didn't seem to show any motivation despite my kind-of continuing efforts in like being flexible, he seemed to just rely on me making all the efforts, and although he agreed to go along with certain regimes, he didn't take any of it up, and I went on for a period of time more-or-less highlighting this and he still didn't take it up, so it was like a long drawn out situation in which he had plenty of, he knew the situation that if he didn't at least comply to some of our agreements that there was no point in continuing on. And anyway it ended after quite a long involvement really, so I'm wary of that now. So, the reason why I'm not formally involved is because of that, and the reason why I'm informally involved is that there were just a couple of things. You see after the assessment he was going to make use of the library because he was a bit isolated or unoccupied, so I was just going to go back to just show interest on what he's done really. So it's that type of situation.

TEAM 2 CPN 11

Referral 1 Week 1

I What happened during those forty-five minutes?

C11 Well, once I got past mother [laughs], who seems to be somewhat over-protective, there was very little the patient could tell me, but by her presentation was sufficient to tell me how ill the girl really is. She was able to tell me - it was a question and answer situation - with mother giving her bit as well. She had all the classical symptoms of being quite depressed, clinically depressed. She hadn't been sleeping, she wasn't eating, no interests. In fact I was up there early afternoon and she was still in her nightie and dressing gown. She was weepy, irritable, all the symptoms of being clinically depressed..... I was concerned about the depth of the depression I was picking up so I felt someone more experienced than me needed to see her, and prescribe some medication [or do] a medical assessment, which is what I did.....and I managed to get her seen on the Friday afternoon [by the psychiatrist]..... and she agreed that she needed admission, and she [the client] reluctantly agreed to be admitted to the ward. She didn't even go back home, she just went straight to the ward. However, she became unsettled, and unfortunately discharged herself on the Saturday against

medical advice.

I And you saw her?

C11 I've been this morning. You see there is no, usually what happens if they discharge themselves against medical advice, in a number of cases, most cases, no follow-up arrangements are made, so she hasn't been given an out-patients appointment, she hasn't been given a prescription. I take that mother has accepted responsibility for her. She hasn't been re-referred to me, but I'm still concerned about her. I went to visit her this morning, but there is nobody in, so I will have to follow her up next week. In saying all this, she has been attending here for her depot injection, which indicates that there is a psychotic side to her, which I haven't witnessed yet. There was certainly no psychotic symptoms on the day of my assessment, there were depressive symptoms.

Week 5 Referral 2

I Why did you accept him as a referral?

C11 Because he is a patient known to us. I've had dealings with him before when he was defaulting in attendance for his depot injection..... He seems to be quite well managed in the community without much intervention, so when [the GP] says then you go because usually there is a reason.

TEAM 3 CPN 12

Referral 7 Week 7

I What did you do with him?

C12 I'd been really just finishing my assessment.

I What do you do?

C12 We have a sort of draft assessment form we use to give us guidelines, to gain the information we need.

I Is that part of [X] model?

C12 I'm not using [X] on him, but if I was using it on him I would use their assessment tool. But I've decided to use [Y Model]. So [Y] doesn't have an assessment tool laid down, so the CPNs drafted um an assessment tool to help us collect information. So I use that as the guideline to get the information. Um, really what I've been doing is just getting to know him, and building a relationship, and getting information really.

TEAM 4 CPN 13

Referral 1 Week 1

I What would you describe as her major presenting problem, symptom.....

C13 Depression, neurotic depression or reactive.

[gap]

I Why did you accept her as a referral?

C13 Um, well what we tend to do is on a Monday go down to one of the surgeries, and obviously if you go there and receive a referral then you usually take it on. It varies to some extent. If a referral comes to the CMHT and it goes to the CPNs then we discuss it there and then. But obviously if you pick something up like that [i.e. from the GP] you usually take it on yourself, unless it's something perhaps you feel you wont be able to manage or you aren't feeling suitable towards.

I So in this case it was a suitable referral?

C13 Yeh. The thing I really enjoy is the depression.

Referral 2 Week 1

I Why did you accept her as a referral?

C13 I'm dying to say 'because I was asked to'. [both laugh] Well no, I mean we just look at people and decide, we look at our own case-loads and we decide

amongst ourselves [the CPNs]. That was fine as far as I was concerned, I'm quite comfortable with that kind of person. I quite enjoy that.

Referral 9 Week 12

I Did the GP give you any indication as to what he or she wanted you to do?

C13 Oh yes! [laughs]

I They were very specific by the sounds of?

C13 Yeh. [laughs] He's a person whose broken his arm.....drunk, which wasn't for the first time [laughs], he's lost his licence as well.....and he'd actually not been eating for about three weeks due to the amount of alcohol he'd been consuming, and he was quite frightened because [the GP] had told him that basically his liver was not good due to the fact he'd been abusing alcohol for about twenty years. So basically she asked me if I could go and see him because he had agreed to actually see someone to talk it over and hopefully give up.

I So it was specific in terms of stopping him drinking?

C13 Yeh.

TEAM 4 CPN 14

Referral 2 Week 3

C14 This particular girl has suffered from depression in the past, albeit this is her second baby and in fact she didn't suffer following the birth of the first one. The depression that she suffered was before she had any family, and I think the fact that she wasn't going to be around [the GP] to go in, you know. So I went to see her and she was back at work, she works part-time, and she was on [an antidepressant] which she had in the past, and she didn't feel too bad, and she was, I left it that er you know I was happy with her. So, I just spoke to the GP last night, and said that I'd been in once and I didn't think that there was er. So the GP will now pick up and see her.....

[gap]

C14 Well, you know when you think about it you're left to do very much to do want you want.

Referral 3 Week 7

I Why did you accept her as a referral?

C14 Because eh [laughs]. This is what I always find amusing. I mean because we always accept anything. No, but em [the registrar] said that she was a little bit

worried about her, because of the physical aspect [she had overdosed], and although she's got two daughters that live locally they weren't aware that their mother was as depressed um. She brought the children up on her own. She was divorced when they were very small children, and I think she'd been quite a strong mother and held everything together, um, and she [the registrar] wanted an eye keeping on her because she has recommenced anti-depressant therapy, she needs it, but she was reluctant to attend the day hospital. She's still very very pre-occupied with what she's done, and ashamed of it, so really just a supportive role and to really monitor the medication because although it's all been written down, she still tends to think that these anti-depressants are to help her sleep, so she's omitting the morning dose and eh so from that point of view I'm trying to you know, and she certainly seems to be pleased that someone was coming in.

Referral 4 Week 7

I Did the referrer [psychologist] give you any indication of what they wanted you to do with the client?

C14 She's been actually known to the department on and off for a period of years, day hospital, well she suffers from chronic anxiety, and he's been seeing her [psychologist] on a one to one basis....., and he feels that he's achieved, you know, what he wanted to

do, or thought he could do, but at the same time, rather than cut her off, we can probably manage her.

I Right.

C14 I sometimes actually question this, er not to the people, and really wonder what role we're actually playing.

I Could you have refused to take that referral?

C14 No, because I know the patient.

TEAM 4 CPN 15

Referral 3 Week 6

C15 The GP suspected that it was a depressive thing that was going on. She [the client] refused to acknowledge that until just two or three weeks ago, and she accepted. She wasn't going out, not doing the housework, she didn't have any confidence in herself, she felt her husband could do everything better than her, and the GP started her on smallish dose of [an antidepressant], and asked me if I would go in and um provide her with the necessary counselling and support.

I Are you the key worker?

C15 Yes.

I Why did you accept her as a referral?

C15 Um. Again, we've discussed this before. Anybody who's referred on that basis then I will see and assess. Not necessarily accepted on to my case-load. I saw the girl at home. She was obviously, she obviously had been quite depressed, if anything she was a little bit better than she had been, er almost a placebo effect in acknowledging the illness and accepting the treatment, but still obviously in need of constructive support, even if you accept that the [anti-depressant] might do the job, she needs some support to go with that, advice, reassurance about the illness and the course of the illness. But from what I saw, first impressions it will be relatively short-term involvement.

6.13.APPENDIX 13

TRANSCRIPTIONS (EXTRACTS) OF FOCUSED-INTERVIEWS

TEAM 3

CONSULTANT PSYCHIATRIST

I What do you consider the role of the CPN to be?

R Right. Um, how can I phrase this? Er, I think the CPN's role is to do with looking after people with mental illness in the community. Now I want to look at that more closely. I think given the current resources available to the health service, the CPN's role has narrowed to looking after the severe cases. There is a trend at times to expand that into guidance for the worried well who have, I'm sure, some measure of distress, some psychological morbidity [unclear]. So yes, in an ideal world the CPN could be expected to be involved with those people, given the resources. I would also say, that CPNs, from my point of view, should be confining themselves to a secondary health care role. I am always uneasy when they are taking referrals directly from GPs, ur, not because I have anything against that at all as such, but again there's a limit on resources, and er we've got to cut our coat according to our cloth. Um, if GPs want to employ CPNs out of their own budget, or buy CPN

time from us, then fine because, well that would enable us to recoup our CPN time.

I So it's an economic argument.....

R Yes.

I .....rather than about the role?

R Yes, I think so, um, then again I think that if a CPN is part of a multi-disciplinary team, and is also seeing primary health care patients, then where does that CPN relate to, to the GP or to the psychiatric team, or a bit of both. You get possible communication difficulties. You do occasionally hear odd stories about CPNs taking on patients on the request of GPs, and getting all tangled-up, and the psychiatrist at the end has to pick up the pieces, so to speak. Ur, now I've fortunately to date not had that sort of experience, but I can see that occasionally it could happen, and [unclear].

I Where do you see the CPN's role in terms of assessing clients?

R Well, I think they do have a role in assessing clients, and usually they're fairly good at it. Ur, having said that, CPNs vary a fair amount in terms of training and experience, and yes some CPNs I

would trust to give a pretty accurate assessment, and other CPNs I would say "yes but you know, have you checked everything through, are you quite sure?". It depends on their experience.

I What about CPNs implementing their own treatment or care programmes?

R Well, as long as I'm satisfied the patient has been fully assessed, and the treatment programmes are appropriate to that patient, fine. It's a question of er if things go wrong who picks up the pieces. I mean despite my earlier comments, CPNs do receive referrals directly from GPs, and they jealously guard these, um, and obviously they do liaise with the GPs. What I will not accept is a CPN seeing a patient from a GP and then trying to dump the medical responsibility on me, and I've never seen nor heard of the patient, and that strikes me as grossly unfair. So I have a rule that any patients referred by GPs to nurses, then the medical responsibility belongs to the GP. If the GP thinks there are problems coming up and wants a psychiatric opinion, they know that I will then assess the patient.

I We are now talking about two sets of referrals, those that are referred by GPs, and those that come from you to the CPNs. On the issue of discharge, how do you feel about CPNs taking the decision to

discharge patients from their case-load?

R Well, they usually do in consultation with myself and other team members, and usually they make appropriate decisions. Sometimes I have to say to them "I'm not quite happy about that because", and discuss it in some more detail, "it may be worth going back and looking at this particular aspect of the problem". Um, so as I say, usually they make appropriate decisions, and usually discuss this.

I Who do you think should supervise CPNs, and what form should that supervision take?

R I think that's a little difficult. There are various models, and you can't say one is better than another because I don't think it's researched, you can't come up with a scientific answer, um, so it's opinion mixed with some experience, I suppose. I think obviously that CPNs should have some supervision or resource input from the nursing profession, but once they're working as part of a multi-disciplinary psychiatric team, there should be supervision from the team, and I suppose very often that's from the consultant. But it would really be in terms of case supervision, "what are you doing with Mrs. so-and-so, have you tried this, have you tried that?".

I Looking at the organisational setting for CPNs,

what do you regard as the most appropriate setting for CPNs?

R Well, it depends what context you're talking about. They seem to work very well as far as the community mental health team, we are quite happy with that. They have their own line management. I sometimes feel a little bit anxious when CPNs, as a professional body, want to do their own thing. I'm sure they want to maintain their own sense of identity, but [unclear].

I Talking about their identity, what would you consider to be the difference between a CPN's role and say the role of a social worker, or an occupational therapist, or indeed your own role?

R Well, CPNs have a nurse training. Um, they are not aware of all the rules and regulations on accommodation, social services, social security benefit, social workers are. Um, they should be acting as nurse to the patient, offering competent support [unclear]. They have a much lower case-load than consultant psychiatrists. They have what, thirty or forty patients on their books at any one time. They have more time than consultant psychiatrists, so they are more able to deal with thing like anxiety management programmes, etc., so in that sense, although I theoretically do that sort of thing with patients, my case-load is such

that I don't have time, and therefore it's important to have someone who can. Now if an occupational therapist can do that sort of thing, then they can do it as well, and maybe a psychologist can as well, and CPNs are cheaper to employ than a consultant psychiatrist as well, and maybe they are better value for money [laughs]. Um, so yes, there is a fair bit of overlap between the professions. I think it is important to realise, I think it is also important to realise the pluses as well. I mean nurses aren't particularly trained to diagnose, and I suppose for that matter in many ways treat, as doctors are, and psychiatrists are involved with certain methods of treatment, and of course nurses are not allowed to prescribe. There are exceptions. Now you can argue the pros and cons of that, I suppose. I think if CPNs were to prescribe, really, they would need quite a bit more training to be in a safe position to do that sort of thing.

I What do you consider makes a good CPN?

R Difficult, I think. The first things that occur to me are that a good CPN has to be someone who's interested in their job, interested in their patients, and is able to develop a good rapport with their patients with a certain amount of empathy. I would see these as pre-requisites for the job. I think a CPN who was able, willing to er

respond to occasional emergencies well, and someone who can work well with other members of the team.

I What would make a bad CPN?

R Um. I'm not sure really, I've not really come across many CPNs who I would call bad. I've come across the odd one I've found irritating, and I found that one irritating because they *were very* much in favour of a free-for-all come in off the streets sort of thing, self-referrals, and so on, which in an ideal world all right, if you've got the staff to do it fine, but that person very soon realised that the work-load was such that even he couldn't do it either [laughs]. I wouldn't say he was necessarily a bad CPN. I suppose other things, sometimes CPNs try to get themselves more involved with primary care at the expense of secondary care, perhaps unable to go and see people with chronic problems because they are too busy seeing people with minor problems. I would say certainly that that CPN was being a bad CPN.

I The final question, what do you think needs to be done to improve CPN practice?

R Well, I would like to see a separation of their primary and their secondary roles. I'd like to be able to say that my, the CPN attached to my team will look to my work-load, exclusively attached to

that team and will go and see people at the behest, after discussion with the team, and if GPs want to provide their own CPNs. It's a question of resources. Um, what else. I sometimes get the feeling that CPNs see themselves as a very exclusive bunch, and in some ways they are right. I think it is important to try and ensure that they are willing to work as part of the team. I don't know whether that needs any formal training, or adjustment of attitude, or what. I mean generally there is no practical problem about that. Um, I suppose extra training is always useful. I know not a lot about CPN training. I know I've had CPNs working with me who've done their job very well, and all of a sudden they've said "Oh well, I won't be here for twelve months, I'm going off on a CPN training course", and you know, what the hell. All right they are getting a formal qualification, but why they hell when they are working perfectly satisfactorily for a number of years, and now they're going off on this course? You wonder how much benefit they're going to get from the course. It seems a bit potty. It would be sensible to give them training from the start. They could have in-service training, and obviously the more experienced they can get at behavioural-cognitive treatments then the more skilled they are going to be and more useful. There's more to a CPN than giving a depot injection.

I Okay, that's it. Thank you very much.

NOTES MADE AFTER THE INTERVIEW: I am recording some of these notes because the Dr was such a quiet speaker.

In answer to the question "What do you see the role of the CPN to be?" he talked about the extended role in terms of having more skills and also the need for CPNs to be looking after the chronically ill in the community and not to be dealing with the "worried well". He expressed the opinion that the "worried well" had problems but the economics of using CPNs wasn't on as there wasn't enough staff. He did believe that CPNs believed themselves to be somewhat "special" but at the same time he also stated "maybe they are".

He distinguished between his own role and the CPN's in terms of training, he also wanted to see CPNs have more training. He saw the Social Worker as having more knowledge in terms of benefits. He accepted that OTs and CPNs did much the same work.

He wasn't too happy about CPNs accepting referrals from GP's, he thought there was an abuse of the service and that CPNs should really accept referrals from him although he did correct himself and say from the community mental health team. He talked about his team and corrected himself and said the community mental health team at another point in the interview as well.

He was very much against the way that CPNs coveted the referrals they got off GPs and CPNs perceiving them as referrals for themselves and not referrals that had

anything to do with the consultant. He said in fact, that he thought it quite wrong that if CPNs did get into any trouble they would come and ask the consultant to take on the medical responsibility which he would refuse to do. He said "it is all very well that the CPNs have referrals as long as they maintain medical cover from the GP's". His whole tone was very much against the CPNs doing this side of their work.

He said CPNs could be acceptable if they assessed clients and implemented care programmes. Very few of them made mistakes he said, but at the same time there would need to be some "coming to him". The Dr appeared to have a superior outlook.

He talked about CPNs needing supervision from their line manager within the nursing profession, and also have some sort of reporting system. He believed that CPNs should belong to community mental health teams. He didn't seem very much in favour that CPNs belong to primary care and kept talking about the need for CPNs to look after secondary care rather than primary care.

He seemed generally to have a good impression of CPNs, somebody who had interest in the job. A bad CPN was someone who perhaps took on things that they weren't supposed to and got themselves into a mess. He criticised one CPN he'd known for "whinging" for having self-referrals loaded onto his case-load. He wasn't in favour of that as he said the resources weren't there.

To improve CPN practice he talked about training although he admitted that he didn't know much about it.

TEAM 4

NURSE MANAGER

I The first question is, what do you consider the role of the CPN to be?

R Um. What do I consider the role of the CPN to be. I think that within like the community team set up the nurse takes like the skills peculiar to nursing to the community team, um, and those are assessment and skilled care to patients.

I How do you see their role being different from say a social worker, or a psychologist, or a consultant psychiatrist? What is it that marks them out to be different?

R We've just been through this exercise in the authority, and I think we all agreed that they are assessment of care needs, and the delivery of care to meet those needs, with a care plan. Also the particular skills of managing a patient with er difficult behavioural problems, and being able to approach another professional, and also the holistic aspect of care.

I Right. I want to look at some of the specific

issues about the referral system. Who do you think that CPNs should take referrals from?

R Um. Who do I, my own personal view is that CPNs should take referrals from the community, the er primary health care team, and from the whole team including the consultant psychiatrist. They are, if you like, in the position of being in-between. I don't think it's either practical or sensible that they should only take GP referrals.

I How much control should the CPN have over deciding who they are going to take referrals from?

R I think, again this is my personal view, that the CPNs must be clear about where the referrals are coming from and not, I think again the situation that does arise is when the CPN doesn't know where to turn because the pressure of work are coming from both ends and they are getting squeezed in the middle, and I think that there is that issue. But I think the professional thing comes and they should have the right to say that this particular referral is not appropriate for us to deal with, I'm not the right person to deal with it, or I will do an assessment but after that I will require support from other people to deliver this care to this patient, and that probably there should be much more emphasis in the future, you know, on team work, and the CPN is one member of it.

I If we were to talk of such things as an open referral system versus a specified referral system, should the CPN be able to say that they are not going to take self-referrals, or alternatively, should they be able to say that they can take referrals from anybody?

R It's difficult for me answering that here because [in this health authority] we have agreed that we won't have an open referral system, but what a CPN can and does do if a patient refers themselves, the CPN then says 'that's fine, but I need to discuss this with your GP', and I think we find that acceptable here. It might sound as though I'm toeing the party line, I am, but it's after a lot of discussion and a lot of heart searching.

I How much control should the CPN have over how much they do with the client with respect to the planning and implementation of care?

R I don't like that word control. I mean to me, what my view is, depending upon which grade they are, but generally they are appointed at G grade, I'd expect the CPN to be able to make an assessment, to plan care, and to deliver it independently. But I also feel that if that happens independently and there's no feedback towards the team, you could end up with CPNs doing something that CPNs are doing

that doesn't fit in with what the rest of the team are doing. For example, the CPN might be going against what the psychologist is doing, and I think there is a need for the, I think the nurse should be able to say 'this is what I think I should be doing, how does it fit in with what you think you should be doing?'. It should be a team issue, but they should be strong enough and professional enough to say 'this is what my role is within this treatment programme'.

I What about discharging clients? How much, I know you don't like the word control and I'm trying to think of another word, how much should be under their influence as to whether or not they discharge or don't discharge a client?

R Again, I feel very strongly, I think that the CPN should strongly influence the decision, but I think at the end of the day it should be a medical decision ultimately. I think the CPNs have to be aware of the ramifications of their decisions, and that's why I say I don't think, my own personal view is that they are professionals, but at the end of the day there are ramifications.

I There is a tension between being a professional and.....?

R I think the way we work here, if you like, the

decision to discharge a patient would be arrived at through discussion, and if the CPN was to say 'I don't feel I can get any further with this patient, it's not appropriate that I see this patient anymore, and it's appropriate to discharge the patient back to the GP', and the CPN goes to the GP and would expect the GP or the consultant to say 'fair enough', but at the end of the day they are aware, it is not a case of the CPN just doing it without going back to the medical officer. In my experience it makes the patient very vulnerable as the patient may never be picked up again. It's also as a nurse they would be liable if the decision was passed back to them. We've discussed it a lot here.

I Some of these issues may be connected to the issue of supervision. Who do you think should supervise the CPNs?

R I currently supervise them. Who do I think they should be supervised by? Certainly they should be supervised by a senior nurse with experience.

I What about the interdisciplinary supervision?

R Again, I think, I wouldn't really call it supervision, but there is a need there to discuss case-work with the likes who are not nurses. But then you always have this sort of two-tier thing where nurses feel that they want to be supervised

by nurses, nurse managers, but you can also get a great deal from just discussing with another colleague, whatever profession, if you're getting peer support, peer review. But again, I think that's different from nurses talking about the profession of nursing. Nurses feel there are issues that only affect nurses.

I As a manager of CPNs, what would your definition of supervision be?

R My own definition of supervision. I supervise as a manager, and I make sure that er I check how many patients have been seen by a CPN, where I think that is compatible with what I think a CPN is able to do, are they able to see that many patients, is the care-plan for that patient appropriate, if care is being given but is not being successful then what is being done about it. So I'm also, I supervise the professional, ethical, and moral issues as well that crop up, you know. If a CPN comes up and says 'I'm doing this' or 'I've been asked to do this, I don't really think that it's appropriate, but I've still been asked to do it, what do you think', you know. Obviously, that does go on within the CPN support system.

I Where do you think that CPNs should be housed, located?

R Ideally, I think CPNs should be located in the area in which they work, not necessarily with the primary health care team, but in the community which they serve.

I Is there any tension there between primary and secondary or tertiary work?

R Yes, I think there is, particularly when the CPNs have a foot in both camps, and we are only a small service. We can't have a hospital based team and a community team.

I What do you think makes a good CPN?

R Er, certainly when I interview for a CPN I am looking for an experienced nurse, who knows what nursing is about, and knows what they are about, and works independently with minimum supervision, if you like, still hang on to what they are about. That's what I look for. I also look for someone I can communicate well with.

I The next question might be just the opposite of all that, but what makes a bad CPN?

R What makes a bad CPN? One that isn't clear about role, one that isn't clear about what nursing is, and couldn't find their part in a team. There is one thing about knowing what you are in a team and

one thing about not being able to share the teamness. I think until you're sure about what you're doing, you can't really do that. In fact one comes before the other for me. I certainly wouldn't appoint someone who wasn't clear about what their role was as a nurse and also have a vision about what CPNing is about, but is also aware of the issues of becoming part of the team, other professionals.

I What do you think needs to happen to improve CPN practice?

R I think what needs to happen is, locally, yes I supervise CPNs but I don't do it often enough. I think that certainly needs to be improved on. CPNs need a network of support from within in the profession, and you know on the ward you've got the opportunity constantly to talk to people, but you don't have that as a CPN, and I think we need to build that in so that they can constantly question what they do. They may have a planned piece of care and six months on they are still doing it. Nobody ever asks them 'well why are you still doing that', whereas on a ward they'd say 'do you think that you still should be doing that?' I think also that the CPN has to be more specific about what they do. I think within the community team I see psychologists, occupational therapists being very specific about what they do, go in and do it, and

finish, whereas the CPN is the one who keeps going. I think the CPN should also be able to say that this is a piece of care I've given, and after they've given it should be able to come out. A lot of people are asking at the moment 'what is the role of the CPN?' I think a lot of people are starting to say 'these are expensive people, what are they doing'.

I Is there anything else you would want to add?

R Er, it's difficult. I think it is time to look and see what the CPN does, and how do they fit into the CMHT team. It certainly seems here that CPNs have gone into teams, but they haven't actually changed what they do. They still think that they are an independent group, and they haven't latched on to the idea that they are actually part of a team, and there are other workers in that team who might be better able to meet that person's need, and also the GPs haven't seen that either, they still refer to the CPN.

I Thank you.

TEAM 2 and 3

PSYCHOLOGIST

I The first question is, what do you consider the role of the CPN to be?

R Right, um, well, I suppose what I'd see as being, I can see their role as being, I can think of answers, I can think what their role would be, from a clinical psychologist's view?

I Yes.

R It would be that different people do different things, and that it all depends on *their own* interests, but I guess what differentiates them from other people is that they do have particular things they can do, unlike the rest, like giving injections. I certainly wouldn't see that as a major part of their work, but that's perhaps what would differentiate them from other people, and I imagine that there might be other things that they do .

I Apart from the medication, what might be the difference between their role and say your role?

R Right, between my role. Well, I think the community bit of it because although I say I work in the

community I don't visit people at home. I see CPNs doing that as an important part of their role. Also, I think it is about them providing support to clients following their discharge from hospital. So, I wouldn't normally see the client at home, and there are other professionals besides the CPN who would, unless they was a specific reason like agoraphobia.

I Okay. What I'd like to concentrate on now is the referral process. Who should CPNs accept referrals from?

R [10 secs. pause] Well, I don't see why they shouldn't accept referrals from anybody. I certainly do see them as being used as the arm of psychiatry, so there may be a pressure for them only to accept referrals from one source, but as far as I'm concerned they should be able to accept referrals from anybody.

I How much control should they themselves have over who they accept as a referral? I suppose there is a difference between saying that CPNs can accept referrals from anybody and CPNs deciding that for themselves?

R I think the thing that comes to mind is that CPNs seem to be a very mixed bunch, and I'm not thinking now of them as individuals, but I'm thinking of

their training. As far as I understand it, CPNs have their psychiatric nurse training, but beyond that quite a lot of them are in the job being a CPN without a CPN training, and perhaps it is the extra training that is important to help CPNs make decisions like that.

I As a follow on from that, how much control should CPNs have over assessing clients.

R Well that's a hard question, I don't see any reason why they shouldn't do it, but I don't really know what they do. It just seems that the CPNs I have come across have very different skills, and very varied training. I suppose the psychiatrist, where the CPNs follow the medical model, has some influence over this, over whether or not CPNs do the assessment. With the question of teamwork, what I see here is a team where it was agreed that the CPNs are encouraged to go out and do an assessment, and come back, not to the psychiatrist but to the team and then anybody might say well that's one for me, or not, and to the extent that there is time to do it then that's the system. But the other system is where the psychiatrist says this is my referral, I delegate , here you are you go and do it. I think that is wrong, and that extent I think CPNs should do there own assessment, and if they haven't got the training then it should be given, because that is really dangerous, and a lot of the time the

psychiatrist, because a lot of the time, you know, the psychiatrist will try to do it to us. They'll say 'he needs cognitive therapy', and then you go and do an assessment and they don't need cognitive therapy, and if you ask them [the psychiatrist] they don't even understand what cognitive therapy is [laughs]. It just like, it's absurd, and I think that sometimes CPNs get stuck with that. I sometimes get people coming to see me about what they are doing with a client, and I say 'what made you decide to do that, where's your assessment?', and they may say 'well, Dr X told me to do it', and I say 'and that's why you did it?', and I think shit, you were stupid to do it in the first place.

I What about CPNs discharging clients. How much control should they have over this?

R I think it's the same as before, they can say they are discharging a client in the team meeting, but there's not an effective check made as to whether or not this is right. CPNs do have control over this. There is an absurd kind of lip service paid to discussing it. You don't get time to discuss when there are ten professionals sitting around, so it's just a case of this is the way it is. Unless the psychiatrist is very involved or one of the other professionals knows the client really well there is no real checking. If there was more time you might be asking why haven't you discharged such

and such a person?

I Where does supervision come into the team? Who should supervise CPNs, and what would you mean by supervision in that context?

R Well, I think that the CPN manager is in the best position to look at the CPN's role and that. I suppose there's a king of kind of case-discussion element in the team, but that depends on time and the people involved. It's not supervision as such anyway. What I've said here is that I could be a resource, that I would provide supervision if they wanted it. Some people may be uncomfortable with the idea that we were giving them supervision. I had one CPN come to me, and she suggested that I joined in to discuss some of my cases, but I said that I didn't really want to do that. That really wasn't my agenda. I get other people to do that for me. As I say, I think a lot of people would be very uncomfortable with me supervising them.

I Anything else about supervision?

R Only that I'd draw a distinction between supervision offered to a trainee and the supervision I was offering the CPNs. As trained people they would still have clinical responsibility for their actions. Anything I was saying to them they would still be their

responsibility. I don't know, it's very difficult isn't it.

I It doesn't seem as though there is any clear pattern to supervision here?

R Yeah, I mean, we get supervision from the psychology department, from a senior psychologist. It has been very much up the CPNs as to whether or not they want to approach me or not for supervision. If they don't want to do that, I don't know where they'd go really.

I Just moving on, where do you think CPNs should be situated, ideally?

R Well, in a community mental health centre. Does, does that answer the question?

I Yes, well, there may have been alternatives.....

R Yeah, I mean they could spend some of their time at GP surgeries, but I certainly wouldn't argue for them to be like based in hospitals.

I What do you think makes a good CPN?

R Oh. I think somebody who can be quite assertive with the psychiatrist [both laugh]. I don't know, I think it's probably very tricky being a CPN. They

have to combine the more nursing input with in their role and the other parts of the role which are more therapeutic, and I can imagine it's quite a difficult line to tread. For example, the CPN might be going to someone's home to have a cup of tea with them, but then might go again to do some form of therapy, and I think that must be tricky. It's about knowing which is most appropriate, so that you're not just a friend but you're not just a professional either.

R You said about being assertive with the psychiatrist, how much is that an issue?

I Well I think it comes back to what I was saying before about the psychiatrist telling the CPNs what to do. It's sometimes that the psychiatrist will always want to give the client something, and will use the CPNs for that purpose, to give a prescription for example, and the CPN is supposed to deal with that. I can't take on people for endless cups of tea and take on ten referrals because there isn't enough time in the week, so which is it going to be, and it's like it takes quite a lot of guts to say that.

R I started off by asking you what makes a good CPN. What makes a bad CPN? It may be just the opposite of what you've just said, or you may have other things to add?

I [pause ten seconds] I suppose someone who just goes around and gives a cursory glance at the client's psychological condition, or just goes around giving injections. I suppose it would be easy to get into that. I had a client who said of a CPN who used to visit her, 'she was very nice, but sometimes I used to think that she just wanted a cup of tea on the way home'. It's stupid, I used to think what the hell are you doing?

I What do you think needs to happen to improve CPN practice?

R If there were more CPNs, then that would be a help. If there could be a situation whereby more senior CPNs were available to supervise, that would help. There needs also to be a better career structure because, from what I understand at the moment, you train as a CPN and then your career stops. I think thing are changing. There is less of the Florence Nightingale in the community approach. But the doctors remain a problem, and how do you get them to change from expecting the CPNs to run after them?

I Is there anything you would like to add to what we've discussed?

R Just to emphasise the business about professional

support and supervision for CPNs.

I Okay, thank you.

6.14.APPENDIX 14

CATEGORIES AND CODES FOR QUALITATIVE DATA

Key for coding substantive and pre-analytical data:

341 Team membership, supervision, and collegiate gaze

342 Referrers' expectations

343 Accepting referrals and constructing caseloads

344 Assessing clients and diagnostic uncertainty

345 Key workers

346 Content of contact and ideology

347 Discussions with colleagues

348 Indirect involvement

349 Discharge and admission

351 Rivalry, conflict, and skulduggery

352 Role ambiguity

353 Surveillance - CPNs as psychiatry's infantry

354 Hierarchy, hegemony, and patronage

355 Inter-professional stasis

356 Controlling referrals

357 Ideal typifications

Key for coding methodological data:

271 **Reflexivity**

272 **Rate of referrals**

273 **Tape recording**

274 **Rapport and role**

275 **Backstage**

276 **Reactivity**

6.15.APPENDIX 15

STATISTICAL TESTS OF ASSOCIATION USED TO ANALYSE DATA FROM DIARY-INTERVIEW SCHEDULE

VARIABLES	Q.NO. & DATA TYPE		TEST
Referral source & referrer's exptns.	55 nominal	62 nominal	Chi-square
Referral source & presenting problem	55 nominal	68 nominal	Chi-square
Referral source & client outcome	55 nominal	71 nominal	Chi-square
Referral source & reasons for accepting client	55 nominal	72 nominal	Chi-square
Referral source & time spent with client	55 nominal	73 ordinal	Kruskal-Wallis (U)
Referral source & therapeutic style	55 nominal	76 nominal	Chi-square
Referral source & discussions held/ not held	55 nominal	77 nominal	Chi-square Phi Cramer's V
Referral source & other involvement	55 nominal	94 nominal	Chi-square
Age of client & time spent with client	57 ordinal	73 ordinal	Spearman's rho

Referrer's expects. & reasons for accepting client	62 nominal	72 nominal	Chi-square
Referrer's expects. & time spent with client	62 nominal	73 ordinal	Kruskal-Wallis (U)
Referrer's expects. & therapeutic style	62 nominal	76 nominal	Chi-square
Presenting problem & therapeutic style	68 nominal	78 nominal	Chi-square
Presenting problem & discussions held/ not held	68 nominal	77 nominal	Chi-square Phi Cramer's V
Presenting problem & other involvement	68 nominal	94 nominal	Chi-square
Reasons for accptng. & discussions held/ not held	72 nominal	77 nominal	Chi-square Phi Cramer's V
Reasons for accptng. & other involvement	72 nominal	94 nominal	Chi-square

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