A COMPARISON OF THE WORK OF COMMUNITY PSYCHIATRIC NURSES AND MENTAL HEALTH SOCIAL WORKERS IN SALFORD

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ABSTRACT

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Case register data are used to describe the basic characteristics of clients who used the community psychiatric nursing, and mental health social work services between 1976 and 1985. These data are placed in the context of psychiatric services as a whole. Observational data are used to describe the day-to-day work undertaken by the two groups of workers.

Although no statistically significant differences in the clinical categories of the clients seen were found, there were significant differences in the ways in which the two groups of workers interacted with their clients. Community psychiatric nurses were found to mainly apply a medical model of care, whilst specialist social workers were found to be mainly concerned to improve the social adjustment of their clients.

There was evidence that the considerable shift away from caring for clients in the 'schizophrenia' clinical category was associated with the community psychiatric nurses' attachment to primary care teams. It was concluded that there were considerable unmet needs for the long-term non-hospital care of this group of clients.

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CONTENTS

INTRODUCTION

The author's interest in the inter-relationships between community psychiatric nursing and mental health social work services dates back to 1978, when, in the course of completing an M.Sc. Thesis, the analysis of case register data showed that the first CPN services in Salford began operating at a time when social work involvement with mentally 'ill' clients was at its lowest ebb. That interest excercised such fascination, that 9 years later, even after virtual total immersion in the subject, the interest lives on. It lives on to such an extent, that the author remains frustrated at the limited use she has been able to make of the wealth of data available to her from the psychiatric register.

Although much of the work presented here has been the result of direct observation by the researcher, the capacity to relate these observations to baseline service data which which have been consistently and comprehensively collected since 1968, provides a unique opportunity to place these observations in an overall context. That such an opportunity is unique is a reflection of the general failure of health and social services to provide themselves with the information required to properly inform their policy and management decision-making processes. It is also a reflection of the failure of epidemiologists to demonstrate the value of their work in a way which convinces people to invest in

it.

Many readers of this work will find the researcher's conclusions contentious. They challenge usual custom and practice, and are from time to time extremely critical. It is acknowledged that they are the result of the researcher's opportunity to undertake her work free from the constraints imposed on service policy-makers, planners and managers - an opportunity for which she is extremely grateful - but hopes that they are nevertheless sufficiently pertinent to the service situation to engender lively and informed debate by those policy-makers, planners and managers.

CHAPTER 1

BACKGROUND

1.1 MENTAL HEALTH SERVICES IN THE UNITED KINGDOM

Before the second world war mental health services in the U.K. were still largely based upon a model of custody, containment and segregation the embodiment of which was the mental hospital. After the war attitudes towards social and health problems changed for a variety of reasons. The mental health of troops had been perceived as being of importance to the defence of the country, psychiatrists acquired more expertise in the treatment of mental illness, the consequences of social divisions of pre-war Britain became less generally acceptable, and the development of social science theory highlighted the social contexts of problems such as poverty, illness and handicap.

Changes in physical treatment methods following the introduction of antipsychotic and anti-depressant drugs, associated with a drop in the numbers of occupied psychiatric beds by 8,000 between 1954 and 1959 (Tooth & Brook 1961), and reductions in the lengths of stay of psychiatric in-patients, preceded the 1959 Mental Health Act. Its guiding principles were that as much treatment as possible should take place on a voluntary and informal basis, that a new system of compulsory admission should safeguard individuals' rights, and that mental health services should be re-orientated from hospital to community. In 1961 in a major policy shift, the Minister of Health announced his intention to

reduce the numbers of mental hospital beds by half over a period of 15 years. Local authorities were urged but not compelled to provide alternative services. "... it is estimated that virtually no existing long-stay patients will remain in hospital after 16 years or a little longer" (Ministry of Health 1961). The era of 'community care' had begun.

The 1960s was a period of optimism. The 'new' drug treatments were perceived by policy makers to imply that long-term in-patient care would not be required in the future. In 1971 a circular entitled 'Hospital Services for the Mentally Ill' (DHSS 1971) proposed the complete abolition of mental hospitals and the siting of 'acute' psychiatric beds within district general hospital units which had been developing for over a decade. No long-term in-patient provision was recommended - even for 'longer-stay psychogeriatric patients' whose bed requirements were stated to be 'under review'. By 1975 it was recognised that district general hospital units alone could not provide the facilities required by the 'new long-stay' patients, and it was estimated that the number of hospital places required for this group of patients aged under 65 would be approximately 0.17 per 1,000 population. Health authorities were encouraged to investigate alternatives to traditional mental hospital provision for these very disabled patients (DHSS 1975).

The axiomatic role of mental hospitals in psychiatric care was also questioned for other reasons. The concept that the symptoms of mental illness were entirely explainable in medical terms was increasingly challenged. The post-war development of

psychological, social and behavioural sciences fuelled the 'literature of protest' and underpinned the 4 models of psychiatric care additional to the 'medical' model (the WHO model; the Seebohm model; the 'conspirational' model and the 'no-model' model) identified by Jones (1972).

Although not all members of professions subscribed to group 'norms', as various theoretical perspectives and 'models' of care emerged and were refined, they became associated with particular professional groups. This could and to some extent did result in wider patient choice as the availability of a variety of treatment methods became more widespread. However, the various professional groups involved in the provision of psychiatric care and treatment evolved their own professional hierarchies, and began to challenge the authority of psychiatrists as each group strove to establish its professional identity. The implementation of the Seebohm Committee recommendations (1968) compounded the fragmentation by removing hospital mental health social work services to local authority control.

Although few people appear to oppose the notion that inter professional teamwork offers the most promising care model, in practice, as Goldberg and Huxley (1980) point out "..there are few signs of the organization and integration.." required to facilitate such teamwork outside hospitals. That the various professions involved in providing mental health care often acted in competition rather than collaboration with each other was recognised by the Standing Medical and the Standing Nursing and Midwifery Advisory Committees of the Central Health Services

Council, and the Personal Social Services Council, who, as a result of their anxieties about "the welfare of patients and clients who appeared to be suffering from the lack of collaboration between these services and receiving adequate care from neither", set up a Working Party on Collaboration chaired by Dame Albertine Winner (DHSS 1978).

How far have the policies which advocated the re-location of psychiatric care away from hospitals been implemented? The numbers of average daily occupied beds in England fell from 133.2 per 100,000 in 1959 to 64 per 100,000 in 1985; first admission rates per 100,000 population fell from 161 in 1964 to 108 in 1983 and rose to 113 in 1985; Lengths of in-patient stay appear to be decreasing - the percentage of all in-patient discharges and deaths from mental illness hospitals and units with length of stay under 1 month increased from 41.9 in 1964 to 59.9 in 1985. However, at 31st December 1985, 342 of resident in-patients had been in mental illness hospitals or units for 5 years or more (DHSS 1969 & 1986), and convincing evidence has been presented that 'new long-stay' in-patients under the age of 65 continue to accumulate (Gibbons et al. 1984; Wooff et al. 1983; Fryers 1979).

Part of the changing pattern of care is reflected in changes in the provision of those professionals who largely care for people outside hospitals. This study aims to examine the current work of two of these - CPNs and mental health social workers. It is against a background of a shifting but by no means complete movement of the locus of care away from psychiatric hospitals, and the general acceptance that non medical models are relevant

to mental health care, that the ways in which CPNs and RMNs carry out their day to day work will be considered.

1.2 MENTAL HEALTH SOCIAL WORK SERVICES

One of the consequences of the changing emphasis of care was the additional burden carried by 'the community'. Social psychiatrists emphasised the inter-relationships between social and medical factors, evidence that families were increasingly under pressure as a result of changes in policy began to emerge (Brad and Sainsbury 1968; Creer and Wing 1973), and awareness of the influence of family life on the course of psychiatric illness was also heightened (Brown et al. 1962 & 1972). These factors combined to demand increased social work support for mentally ill clients and their families.

In 1971 far reaching changes in the organisation of social work services were implemented. In this text the terms social work and social workers will be used to denote fieldworkers as distinct from social workers working in day care and residential settings. Before the Seebohm Report (op. cit.) was implemented social workers were employed by both hospital management committees and by local authorities where three separate departments took responsibility for the provision of mental health, children's and welfare social work services. This division of responsibility led to difficulties in the co-ordination of social work help given to families which had multiple problems.

Following the report of a committee under the chairmanship of Frederick Seebohm, which undertook to review the organisation of personal social services with the objective of providing an effective family service (Seebohm op. cit.), local authority responsibility for providing social work services was assigned to new local authority social services departments (SSDs) whose main objective was to provide a 'community based and family-oriented service' available to all. These recommendations were widely interpreted as demanding an all-purpose generalist worker, and 'generic' social work teams covering specific geographical areas were established all over the country.

Thus the aims of the social services departments appeared to co-incide with perceptions of the social work needs of psychiatry for a service to the whole family rather than to individual family members only. Fears were expressed, however, that the great load expected to be carried by the social services departments would lead to the neglect of some client groups, including the mentally ill, as statutory obligations, for example in the field of child care, demanded most of the available resources. Additionally, it was argued that whatever the drawbacks of the old mental health departments, they were largely staffed by people who were experienced in mental health work even if they lacked formal qualifications, and that this experience might not be replaced.

The re-organisation of the National Health Service which resulted in the transfer of all hospital social work to local authority control, and the rationalisation of local authorities' boundaries

in 1974, led to further administrative upheaval. The Otton Report (DHSS 1974) emphasised that "there is nothing in Seebohm to imply the wholesale abandonment of specialism in social work practice" but the administrative changes, rapid staff turnover and recruitment of young and inexperienced staff combined to disturb previously well established specialist services and resulted in "considerable disquiet" being expressed by members of the Society of Clinical Psychiatrists (Little & Burkitt 1976).

Virtually all specialist mental health social work disappeared between 1971 and 1974, and though it has gradually re-emerged in the last ten years, there is considerable variation throughout the country (Challis and Ferlie 1986). There are three main ways in which mental health services are presently organised - with:

a. Specialist, psychiatrist-attached workers;
b. Specialists attached to area or patch social work teams;
c. Patch social work teams where all workers have mixed caseloads and where there are no specialist psychiatrist attached workers.

1.2.1 The Roles and Functions of Mental Health Social Workers

The Otton Committee (op. cit.), which considered general social work support for the health service, listed four stages at which the social worker had a contribution to make to the clinical team in the care of hospital patients:

1. Diagnosis. Assessment of the social factors involved as a

contribution to the medical diagnostic process;

2. Treatment. Provision of advice on the social considerations which should be taken into account when alternative treatment methods are under consideration, and preparation and support to patients who may have to face unpalatable realities;

3. Discharge. To provide an assessment of social problems which should be considered when decisions about the timing and arrangements for discharge are being made, and to take such action necessary to provide appropriate family and material support;

4. After-Care. To provide social rehabilitation and therapy after hospital discharge, much of which was expected to be long term.

In addition to direct patient care roles listed above, other roles the report perceived were:

5. Providing the clinical team with a wider community perspective through contacts with a wide range of organisations and through awareness of social conditions;

6. Providing and receiving training through the experience of working with others.

The range of functions social workers attached to primary care teams might carry out were summarised as follows:

1. Social assessment and evaluation as a contribution to diagnosis;

2. Application of therapeutic social work to assist the

treatment process;

3. Mobilisation of services outside the health service;

4. Educational work on the significance of social factors in health care;

5. Consultancy and advice for other staff in the social services department.

The Barclay Report (1982) concluded that the social work services were needed:

1. To plan, establish, maintain and evaluate social care networks by:

   a) promoting community networks;

   b) negotiation and advocacy;

   c) controlling access to resources;

   d) carrying out social policing;

2. To provide direct client/family services by carrying out counselling i.e. "a range of activities in which an attempt is made to understand the meaning of some event or state of being to an individual, family or group and to plan, with the person or people concerned, how to manage the emotional and practical realities which face them."

The social work roles outlined above relate to social work as a whole and not just to mental health social work, they also show a shift in emphasis from individual to community work. Although mental health social work has been perceived to require particular additional expertise and knowledge (Hudson 1982, DHSS

1974, Ministry of Health 1959, WHO 1972), there has been little evidence that mental health social workers see themselves as fulfilling different functions or applying different theoretical perspectives from their other social work fieldwork colleagues. The report from a W.H.O. Working Group which discussed the role of the social workers in the psychiatric services (WHO op. cit.) noted that social workers' activities could not be separated from the social and political context in which they and their clients existed, but did not advocate any roles which were not related to social work in general.

The number of systematic enquiries into the day to day work of social workers has been limited. In 1959 the Younghusband Report (Ministry of Health 1959) remarked: "We were struck, in planning the field inquiries, by the lack of any systematic study of the part played by social workers in meeting needs within the framework of the social services." In 1981 the Association of Directors of Social Services commented: "A traditional weakness in the social work profession has been the lack of documented information on the impact of different policies in practice" (ADSS 1981).

It is generally accepted that one of the factors which influences the kinds of work done by particular workers is the setting in which the worker is located and the few studies of MHSW practice which have taken place have tended to focus upon comparisons of variously organised services or, since 1971, the size and nature of the mental health component within generic departments.

Mental health social work studies in the 1960s concentrated upon the differences between hospital and local authority social work. Rehin et al. (1964) undertook an administrative study of mental health social work services in four areas, one of which was the County Borough of Salford - the site of the present study. Social workers were asked to record various aspects of their work over two separate working weeks. Local authority mental health social workers (LASWs) were found to be largely home visitors who called to see clients mainly on their own initiative. In contrast, over seventy per cent of the hospital social workers' (HSW) clients were interviewed in a hospital setting and around 30% of these interviews were on the social worker's initiative. Social workers' aims were divided into three categories i.e. ancillary to medical treatment, instrumental in social care (therapeutic intention) and residual (practical tasks and support). When the predominant aims were analysed, LASWs chose the three groups in equal measure, the HSWs chose residual aims (31%), ancillary and instrumental aims (22% each). The proportion of cases in which no single aim predominated was 10% for LASWs and 15% for HSWs.

Rehin et al. (op. cit.) concluded that the work of the HSW was of a short-service nature at transitional points in the illness/treatment process and that the close connection with the clinical milieu may have made the HSWs less aware of any need for, or potential in, community support services. They argued that a single unified mental health social work service, based in a local authority setting would offer more opportunities for the development and use of instrumental social care skills.

After the Seebohm re-organisation there were major investigations of the ways in which the new generic departments operated (Carver & Edwards 1972; McKay et al. 1973; Goldberg et al. 1977 & 1978) but few published studies of mental health social work per se.

Pritchard (1975) who studied differences between specialist hospital (SSW) and generic area team workers (ATWs) in Manchester found that, when 'ward rounds' were included under the heading of 'client contact', SSWs spent more of their working time than ATWs in client contact (57% compared to 40%) and that the proportions of time Manchester area workers spent in client contact, travel, desk jobs and 'other', were very similar to those found by other researchers investigating the operation of area teams (Carver & Edwards op cit., Goldberg et al. op cit., Hillingdon 1973). Another notable finding was that, largely on account of 'ward rounds' and 'ward meetings' the specialist social workers spent more time in consultation with others than area based workers.

Details of the activities which took place in connection with client contacts showed that compared to the ATWs the SSWs were - more directive (7% v 2% of interviews), gave more practical help (14% v 12%), made more assessments for diagnostic purposes (10% v 0%) and undertook more casework (25% v 12%). Compared to SSWs, ATWs were more likely to make assessments for admission (27% v 0%), undertake supportive work (33% v 28%) and to make contacts for 'fact finding' purposes (14% v 7%). These differences were discussed in relation to organizational parameters rather than related to any differences in client needs which may have been

present.

Pritchard noted that ATWs had "a continuous problem in trying to match the needs of existing clients with already stretched resources while seeking out previously unmet need and coping with a volume of new and often crisis work". She contrasted this position with that of SSWs who had a greater freedom to select clients without incurring criticism for failing to provide a service to all applicants, and who worked in a setting where consultant psychiatrists carried overall responsibility for patients' welfare whereas ATWs carried all the responsibility for their clients. The solutions she proposed were to develop "institutionalised" methods of protecting ATWs from the pressure of crisis work so that they could undertake work with clients such as the mentally ill, who had complex and long-term needs, and to ensure, primarily through in-service training mechanisms, that ATWs were exposed to 'learning situations' to enable them to acquire greater knowledge of the major forms of mental illness and their social effects.

Wooff (1978) undertook a survey of the proportion and characteristics of clients referred over a period of one year to two social service department area teams in Salford, who had contacted psychiatrists within 3 months (either before or after) of the referral date but who had NOT been classified by social services staff as 'mental health' cases (NMH). This group of clients was compared with those clients referred to the area teams who were classified as 'mental health' cases (MH) and with all other clients referred to the area teams over the course of

the year (SSDI.

Using case register data she found that the proportion of people who had contacted psychiatrists and who also contacted the SSD over the course of the study year was ten times higher than the proportion of the general population who contacted the SSD. The proportion of NMH clients was found to be approximately half that of MH clients and 27% of the former had been classified as 'elderly', 25% classified as 'family care', 16% as 'accommodation' and 10% as 'financial' cases. The NMH group aged under 65 contained high proportions of young women living either alone or with young children whose psychiatric diagnosis was 'depression'.

Details of the kinds of social work help given to the MH clients were unavailable, but the proportion of clients who received care for more than 4 weeks (the only difference found between the kinds of help given to NMH and SSD clients) were 66% MH cases, 16% NMH cases and 11% SSD cases. The author concluded that further studies were needed to establish whether different kinds of help given to the three groups of clients identified were the result of clients having different 'needs' or whether they were consequences of workers imposing their own different solutions according to the constraints of the organisation and/or their previous experience and training.

The most recently published major investigation of mental health social work was conducted by Fisher et al. (1984) in Derbyshire. They studied the size and nature of the mental health component

of work in area teams with the objective of looking for ways in which the quality of social work care to individuals and families with mental health problems could be improved. They found that even though a 'substantial minority' of clients did not have any formal psychiatric diagnosis there was a considerable mental health component in the problems they faced and that the emphasis on short term ameliorative work did not help clients to resolve their underlying problems or to prevent the recurrence of their difficulties. They noted inconsistencies of response to similar 'needs' brought about by differences in criteria for case closures which operated between 'intake' and 'long-term' teams. They were also of the opinion that the skills and knowledge required to undertake adequate assessments required for social work recommendations for compulsory admission to hospital were not acquired during training for the Certificate of Qualification in Social Work.

They recommended a model for the care/support of clients with long-term difficulties, in which short periods of active intervention by highly qualified and experienced workers supplementing monitoring by more junior workers, should be followed by systematic periodic reviews with team responsibility replacing individual responsibility for client welfare. In respect of elderly clients, where they perceived a shortage of health service input into care, they recommended urgent clarification of the boundaries of responsibility between health and social services. Further clarification of minimum acceptable standards of care within individual sectors of the social services department was urged, as they found that the failure to

address this issue resulted in individual fieldworkers being left to take decisions about relative priorities without the relevant information on which to make judgements. The paucity of resources for adequate community care for the mentally ill was noted.

Thus, the few systematic studies available, whilst applying somewhat different perspectives to their analyses, appear to highlight organizational difficulties in area teams, many of which became apparent because limited resources constrained attempts to deliver care to a wide and ever increasing variety of clients and families. The work which took place before the implementation of Seebohm implied that a 'community' rather than 'hospital' setting afforded the best opportunity for social workers to effect the integration of the individual within society, but post Seebohm work suggests that community based generic social workers have little opportunity to undertake long-term work with people who have mental health problems and little training specifically to help them to do so.

1.3 COMMUNITY PSYCHIATRIC NURSING SERVICES

Although the first community psychiatric nursing service was established as early as 1954 (May & Moore, 1963; Moore 1964), it was not until the early 1970's - the time of the genericise of social work - that the pace of development of these services increased. The recent rapid growth of the CPN services is evidenced by the fact that "Better Services for the Mentally Ill" (DHSS 1975) made very little mention of CPNs; ten years later the Select Committee on Community Care (House of Commons 1985) devoted more space to a discussion of CPNs and their roles than they did to any other group of staff. Interestingly, whereas "Better Services for the Mentally Ill" discussed the roles of social services fieldwork staff extensively; in the Select Committee Report they were discussed very little.

The exact size of the increase in CPN staff is difficult to establish, but in the absence of any official statistics concerning the numbers of psychiatric nurses working outside hospitals, the Community Psychiatric Nurses Association (CPNA) estimated that in 1978 1300-1500 staff and in 1985 2375 staff were engaged in such work (CPNA 1978 and 1985).

Parnell's survey (1978) showed that there was no uniformity in the ways in which CPN services were organised although the majority of the schemes identified were hospital based. There is little agreement but much discussion regarding the most 'appropriate' ways of organising services, but there is evidence that more and more services are moving towards, at least some,

direct contact with primary care teams. (Skidmore & Friend 1984a).

The ways in which CPN services are presently organised throughout the country and the numbers of nurses involved in this work are not precisely known but Skidmore & Friend (1984b) identified four types of service:

a. hospital based;

b. primary care based;

c. dual hospital/primary care based;

d. community based without hospital support.

1.3.1 The Roles and Functions of Community Psychiatric Nurses

The role prescriptions of CPNs are diverse. General nursing is divided along hospital/community lines but how far this is a consequence of the past division of responsibility between the hospital and local authority services or how far it is a true reflection of differing perspectives is uncertain. It is of interest to note, however, that a residential/community debate has arisen amongst psychiatric nurses, where there is no recent history of a split between hospital and local authority employment. Some CPNs consider that they have or should become a separate group within psychiatric nursing; some CPNs consider that they share the perspectives of their general nursing colleagues in the community more than they share the perspectives of psychiatric hospital nurses; others believe that changes in the perspectives of psychiatric nursing in general will enable psychiatric nurses to work in residential, day care or community

settings.

The debate widens into a consideration of how far the links between psychiatric nursing and general nursing should be strengthened or severed. The WHO working party (WHO 1975) which considered this question stated that "the overall functions of nursing in mental health services are the same as those in other health services. Differences are a matter of emphasis". More recently expressed views differ - "I am fundamentally opposed to any notion that psychiatric nurse training bears a common relationship to general nurse training. There are very real differences in our ideology and our perceptions of role and function" (Butterworth 1984).

As these issues have yet to be resolved, and no consensus view of what the relationships between the various branches of nursing are or should be has emerged, it is proposed to confine the present discussion of nursing roles to CPN roles per se.

Most early CPN literature discussed roles in terms of unsystematic descriptions of the kinds of work done (Griffith & Mangen 1980). In contrast, one systematic description of the domiciliary nurses' activities in a therapeutic community setting by Altschul (1973) noted the following:

1. The selection of priorities for group discussion;
2. The interpretation of inter-personal dynamics;
3. The assessment of mental state;
4. The assessment of patients' social and economic conditions;

5. The observation of physical symptoms;

6. The observation of family interpersonal relationships;

7. The application of knowledge of local culture and social conditions.

The roles and functions outlined above related to a work setting that was far from typical, and roles which were considered to be applicable in services elsewhere, as described by Carr et al. (1980) were outlined in 1983 by the CPNA (1983). These were:

1. The nurse consultant - advising other professionals about the type and level of psychiatric nursing care required at any given time;

2. The nurse clinician - the "technical" e.g. giving injections, and "basic" e.g. ensuring adequate diet, nursing actions undertaken;

3. The nurse therapist - "the therapeutic activities of psychotherapy and behaviouralism";

4. The nurse assessor - the assessment of nursing requirements;

5. The nurse educator - the education of people about "the potential hazards of mental disorder;"

6. The nurse manager - the organisation of work priorities.

As new services were established, nurses began describing the ways in which they worked, and early CPN literature, reviewed by Hunter (1974) and Griffith and Mangen (op cit.), emphasised continuity and extension of care, and improvement of communications between hospital and community workers (May & Moore op. cit.; Maraje 1976). As services developed CPNs began

to emphasise the importance of involvement with families as well as individual patients and reported on the application of certain therapeutic techniques such as behaviour therapy (McDonald 1975) and reported on attachments to primary care teams (Harker et al. 1976; Corser & Ryce 1977). Systematic descriptive studies of the full range of CPNs' work have been few although detailed studies of various aspects of CPNs' work have been made such as that by Butterworth (1979) who documented the nature of nurse-patient assessment.

Sladden's (1979) descriptive study of hospital-attached CPNs working in Edinburgh, remains the most comprehensive published. She found that the CPNs used two distinct frames of reference for their work. One, derived from a clinical concept, was task-oriented and was apparent when contacts took place in a clinic setting; the other derived from "socio-psychological or interactional concepts", was concerned with psychological adjustment and social relationships and socio-economic problems and resources, and was applied when contacts took place at patients' homes. She found "The nurses' concerns were rather to use supportive techniques and 'direct influence' to alleviate immediate distress, maintain patients' existing level of functioning, and encourage families' tolerance." The nurses "did not follow the mainstream tradition of social psychiatry; this would have prescribed constructive intervention in unstable situations, and set optimistic goals for learning and social change".

The nurses' contacts with primary care workers were so limited,

and the amount of time they spent on hospital premises was so great that the researcher considered them as occupying an intermediary role, maintaining communication between the hospital and its extra-mural patients, and extending the territorial boundaries of hospital care. Sixty-one per cent of the patients seen during the course of the study had a diagnosis of "schizophrenia"; 13% were diagnosed as "depression" or "neurosis"; 6% had "organic psychoses". Ninety-one per cent of all patients had been in hospital at some time during the past five years.

Paykel and Griffith (1983), who outlined the nature of CPNs' work with a group of neurotic patients (see below), found that 76% of nurse/patient contacts took place at the patients' homes and that their management of patients involved the use of predominantly social and psychotherapeutic means, although general supervision of medication took place in 32% of contacts. Increased emphasis was placed on dynamic explanations of behaviour as the nurses' work with this group of patients progressed.

More recent work by Skidmore and Friend (1984b), found that the nurses in the 12 CPN services studied, made 35% of visits in order to assess clients, 22% to administer injections, 11% to give support and 1% to give counsel. They found that the only differences between services which had primary care, dual, or hospital bases, were differences in the ways in which nurses described their work (these differences were not confirmed by observations of actual visits) and the main sources of their referrals - the primary care based workers receiving referrals

from a wider spectrum of sources than the hospital based workers. Over half the nurses questioned expressed concern that their training, even those who had undertaken the JBCNS community psychiatric nursing course, did not equip them with the skills they felt necessary to "manage effectively new encounters with clients" and the authors expressed concern that case loads were ineffectively managed. The two "major problems" that were perceived were that nurses needed more skills training, particularly in counselling, and that nurse managers' lack of community experience appeared to inhibit their abilities to provide appropriate guidance and support to CPNs.

Three major evaluative studies have been conducted which aimed to assess the effects of therapeutic interventions undertaken by psychiatric nurses. Hunter (1978), compared two groups of patients diagnosed as suffering from schizophrenia who were discharged from in-patient care between 1967 and 1969. The group of patients who received CPN care were found to have spent more time in in-patient and day patient care than the comparative group of patients, none of whom received CPN care. The reasons for this difference were not clear cut and were "not disclosed in this study". However, using caregivers' views of their experiences of CPN care to formulate his conclusions, he found that the nurses were valued for their knowledge about mental illness, the security they gave to the caregivers, and for the authority their association with psychiatrists and the specialist services gave them. An analysis of the difficulties reported by patients and caregivers indicated three main areas where improvements might be made. The first concerned the need for a

continuous programme of monitoring and assessment of patients' social and family situations, the second involved the need to involve families in a more active therapeutic approach to problems, and the third that nurses needed more assistance in developing their inter-personal skills and to use them to intervene in crises rather than to screen for abnormalities.

Paykel et al. (1982), found that CPNs who worked as part of a psychiatric team, none of whom had completed the JBCNS adult behavioural psychotherapy course (Marks et al. 1983), were as effective as psychiatrists when assigned a role of main treating agent in the after or continuing care of neurotic patients with low levels of disability. Patients reported higher levels of satisfaction when nurses rather than psychiatrists were the main treating agents.

Marks et al.(op. cit.), found that selected groups of psychiatric nurses were, after intensive training in behavioural psychotherapeutic techniques, able to "exercise independent professional judgement and skill" in assessing patients' suitability for treatment, to undertake therapy, and to obtain results which compared favourably with those of psychiatrists and psychologists reported in the literature. They successfully worked in settings outside hospital wards.

Three of the studies discussed above (Gladden op. cit., Hunter op. cit. and Skidmore & Friend op. cit.) concluded that further training in inter-personal skills would enhance CPNs' contributions to the care of clients and their families. Two of

these (Bladden op. cit., and Hunter op. cit.) were particularly concerned to point out ways in which the care of psychotic patients could be improved upon. Paykel et al. (op. cit.) found that even in the absence of further training, CPNs' care of neurotic clients recovering from their acute symptoms compared favourably with routine follow-up by psychiatrists. Work by Marks et al. (op. cit.) illustrated how intensive training in behavioural psychotherapeutic techniques can enable psychiatric nurses to undertake specific therapeutic tasks on their own account.

Both recent evaluative studies concerned the treatment of adult neurotic patients and there is little doubt that CPNs, whether working within the primary care or the psychiatric team, are increasingly becoming involved in the treatment/care of non-psychotic patients. Systematic data on the prevalence of various diagnostic groups of patients on CPNs' caseloads and changes over time are few, but evidence (Wooff et al. 1986 & 1987) suggests that nurses working in primary care settings may have a higher proportion of neurotic clients on their caseloads than nurses working as part of a psychiatric team.

1.4 THEORETICAL AND CONCEPTUAL FRAMEWORKS

The theories and principles upon which which social workers based their casework and group work techniques and the value systems that underlay them have been extensively documented in the literature (Yelloly 1980, Fischer 1978, Timms & Timms 1977,

Pincus & Minahan 1973, Reid & Shyne 1969). The first training course for psychiatric social workers was set up in 1929 at the London School of Economics, and was intended to give workers who had already studied social administration sufficient knowledge of psychology, psychiatry and psycho-social development to enable them to practice with mentally disturbed clients (Vickery 1977). Other Psychiatric Social Work courses established after the second world war were concerned to train workers to apply psychoanalytical theory to casework practice. As the 'literature of protest' grew, social workers became particularly associated with the 'anti-psychiatry' movements.

The changes in social work methods over time were summarised in 1981 in evidence submitted to the National Institute of Social Work Working Party by the Association of Directors of Social Services (ADSS op. cit.); a detailed account of changes in the theory and practice of social work is given by Younghusband (1978). The period between 1948 and 1960 was characterised by training in social casework methods which aimed to help individuals achieve better balance in their relationships by learning insight and nurturing their capacity for emotional growth. In response to a growing awareness that clients might become over dependent on professionals, the concept of 'community based' social work grew and was pursued on a wide scale during the 1970s. This approach sought to develop and strengthen networks to support families before they reached critical situations. Social work intervention with individuals was thus seen to be required only when some kind of breakdown was imminent - and was known as 'crisis intervention' (Reid & Shyne op. cit.).

In contrast to social work, psychiatric nurses' day to day work has been based upon practical rather than theoretical considerations. The model of custody and containment as practised in mental hospitals in the early part of this century was applied by hospital attendants. The general post war shift to a biological or medical model of psychiatric treatment and care demanded that psychiatric nurses were trained in the application of these models. Consequently, as psychiatrists 'joined the mainstream of medicine' so psychiatric nurses joined the mainstream of nursing. In 1957 the training of mental nurses, previously the responsibility of the Royal Medico-Psychological Association, was handed over to the General Nursing Council and a new training syllabus was developed.

Until the early 1970s, psychiatric nursing was largely confined to work within hospitals, either on wards or in day care settings. As previous work had indicated that nurses tended to adopt the ideology prevailing in their current workplace (Strauss et al. 1964; Burgess and Lazare 1973), it was not surprising that the acute medical model of care was found to underpin much of psychiatric nursing activity on acute admission wards (Cormack 1976). Further, Towell (1975) considered that when the acute medical model of care provided an inappropriate frame of reference for nursing staff (for instance, on geriatric wards), they adopted various identifiable sub-cultures, and Altschul (1972) observed that nurses' verbal interactions with patients lacked an identifiable conceptual base.

As psycho-social models of treatment/care were increasingly adopted in hospitals, psychiatric nurses extended their medical knowledge base to incorporate these models but the evidence cited above suggested that the expension of nurses' roles to include therapeutic work based upon non-medical models remained relatively undeveloped. The move from ward bases implicit in the growing CPN services and the perception of CPNs that their RMN training did not in itself equip them to meet the demands of community work (Carr et al. op. cit.; Skidmore & Friend 1984a) combined to produce a demand for change from a predominantly medical model of psychiatric nursing care to one which espoused a spectrum of models, some of which could be held to be theoretically incompatible with each other. Thus, at a time when other professional groups working in the mental health field became associated with specific concepts and theories, as Gladden (op. cit.) pointed out, nursing literature "does not waste time over the conceptual problems of the eclectic approach, but assumes that it is necessary for nurses to be able to distinguish between and utilize the different concepts." Gladden suggested that CPN practice was based on "haphazard applications of intuitive insights and individual experience".

Thus, published work indicates that neither psychiatric nurses nor CPNs have yet developed a common set of 'principles' or an 'organised set of professional values' both of which form integral parts of Bligh's (1979) scheme for teaching decision making skills. Indeed, Menzies (1960) showed how nurses had created a structure for themselves which facilitated their escape from the stresses of decision making.

1.5 OVERLAP BETWEEN MENTAL HEALTH SOCIAL WORK AND COMMUNITY PSYCHIATRIC NURSING

Until psychiatric nurses began to work outside hospitals there was little discussion of the extent to which their roles overlapped with those of mental health social workers. This may have been due to the fact that social psychiatric models of care were not widely implemented until the 1970s, but other factors may also have been involved.

Before the implementation of the Seebohm Committee recommendations, many mental welfare officers were recruited from the ranks of psychiatric nurses. It is possible that the increasing professionalization of social work, with the consequent requirement for specific social work training, has blocked a traditional route by which psychiatric nurses moved from the confines of hospital wards and extended their roles within the wider community. Thus, it may be that the expansion of CPN care in the 1970s occurred not only because mental health social work services were considered to have deteriorated as a result of Seebohm, and that psychiatric nurses "filled the gap" as suggested by Carr (House of Commons op. cit.), but because (at least in part) psychiatric nurses had been denied their traditional 'escape route' into social work, and began to 'escape' in a different way' - by forming a sub group within the psychiatric nursing profession itself.

Whatever reasons underlie the expansion of CPN care, in view of

the juxtaposition of the factors discussed above, it is not surprising that the extent to which the roles of CPNs and MHSWs overlap has become a matter of some debate.

The social work roles outlined in the mid 1970s by the Otton Committee (op. cit.) were remarkably similar to the CPN roles outlined by Carr et al.(op. cit.) which comprised consultant, clinician, therapist, assessor, educator and manager.

However, the social work roles as perceived by the Barclay Committee in 1980 (op. cit.) demanded a change of emphasis from work with individuals to work with whole communities. Psychiatric nurses do not appear to have outlined such a community role for themselves, but it is too early to judge how far any difference in emphasis between communities and individuals will distinguish social work and CPN roles in the future.

Both the social work and nursing professions have developed systems within which interventions may be planned and executed. The case review system (Goldberg & Fruin 1976) raises the following questions:

1. What is the problem?
2. What has been done/achieved so far?
3. What are the aims for the immediate future?
4. How are they to be fulfilled?

The nursing process (Crow 1977) may be summarised as:

1. Taking the nursing history. Gathering facts; identifying needs;
2. Analysis and interpretation of social, physical, emotional and financial problems;
3. Formulation and implementation of care plan;
4. Evaluation of care given.

Although these systems are similar, it is widely accepted that one of the factors which governs choice of intervention is the theoretical base applied. Thus discussions of role and work setting alone will not define process as process will vary according to the concepts applied. Theories explain a wide variety of connected phenomena. They generate principles which inform decision making. Various professional groups are generally distinguished by, amongst other things, specific theories, value systems, bodies of knowledge, and characteristic techniques, areas of competence and responsibilities. Although individual members of a profession may not conform to orthodox patterns, membership of a particular profession will usually imply, if not agreement with, at least a knowledge of the norms of the group.

The extent to which there are differences in the personal characteristics of the people recruited into either profession is beyond the scope of this study, but there is little doubt that these factors will also influence the ways in which they carry out their work. On the basis of the evidence discussed above, though, on the one hand, CPNs' and HHSWs' roles and functions

appear to overlap considerably, and both are organised in a variety of ways some of which co-incide, yet on the other, they do not appear to apply the same theoretical perspectives to their work, and there is evidence of conflict between nurses and social workers (Bingeall 1975; Macleod 1970; John 1961) much of which appears to be rooted in the nurses' quest to establish parity of 'professional' status with social workers. It is the author's view that the scientific literature concerning CPN and mental health social work services clearly illustrates the need to examine systematically the growth of CPN services and the ways in which CPNs and MHSWs work both in relation to each other and in relation to other specialist psychiatric services.

Just as the perspectives of various mental health professionals differ, so do the perspectives of researchers. There are many ways of examining mental health services and their development, and all have their contributions to make to our understanding of events. Miller (1976) has pointed out the importance of declaring the particular perspectives employed by researchers, and it is appropriate here to present a brief outline of the perspective which will be applied in the present study.

1.A THE PERSPECTIVE OF COMMUNITY MEDICINE

Community medicine is concerned with the health of whole populations. It thus differs from clinical medicine which is primarily concerned with the health of individuals. The nineteenth century public health movement in the United Kingdom, from which community medicine derives, grew from an increasing awareness of the associations between health, environment and poverty. Chadwick's report on sanitary conditions (Chadwick 1842) and Farr's analyses of death certificates (1885) laid the foundations of epidemiology - the science upon which community medicine bases its conceptual framework (Smith 1968). According to Alderson (1976) the three main aims of epidemiology are:

1. To describe the distribution and size of disease problems in human populations;

2. To identify aetiological factors in the pathogenesis of disease;

3. To provide the data essential for the management, evaluation and planning of services for the prevention, control and treatment of disease.

If community medicine is concerned to observe, record, analyse and if necessary attempt to modify environmental conditions, it must also be concerned to observe, record, analyse and modify factors which influence the formation, operation and management of the environment. It is also necessarily concerned with the

effective and efficient use of resources and the description, comparison and evaluation of services. Thus epidemiological method, which relies heavily on numerical techniques, must be informed not only by medical science, but also by other sciences concerned with the structure, organisation and behaviour of human communities.

Descriptive studies have a well established place in epidemiology. In situations where very little is known, such as the relationship between community psychiatric nursing and mental health social work services, there is a need for descriptions based on epidemiological principles to generate hypotheses and establish some basis for further measurements and comparisons.

The present study is mainly concerned with the working of the health services, but will also have an historical and community health perspective. It aims to describe, using an epidemiological framework, the ways in which CPNs and MHSWs worked in one particular District, in an attempt to inform the debate regarding the extent to which the activities of CPNs and MHSWs may be said to be distinct or overlap.

CHAPTER 2

SALFORD AND ITS MENTAL HEALTH SERVICE

Salford Metropolitan District (Salford MD.), part of Greater Manchester, was designated a local authority unit following the local government boundary changes which took place in 1974. The new District incorporated the old City of Salford (population of 130,000 in 1971), and parts of Lancashire County (combined populations of 150,000 in 1971) and the two parts of Salford MD had very different characteristics. In 1981 the population of Salford M.D. was 233,870 the age structure of which was close to that of England and Wales as a whole except that Salford had lower proportions of people in the 25-34 age range and higher proportions of people in the 55-64 age range.

The City of Salford (Salford East) was Engels' 'Classic Slum' - a highly industrialised area of eight square miles whose population grew rapidly during the latter half of the industrial revolution. From a peak in 1927 of 247,000, the population of Salford East had fallen to 131,000 in 1971. The people of Salford were overwhelmingly working class, were poorly housed and even in the prosperous period of the late 1960s suffered high levels of unemployment. In contrast, the old Lancashire county areas (Salford West) were less densely populated, less industrialised, more prosperous, and had fewer social and health problems than Salford East. The population of these areas grew until 1971 and declined thereafter.

However, the prosperity of Salford West was relative only to Salford East, and 1981 Census statistics showed that although vigorous local authority initiatives had succeeded in improving housing conditions, compared to England and Wales, Salford M.D. had higher proportions of people living alone, of single parents, of economically inactive, of permanently sick, and of unemployed people (Gibbons et al. op. cit.).

Salford East and Salford West not only differed in their demographic characteristics, their local authorities had provided different patterns of services. The old City of Salford had a strong public health tradition which could be largely attributed to the work of the Medical Officer of Health between 1941 and 1969, Dr. J.L. Burn. In 1956 he was responsible for initiating a unique link between doctors and research workers from the Department of Social Medicine in the University of Manchester and the duly authorised officers of the Local Authority Health Department.

In 1961, the co-operation between hospital and local authorities was strengthened by the appointment of a Consultant Psychiatrist who was also Honorary Consultant to the City Health Department. The same year saw the appointment of a trained Psychiatric Social Worker, and by 1967, the local authority health department was appointing only graduates to its mental health social work service. In 1965, another revolutionary step was the appointment of a social worker who was funded jointly by hospital and a local authority. Detailed accounts of the development of mental health services in the City of Salford appear elsewhere (Freeman 1984a

and 1984b).

The close co-operation between Hospital and Local Authorities in the care of the mentally ill in Salford survived the administrative upheavals of the early 1970s. The rapid movement of social work staff during the immediate post Seebohm years disrupted services to some extent, but some specialist mental health social workers remained in post throughout this period. Thus, at the time of the local authority boundary changes, the mental health services in the City of Salford were well integrated and of high quality whereas the services in Salford West were more typical of those in the rest of the country in that hospital/local authority co-operation had not been developed, and social work staff were not especially well qualified or trained.

Mental health hospital in-patient services in Salford are presently provided by a District General Hospital (30 beds), an E.S.M.I. unit (38 beds) and a Psychiatric Hospital (1,121 beds; 875 of which are occupied by long-stay patients). The psychiatric hospital is managed by Salford Health Authority, but is sited in an adjacent local authority area. Its catchment area is not confined to Salford and it manages regional and sub-regional specialist services for forensic psychiatry, adolescent psychiatry, alcoholism, drug dependence, adolescent forensic psychiatry and psychotherapy. Long-stay in-patients who were originally Salford residents are accommodated in a variety of psychiatric hospitals throughout the North West.

Out-patient clinics for Salford people, are held mainly in the district general hospital, but some sessions are conducted at the psychiatric hospital, and the majority of consultant psychiatrists hold out-patient sessions in health centres. Day care is provided by all the hospitals and by the local authority. Other non-hospital residential places are serviced by health and local authority staff. Details of staffing provision in 1981 which appear elsewhere (Gibbons et al. op. cit.) show that compared to other areas which have case registers (Southampton, Nottingham, Worcester, Oxford), Salford has median numbers of psychiatrists, specialist social workers and OT/IT workers and high numbers of psychologists and CPNs.

2.1 Mental Health Social Work and Community Psychiatric Nursing Services

In 1975 a hospital based/consultant-attached psychiatric social work team was established which continues to provide specialist mental health social work care. Patch Social Work Teams (Patch SWs) provide a generic service which includes some mental health provision. At the time of the study, two team leaders headed the hospital based mental health social work department (SSW) which comprised 6 SSWs attached to general psychiatric teams and 8 SSWs working in special psychiatric units or sectors for example, the psychogeriatric team, community alcohol team, regional units. All the SSWs attached to general psychiatric teams had offices in the social work department at the psychiatric hospital. Two social workers also shared an office in the psychiatric department at the local district general hospital.

The CPN service with three full-time nursing staff based at the local psychiatric hospital was established in 1973. Its initial purpose was the follow-up of people who failed to attend for regular treatment. The service steadily expanded and, following a move to community and primary care bases in January 1979 and the acceptance of referrals direct from GPs or other primary care workers, the diagnostic composition of caseloads shifted from being dominated by people suffering from schizophrenia to a diagnostic mix which reflected that found in the hospital based psychiatric services. Detailed accounts of the growth of the CPN service and its impact on the use of hospital based psychiatric services appear elsewhere. (Wooff et al 1983; Wooff et al 1986). When the study began, 16 full-time nurses with generic caseloads were supervised by one acting nursing officer.

Other CPNs worked in special and regional units where they worked in multi-disciplinary teams and were effectively 'managed' as part of those teams rather than being 'managed' by the CPN service manager. For this reason, referrals to CPNs who worked as part of these teams are not included in the register data to be presented here.

In October 1984, 4 CPNs (2 additional and 2 CPN posts transferred from the general psychiatric team), were appointed to work within a newly formed psychogeriatric team. The CPN members of this team were managed by their own nursing officer. Referrals were made to the team as a whole, and initial assessments were carried out by the Consultant Psychogeriatrician. Thus, the CPNs in this

team did not accept direct referrals from GPs and others. The data to be presented here include people referred for CPN care within the psychogeriatric team.

2.2 Use of Psychiatric Services in Salford

The extent of psychiatric service use in Salford has been closely monitored since 1968 when the Psychiatric Register began routine operations. Various publications have given details of: the run-down and build up of long-stay in-patients (Fryers 1973 & 1979); changes in point-prevalence of service use between 1968 and 1978 (Wooff et al. 1983); an overview of service development between 1968 and 1982 (Fryers & Wooff 1986); comparisons with other areas which have case registers (Wing & Fryers 1976; Gibbons et al. op. cit.).

These data show that 'new long-stay' in-patients continue to accumulate, and that the use of services as shown by unduplicated point-prevalence counts has changed little over 10 years except that there has been an increase in the rates of people who receive regular injections of neuroleptic drugs and who have CPN care. They also show that compared to other register areas, in 1981, Salford's year prevalence rates for service use involving direct contact with psychiatrists (1,340 per 100,000 population aged over 15) fell in the middle of the range.

The associations between levels of 'chronic' mental illness in a community and overall population movement have been discussed elsewhere (Orr & Wooff 1986). In Salford M.D. there are higher long-stay in-patient rates in Salford East (where the population has declined steeply since 1927) than in Salford West (where the population has grown). A breakdown of figures for the two parts of Salford is unavailable, but it is reasonable to suppose that

the build up of 'chronic' psychiatric service users who do not live in hospitals follows the same pattern, with the inner city area of Salford having higher rates than Salford West.

A minimum estimate of levels of 'chronicity' in Salford as a whole (Wood 1984), showed that the number of people aged between 15 and 64 who had contacted psychiatric services in 1976 and in 1984 was 738 - an age-specific rate of 4.46 per 1,000 in 1976. In total 16.79 per 1,000 population aged between 15 and 64 contacted psychiatric services in 1976 which showed that 27% of 'acute' service users in this age group were in fact 'chronic' patients.

CHAPTER 3

METHODS - CASE REGISTER DATA

Part 1 of the study aims to show the development of CPN and Mental health social work services over time, and to place these developments in the context of the whole mental health service in Salford. It is proposed to use the data base of the Salford Psychiatric Register for this purpose. There are few such data bases in existence in the United Kingdom, and only two (Worcester and Southampton) which collect data on both mental health social work and community psychiatric nursing care. The Worcester Case Register was closed in 1986 and the Southampton Register closed in April 1987. The importance of the data to be presented here cannot therefore be over estimated as it is probably the only such data available in the world. The history of British Registers, comparative register work in the U.K. and a world wide inventory of case registers can be found in - Wing & Bransby (1970), Wing & Fryers (op. cit.), Gibbons et al. (op. cit.) and ten Horn et al. (op. cit.).

3.1 THE SALFORD PSYCHIATRIC REGISTER

The Salford Psychiatric Register in its present form began operations with a census (i.e. a 1 day prevalence count) of all people who had City of Salford addresses and who were in some form of specialist psychiatric care on December 31st 1967. The types of care included were: in-patient; day patient (local authority and hospital); out-patient, and mental health social

work. Since then, a data bank of information has been continuously collected and data collection was extended to include the whole of Salford H.D. in July 1975.

3.1.1 Data collection

In order to maximise coverage and standardisation, data are collected, coded and processed by register personnel who visit all service delivery points regularly. The demographic, diagnostic and service details required by the register are obtained directly from case notes and agency record keeping systems. Where these methods prove to be either unreliable or incomplete, attempts are made by register staff to remedy deficiencies by asking care staff for details directly, and by devising methods of cross-checking or amending various administrative procedures. The close contact between register clerks and staff who are directly responsible for administering psychiatric care helps to ensure that, as new services develop, the register system itself develops in order to reflect them.

3.1.2 The mechanics of coding and storage

Records are person-based and cumulative in that they allow for the storage of 'old' and 'updated' data; they are stored and analysed on a mainframe computer. Patients are identified on the computer system by means of a unique register serial number. Register data collection forms which identify patients by name are destroyed after the coding and checking procedures have been completed. All other data, including address, are also stored on

computer in numeric form in order to preserve confidentiality. The data with which this study is primarily concerned are diagnostic and service utilisation, and it is these which will be discussed in detail here. The full range of data collected appears in Appendix 1.

The diagnoses recorded in the register system are those assigned by the psychiatrists by whom patients are treated. A data collection form is attached to the notes of all newly referred patients, and the psychiatrist is requested to complete the diagnostic information required. In the event of their failure to provide the data, register clerks use case notes and letters to GPs to provide the information, and where diagnoses remain unclear, seek the advice of the psychiatrists concerned. No psychiatrists have refused to divulge this information on the grounds of confidentiality.

The system allows up to three psychiatric diagnoses to be recorded at any one time, which are in turn linked to an 'underlying cause'. Physical abnormalities are also recorded where they have been elicited by psychiatrists. Detailed diagnostic codes are stored within the data bank, computer programs group these into a variety of systems which are used for the purposes of analysis. The raw and grouped codes were originally developed for the Camberwell Register by Dr. L. Wing (1970). The three permitted diagnoses are arranged hierarchically, with the more 'severe' having the highest rank. The diagnostic data used in this study have been grouped according to the highest ranking diagnosis in each set. Raw and

grouped diagnostic codes, together with the hierarchical order, appear in Appendix 2.

Diagnostic and demographic/social data are updated:

a. whenever an admission takes place;
b. when a patient contacts services after a gap of more than 1 year.

Thus, it is possible that the data recorded on the register which relate to patients who have continuous contact with services for many years and who have not regularly been admitted to in-patient care may be out of date, although the regular contact between register and unit staff may mitigate against this to some extent as administrative staff are aware of the register's wish to update patient information when changes take place.

All care agencies/units, for example, individual hospitals are identified within the coding system. The service data collected are as follows:

1. In-patient admission and discharge dates, dates and sections of Mental Health Acts where applicable;
2. Psychiatric day care (Local Authority and Health) admission and discharge dates;
3. Psychiatric out-patient attendance and psychiatrists' domiciliary visit dates;
4. Referral and discharge dates to:
   a. Specialist, consultant attached, mental health social

workers;

b. Patch team social workers designated as 'mental health' referrals by social workers for the purposes of routine social services department 'case type' statistics;

5. Referral and discharge dates to and from community psychiatric nurses.

The single psychiatric service 'gap' in register data is the individual patient care given by psychologists, some of whom accept referrals directly from GPs. The psychologists do, however, tend to engage in lengthy behavioural programmes, and it is considered that the exclusion of this group of patients will not seriously underestimate the incidence and prevalence data of service use produced by the register.

3.1.3 The mechanics of recording mental health social work referrals

Mental health social work care is given by two main social services agencies:

1. A specialist, hospital-based and consultant-attached mental health social work team (Specialist SW);

2. Patch social work teams which provide assistance to all kinds of clients (Patch SW).

The documentation of referrals made to the Patch teams involves the completion of a 'referral form' by social work staff which

specifies client/family identification details, presenting problem, classification of case 'type' and action taken. Referrals are listed each day in a 'referral book' which contains details of clients' names addresses, case types and dates of referral and discharge from SSD care. Register staff check the contents of each patch team referral book in order to document the referrals classified as 'mental health' cases and collect copies of each referral form.

Referrals made to the Specialist mental health social workers are documented in the same way, but all these referrals relating to people living in Salford are collected by register staff. The information collected from Patch teams and the Specialist team is then added to the register data bank. Trivial enquiries needing minimal input from social workers - usually dealt with during their 'duty' periods are not recorded on referral sheets.

It should be noted that before the Social Services Department was established (i.e. before 1972), all referrals to and discharges from the social work staff of the Mental Health Department of the Local Authority were included in the register data bank.

3.1.4 The mechanics of recording CPN referrals

Before 1982 case register staff collected details of referrals to and discharges from CPN care by extracting details from records of visits kept on 'Kardex Files' and from daily worksheets which specified the contacts which took place between nurses and clients. After January 1983, referrals to and discharges from

CPN care have been recorded by the nurses using referral and discharge forms which give details of clients' names and addresses copies of which are made available to case register personnel.

Referrals to and discharges from SSW and CPN care when this is given as part of a multi-disciplinary team 'package' (i.e. in the case of the community alcohol and drug teams), are not separately identified in case register data but are recorded as team contacts. The Specialist SW and CPN data presented in this study therefore exclude the social work and nursing input into these teams.

3.1 ANALYSIS AND DEFINITIONS

Standard computer programs have been developed which enable incidence, prevalence and event data to be produced in standard formats. The mechanisms and rules which govern the production of these data are as follows:

3.2.1 Incidence As service agencies increase and networks grow more complex, the more difficult it becomes for individual agencies/services to distinguish between 'true' incidence (first lifetime contact), and first-ever contact with each individual service component or agency. For instance, a patient may make his 'first-ever' contact with the social work service in 1985, but have had numerous contacts with other services for example the out-patient service, in the past. Even within single services such as the local authority social work services,

administrative arrangements may be such that co-ordination over time between sub-systems e.g. individual patch teams, may be difficult to achieve.

Because of the difficulties of establishing whether patients 'new' to a single agency are also 'new' to the services as a whole, it follows that there is a strong likelihood that 'chronic' and 'intermittent' service users will remain unrecognised because they continually use an array of service components/agencies not all of which will be aware of the extent to which services other than their own are being used.

The register data bank is person-based rather than event-based, and it is therefore possible to distinguish between 'true' inceptors and those patients who make their 'first-ever' contact with a particular part of the mental health service. The register routinely collects information about previous psychiatric service use on all newly referred patients and data are recorded which specify whether the patient received any care before being eligible for inclusion in the data bank. Thus, patients who received care whilst they were not living in Salford or who had received care before the register began collecting data, would be coded as 'having previous psychiatric care'. Positive statements of whether patients have received care in the past are not always available, and a code of 'previous care not known' is used in these cases.

Thus 'true' incidence or first lifetime contact data would include only patients who had definitely stated that they had

never before received psychiatric care. 'First known contact' data would comprise those patients plus those whose previous contact was unknown. Reliability studies suggest that the majority of the 'not known' group are indeed 'true' inceptors. Throughout this text the term 'incaptors' has been used to denote first known contact.

Case registers which record the different types of psychiatric services used by individual clients, are probably the only data sources which can at present be used to estimate incidence and prevalence of psychiatric service use in defined communities with any degree of certainty.

3.2.2 Point or one-day prevalence data (the numbers of people in receipt of specified care on a specific day) may also relate to either the service as a whole or to any single service component. In order to avoid the duplication inherent in summing the number of patients in contact with individual service components, a hierarchy of service components is imposed, and a patient who in fact is in contact with more than one service component at any one time is counted once only, and is designated under the type of care which appears highest in the hierarchy. The hierarchy imposed is:

1. In-patient;
2. Hostel/other residential;
3. Day-patient;
4. Out-patient;
5. Mental health social work (SSW & Patch);
6. Community psychiatric nurse care.

Thus, an out-patient, who is also being seen by a social worker and/or a CPN, will appear in a total service unduplicated count under the heading of 'out-patient care'. It should be noted that this hierarchy is not imposed when one-day prevalence counts for individual service components, such as CPN care, are being made and such counts will include all patients in receipt of the care component specified.

The one-day prevalence count is based upon the application of a set of rules which does that a patient is in receipt of care. Although the British case registers have adopted standard definitions, the rules are arbitrary and may be open to question. There would be general agreement that people actually in hospital in-patient care on the point-prevalence day should appear in the count, but even here there are complications to be considered such as whether patients who were on extended leave should or should not be included. (The register does in fact include these in its standardised count).

Whether patients in receipt of other types of care (for example, day-care, mental health social work and CPN), who are recorded on a referral and discharge basis should be included in such a count is a matter for debate. Ideally, register data should comprise all dates of actual contacts made between workers and patients, but for practical purposes (the data bank would be enormous, and the data collection would be too time consuming both for care staff and register staff) this option has been rejected. Thus the register's inclusion of people who have been referred for but

not discharged from such care on a point- prevalence day will include people who may receive care of varying intensity and represents a compromise between specificity and practicality.

In contrast, contact data are available for people who receive out-patient care from psychiatrists and it is possible to impose some notion of 'intensity' of care upon inclusion criteria. The rule adopted for inclusion in the standard count is that people must have attended for out-patient consultations before and after the point-prevalence day, and the time gap between these two attendances must be less than or equal to 90 days. Analyses of out-patient data show that the application of these rules is likely to mean that the majority of people who are included in these figures make greater than average use of out-patient facilities (see 'event' data below).

These two rules (before and after contact, and maximum permitted time span between 2 designated contacts) are also applied to a mixture of referral, discharge and contact data so that, for example, patients discharged from in-patient care before the point prevalence day who make one out-patient contact after the point-prevalence day are included in the count if the maximum gap between the two events does not exceed 90 days.

3.2.3 Year prevalence Incidence is the most useful measure of frequency in a population for conditions of short duration. Point-prevalence is most useful for conditions of long duration. Because the natural histories and thus duration of many types of mental ill health have never been clearly described, and, as

discussed previously, psychiatric patients have a mixture of 'chronic', 'intermittent' and 'short term' problems, a different statistic, year prevalence, proves to be of value.

Year prevalence rates show the proportion of people who received care in any one year and are used in conjunction with point or one-day prevalence, and referral data in order to clarify the relationships between short-term and long-term patients.

3.2.4 New episodes Together with point prevalence data, 'new episodes' are a component of a variety of period prevalence counts. In any one period those people who use specified services who do not appear in the preceding one-day prevalence count, are included in 'new episodes' statistics.

Thus, the year prevalence count for the year 1981 would include both:

a. People in care on 31.12.80; and

b. People who appeared in the 'new episodes' count for 1981.

3.2.5 Event and person data are the most easily understood and form the basis of the kinds of data which are most usually collected by individual components/agencies of any service. They are straight counts of events such as in-patient admissions. Even here, however, attention must be drawn to the distinction between 'events' and 'persons'. One person may experience more than a single 'event' over any given period - in 1981 Salford

residents made 7,070 out-patient contacts whereas 2,454 people made them - a mean number of attendances per person of 2.88 (Wooff 1984). People may also be admitted to in-patient care more than once, even over a relatively short time period such as one year.

3.3 DISCUSSION OF CASE REGISTER METHODS

It is important to point out that case register data should not be used too readily as surrogates for measuring incidence and prevalence of mental ill health in a given community. They measure psychiatric service use, and it is by no means the case that all people with mental health problems contact specialist psychiatric services. Studies of primary care services (Shepherd et al.1966 & Goldberg & Blackwell 1970) have shown that substantial proportions of people who consult their general practitioners have mental health problems. Community surveys, reviewed in detail by Goldberg & Huxley (1980) have shown that although most people with mental health problems did in fact consult their GPs, (although much of the mental ill health of GPs' patients was not in fact detected by them) there remained a proportion of people who did not seek medical help at all.

Epidemiological studies are concerned with comparisons and comparative work demands that like should be compared with like. One of the major difficulties encountered by epidemiologists in their studies of mental ill health has been the problem of classifications of patients' symptoms/behaviours/problems.

The fact that the different professional groups concerned with care/treatment of mental ill health use different concepts and parameters to describe patients symptoms/behaviours/problems was discussed in Chapter I. Even when the descriptions of patients 'illnesses' are confined to a biological or medical model, it is well known that medical diagnostic practice is far from standardised even within a single country, let alone worldwide.

The International Classification of Diseases (1977) specifies broad rubrics and their sub classifications. Various other standardised diagnostic classifications (Wing et al. 1974; Feighner et al. 1972; Spitzer et al. 1970) have emerged which attempt to establish the presence or absence of a wide range of symptoms by use of standardised interviews. Once specific symptoms have been established, they are grouped in a standardised way in order to produce rubrics of varying degrees of detail. They have done much to enable structured diagnostic rules and classifications to be applied, but demand specially trained interviewers to complete long and detailed interview schedules.

Such diagnostic tools are not widely used in ordinary psychiatric practice in the United Kingdom, and routine information systems, as distinct from research information systems are unlikely to be able to achieve high standards of diagnostic reliability within the forseeable future. As discussed earlier, the diagnostic data on the psychiatric register have been gathered from individual psychiatrists, will reflect their particular diagnostic habits, and can not be claimed to be highly standardised. In an attempt

to limit this difficulty, the classifications used are very broad, although as a result, the complexities of people's mental health problems will not be apparent. In order to differentiate these from more standardised data, they are referred to as 'clinical categories or groups' throughout the study.

The collection, coding, storage and analysis of register data can be seen to be extremely complex, and consequently may be thought to be error prone. Throughout the collection process, routine verification procedures which attempt to ensure comprehensive coverage are applied, and all data codings are checked by the Data Organiser before punching takes place; data input is verified by double punching.

All computer outputs in the form of tables are accompanied by detailed listings of all the individual records included and are then checked against the manual records held to minimise programming errors. It is the computer output which has proved to be the most error prone part of the system, as not only do extremely complex programs need to be written, but raw data usually need to be grouped in some way in order to facilitate appropriate forms of presentation. However, over the years, standard programs which produce a wide variety of outputs have been verified and found to have achieved high levels of reliability.

There is no doubt that the case register data to be presented in this study should be interpreted with due caution, but the information is, nevertheless, probably the most reliable

available. The researcher's personal experience of the register system (which has an unusually low turnover of staff, most of whom have worked in the system for at least 5 years) and the fact that the data have been successfully used over many years, lead her to believe that the data have been comprehensively collected and processed in a standardised way since 1968 and are of sufficiently high quality to be used in this study with confidence.

CHAPTER 4

CPN SERVICES, CASE REGISTER DATA

Components of Year Prevalence

Year prevalence numbers and population rates refer to all people who received CPN care at any time during each specified year.

4.1 CPN YEAR PREVALENCE 1976-1985

The rates per thousand total population for components of CPN year prevalence are illustrated in Figure 1. Numbers and rates are given in Table 1.

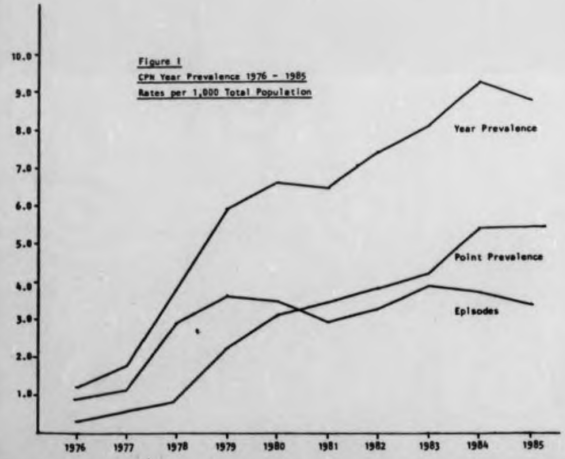


Figure 1, above, shows that both components (point-prevalence plus new episodes) of year prevalence increased, but point prevalence did so at a somewhat faster rate. In 1976 the point prevalence on 31 December 1975 accounted for less than 30% of the total year prevalence: by 1985 the point prevalence component had increased to 62%. In the psychiatric services as a whole the point prevalence component was 52% of the year prevalence in 1985, and 49% if long-stay in-patients (one year and over) were excluded from the point prevalence and year prevalence figures.

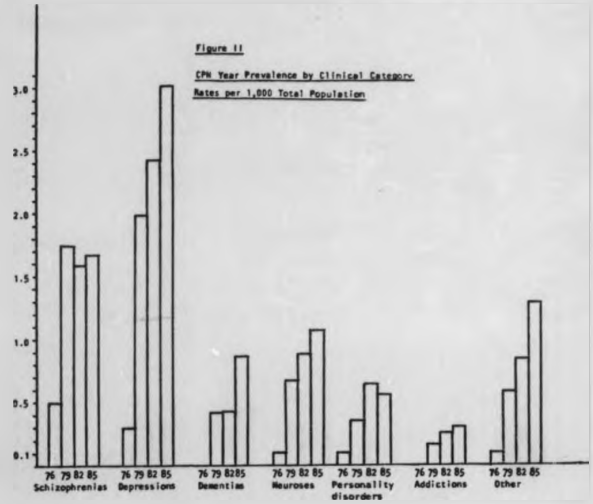
TABLE 1
CPN Year Prevalence 1976-1985
numbers and rates per 1,000 total population

Year	Point N	Episode N	Total N	Total Rate	Staff*
1976	89	219	308	1.2	3
1977	152	280	432	1.7	3
1978	201	732	933	3.7	8
1979	568	921	1489	5.9	12
1980	767	858	1625	6.6	13
1981	852	724	1576	6.5	13
1982	923	769	1692	7.0	13
1983	1011	973	1984	8.1	18
1984	1307	953	2260	9.3	17
1985	1316	819	2135	8.9	17

*Whole time equivalent as at 1st July each year.

4.1.1 Year prevalence by Clinical Category

As shown in Figure 11 below, while all clinical categories shared in the increase in CPN year prevalence counts, the distribution of these categories changed. The rates for schizophrenia increased from 0.5 per 1,000 total population in 1976 to 2.1 per 1,000 in 1985, but the proportion of patients in this diagnostic group fell from 39% in 1976 to 17% in 1985. Almost all these patients received depot neuroleptic drugs from the community psychiatric nurses. Over the same period the proportions for 'depression' increased from 26% in 1976 to 31% of the total in 1985: equivalent proportions in the 'dementia' category increased from 4% to 9%. The proportions in the other clinical groups remained steady.



In the early years of the CPN service the largest single diagnostic group in the year prevalence was schizophrenia; from 1979 onwards it was depression. The latter distribution closely reflects the pattern of general psychiatric services in Salford. From 1976 to 1985 the numbers of people attending hospital to receive depot neuroleptic drugs remained steady, at around a mean of 236. The threefold increase in the numbers of people receiving these drugs from community psychiatric nurses therefore represents an overall expansion in the numbers of people receiving regular depot neuroleptic injections.

4.1.2 Year prevalence by age group

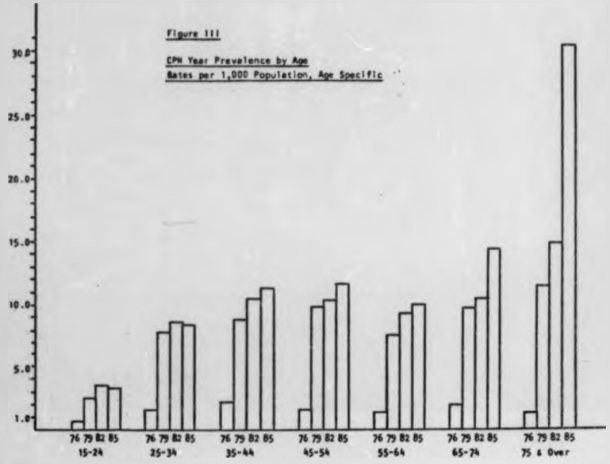


Figure III shows that rates increased in all age groups, especially in those aged 75 and over where rates rose twenty-three fold between 1976 and 1985. A bi-modal distribution, with rates peaking in the 45-54 and 75 and over age groups, can be clearly seen. The increases in the 75 and over age group were so great that proportions in this age group increased from 5% of the total in 1976 to 21% of the total in 1985. The Office of Population Censuses and Surveys' estimate of the proportion of people aged 75 and over in the general

population was 5% in 1976 and 7% in 1985.

From 1979, the age distribution of CPN cases was similar to that in the psychiatric services as a whole, although there was a slight tendency for CPNs to have more contact than the total service, with people aged less than 45. There had been a gradual increase in the proportions of CPN clients aged 75 and over throughout the period, but the most rapid growth occurred following the establishment of a specialist multi-disciplinary psychogeriatric team which included 4 CPNs.

4.2 CPN POINT-PREVALENCE

4.2.1 Point-Prevalence by clinical categories and age groups

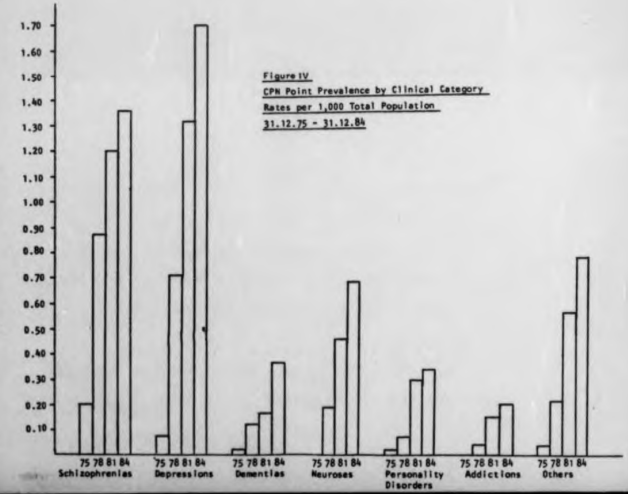


Figure IV
CPN Point Prevalence by Clinical Category
Rates per 1,000 Total Population
31.12.75 - 31.12.84

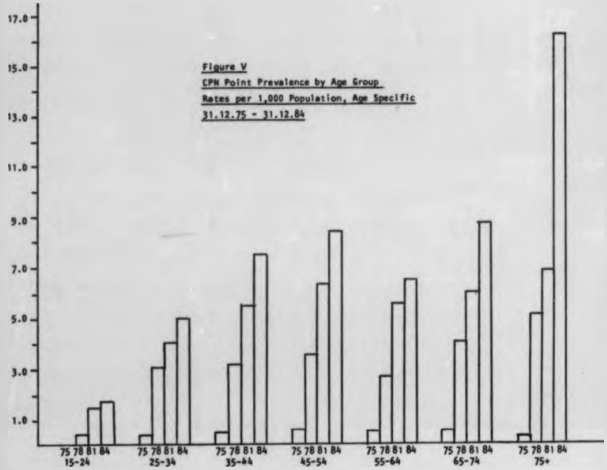


Figure V
CPN Point Prevalence by Age Group
Rates per 1,000 Population, Age Specific
31.12.75 - 31.12.84

Figures IV and V show that increases occurred in all clinical categories and age groups. The proportion of CPN patients suffering from schizophrenia decreased each year from 50% at 31.12.75 to 25% at 31.12.84. A point-prevalence count, will tend to include a high proportion of chronic or intensive users of services. This accounts for the fact that the 'schizophrenia' clinical category, although after 31.12.1979 not the single largest group, accounted for a higher proportion of CPN clients

than in the year prevalence figures (25% of point prevalence; 17% of year prevalence).

As figure V illustrates, the age distributions of the point prevalence counts follow the same pattern as the year prevalence, where the greatest increases occurred in the 75 and over age group and a bi-modal distribution was seen.

4.3 LENGTH OF CONTINUOUS CPN CARE

As discussed earlier, both referrals to and discharges from CPN care are recorded on the Case Register. In order to appear on a point-prevalence count, clients must be 'active' cases i.e. they must have been referred before the point-prevalence day and not discharged from care before it. Thus length of care on point prevalence day measures the length of time which has elapsed between referral for CPN care and the point prevalence day, and is an indicator of duration of episodes of continuous care.

When clients were handed over from general psychiatric CPN care to the psychogeriatric team, the Case Register recorded these events as discharges from general psychiatric CPN care and referrals to CPNs working within the psychogeriatric team. As length of continuous care is calculated as the time which elapses between referral to and discharge from each part of the CPN service, length of continuous care for those clients transferred to the psychogeriatric team would not take into account length of continuous care received from the general psychiatric CPN team. Thus comparisons of lengths of stay after 31.12.84 with those

before this date would be spurious.

Figure 1 showed increasing numbers and proportions of people being cared for at any one time. Table 2 shows the length of continuous CPN care on successive point prevalence days. It can be seen that the number of patients in receipt of long-term care (1 year and over) rose dramatically after 1979, and by the end of 1984 accounted for 57% of the point prevalence.

TABLE 2

CPN Length of Care

on Point Prevalence days

numbers and percentages

	31.12.1975		31.12.1976		31.12.1977		31.12.1978		31.12.1979		31.12.1980		31.12.1981		31.12.1982		31.12.1983		31.12.1984		31.12.1985	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
< 1 month	13	15	12	8	17	8	23	6	50	6	26	3	31	3	44	4	81	6	78	6	92	6
1<2 months	10	11	12	8	10	5	53	9	64	8	39	5	17	2	81	8	74	6	125	9	43	3
2<12 months	29	33	69	45	105	52	411	72	343	47	318	38	267	30	205	20	495	38	342	27	443	33
1 year +	37	42	59	42	69	34	81	14	290	38	461	55	568	64	610	59	657	50	751	57	789	59
TOTAL	89	100	152	100	210	100	568	100	767	100	844	100	883	100	1011	100	1307	100	1316	100	1327	100
No. of 1 year + per nurse	12		20		23		10		24		35		44		33		36		44		46	
No. of staff	3		3		3		8		12		13		13		18		18		17		17	

The cohort effect of service expansion can be seen in that the 3-fold increase in numbers of patients in continuous CPN care for between 3 and 12 months shown at the end of 1978, was reflected in the 3 fold increase in the numbers of patients in continuous CPN care for at least 1 year, which occurred at the end of 1979.

The increasing mean numbers of patients per nurse in contact for at least 1 year, show how the pressures of service expansion built up over time. The reduction in the mean numbers of long-term patients per nurse which occurred in 1978 as a result of a staff increase was temporary only, as was the reduction which occurred at the end of 1982.

TABLE 3

Clients in continuous CPN care for 1 year and over by clinical category

percentages

Clinical Category	31.12 75	31.12 77	31.12 79	31.12 81	31.12 83	31.12 84
Schizophrenia	78	71	54	40	37	36
Depressions	13	12	23	27	27	27
Anxiety States	-	3	5	10	9	10
Senile Dementia	-	-	4	3	4	5
Other	8	14	14	19	22	22
Total	100	100	100	100	100	100
(N)	(37)	(69)	(290)	(370)	(457)	(751)

As Table 3 shows, up to 1977 almost all the long-term patients suffered from 'schizophrenia'. Although by 1985 the proportion of such patients remained high (33%), the proportions in other categories had increased steadily. This distribution represents

the hard core of chronic patients receiving CPN care and shows how patients in all clinical categories except 'senile dementia' continued to accumulate over time. The reduction in the proportion of people in the 'schizophrenia' category who received continuous CPN care for 1 year and over co-incided with the CPNs' move from hospital to primary care bases.

Point-prevalence figures show length of current episodes of care at any one time. An analysis of the total duration of continuous episodes of CPN care following each referral for CPN care provides additional information on the dynamics of care.

TABLE 4

CPN Referrals

By Length of Continuous CPN Care

Year of Referral	<1 month		1<3 month		3<12 months		Over1 year		Total		Mean Dyrs per nurse
	n	%	n	%	n	%	n	%	n	%	
1976	67	30	22	10	137	61	48	21	223	100	16
1977	60	22	42	15	98	35	77	28	275	100	26
1978	154	18	63	7	572	31	355	43	832	100	64
1979	175	17	107	10	337	33	406	40	1025	100	34
1980	388	37	93	9	231	22	331	32	1043	100	25
1981	380	42	62	7	196	21	276	30	914	100	21
1982	283	29	85	9	319	33	279	29	906	100	21
1983	154	13	194	16	446	37	394	33	1188	100	19
1984	114	10	209	19	459	43	306	28	1088	100	18
1985	69	11	134	21	245	38	202	31	650	100	13

Table 4 above shows the numbers and proportions of referrals for CPN care resulting in continuous CPN care for varying periods of time. It can be seen that the proportion of patients having care for less than 1 month decreased dramatically after 1983. The patients who ultimately received continuous care for over 1 month tended to rise throughout the period whilst the numbers who received care for 1 year and over remained reasonably constant. The mean number of patients per nurse who received continuous care for over 1 year, rose from 16 in 1976 to 44 in 1978; it fell thereafter to 13 in 1985.

These data taken in conjunction with point prevalence data suggest that each year a proportion of newly or re-referred patients continued to graduate to long-term care, that each staffing increase itself had led, at least in part, to increasing accumulation of long-term cases, and that these cases were by no means confined to patients in the schizophrenia clinical category.

4.4 FIRST CONTACTS WITH CPN SERVICES

In measures of service use or contact, the nearest proxy for incidence of illness is inception to the service. Year prevalence rates show the proportion of people who received care at any time in any one year. Some of these will have presented for the first time ever (inceptions) and others will have had some previous contact with psychiatric services. The inception rate gives the clearest indication of the pressure of new cases on the service.

Inceptions arise at any point in the service where direct referral from a 'non-mental health' service occurs. Traditionally, psychiatrists were the only professionals in the mental health service who saw 'new' cases, but since CPNs were attached to GPs and able to accept direct referrals from them, this is no longer the case.

Table 5 below shows the clinical categories of patients whose first-ever known contact with mental health services was with a CPN.

It can be seen that before the move to primary care bases in 1979, few first-ever referrals for psychiatric care were made via the CPN service. Since then, around 20% of all inceptors to the mental health services in Salford made their first contact with a CPN. Perhaps because total numbers were rather small, (and small changes in numbers could therefore have produced large changes in percentages) proportions within some clinical categories varied

somewhat over time and showed no clear trends. There did however, appear to be a gradual rise in the proportions of patients in the 'depression' and 'anxiety states' categories.

TABLE 5

First-ever known psychiatric contact with CPN as initial contact by clinical categories.

Percentages

Clinical Category	1976	1979	1982	1985
Schizophrenia	26	2	3	2
Depression	21	39	39	43
Senile dementia	-	20	9	5
Anxiety states	5	20	15	31
Personality dis.	21	6	9	6
Addictions	5	3	6	3
Other	21	10	18	12
Total	100	100	100	100
(N)	(19)	(125)	(206)	(205)

It is instructive to compare these figures with those for patients whose first known contact was with a psychiatrist where there were clear trends to be found in the distribution of patients by clinical group. Rates per 1,000 total population increased from 3.65 in 1976 to 4.07 in 1985. The clinical categories which showed proportional increases were 'senile dementia' (6% in 1976, 16% in 1985) and 'other' (16% in 1976, 30% in 1985). The categories which showed proportional decreases were 'anxiety states' (23% in 1976, 9% in 1985) and to a more limited extent 'depressions' (37% in 1976, 32% in 1985).

CPNs' clients' age distributions also contrasted with those of psychiatrists' clients. Table 6 shows that after 1979, although

totals rose, the proportions of patients in various age groups whose first contact with psychiatric services was with a CPN varied little over time, except in the 35-44 age group which increased after 1979, and the 65-74 age range, where proportions declined.

TABLE 6
First-ever psychiatric contact
with CPN as first contact
by age group
Percentages & rates per 1,000 total population

Age Group	1976	1979	1982	1985
0-14	-	-	1	-
15-24	32	16	18	17
25-34	26	17	18	21
35-44	21	10	13	21
45-54	10	7	8	7
55-64	5	11	10	12
65-74	5	21	13	8
75+	-	17	17	14
Total	100	100	100	100
(N)	(19)	(125)	(206)	(205)
Rate	0.07	0.50	0.86	0.85

For inceptors whose first contact was with a psychiatrist, total rates rose from 3.65 per 1,000 total population in 1976 to 4.07 per 1,000 in 1985, but between the ages of 15 and 64 numbers, rates and percentages of new patients fell. However, patients between the ages of 65 and 74 almost doubled, and the numbers of new patients aged 75 and over increased from 54 in 1976 to 292 in 1985 - an increase from 6% of the total in 1976 to 30% of the total in 1985.

First CPN referrals, (shown in Tables 7 and 8) represent clients 'new' to the CPN service whether or not they had previous contact with another element in the mental health service. By 1984 total rates of first CPN referrals had risen to more than 3 times their 1976 level. Staffing levels rose at least 5 times over the period, indicating that over time, the CPN service gradually acquired its own 'chronic but intermittent' service users.

TABLE 7

First CPN Referrals by Clinical Category

Percentages and rates per 1,000 total population

Clinical Category	1976	1981	1984
Schizophrenia	27	11	5
Depressions	26	36	38
Neuroses	15	16	19
Personality disorders	8	10	7
Addictions	4	5	3
Senile Dementias	4	6	6
Other	14	16	22
TOTAL	100	100	100
(N)	(199)	(454)	(708)
Rate	0.76	1.86	2.92
Percentage of CPN Year prevalence	65	29	31

Table 7 shows how the proportions in each clinical category of 'new' CPN clients changed over time. Before the move to primary care bases in 1979, 'schizophrenia' was overwhelmingly the

largest single clinical group: after 1979, although rates remained relatively stable, they formed a decreasing proportion of the total as proportions in the 'other' category rose.

As a proportion of all clients seen each year by CPNs, 'new' referrals fell until 1982 rose until 1983, and fell in 1984. Proportions of 'new' clients rose each time staffing increases occurred and fell when a decrease occurred.

TABLE 8
First CPN Referrals By Age Group
Percentages

Age Group	1976	1981	1984
0-14	-	-	1
15-24	12	12	13
25-34	18	18	19
35-44	21	16	15
45-54	17	13	10
55-64	11	13	12
65-74	16	14	12
75 & Over	5	14	18
Total	100	100	100
(N)	(199)	(454)	(708)

The most striking feature of the age breakdown of new CPN clients, given in Table 8, is the increase in the proportion of clients aged 75 and over which increased more than 3 times over the period. Proportions, but not rates, fell over time in the 45-54 age range.

Figure VI
First Known Psychiatric Contact 1976-198
Rates per 1,000 Total Population

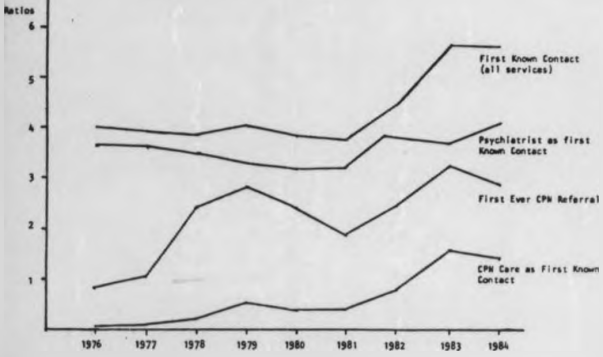


Figure VI illustrates the relationships between all inceptors, a. whose first known contact was a psychiatrist, b. whose first known contact was a CPN and c. those referred for the first time ever. First CPN contacts are also shown. It can be seen that in 1982, first-ever referrals for psychiatric care began a rise which continued until 1984. Although it can be seen that numbers of patients whose first known contact was with a psychiatrist rose slightly, the numbers whose first contact was with a CPN rose more steeply. It may therefore be assumed that much of the overall increase in inceptions was due mainly to patients whose first contact was a CPN.

CPN staff increases coincided with increases in first referrals

for CPN care and increases in the mean numbers of long-term patients per nurse. This suggests that as staff increased, CPNs tended to accept more new cases and re-referrals, rather than reduce the mean numbers of long-term patients on their caseloads.

4.9 OVERLAP OF CPN WITH OTHER SPECIALIST PSYCHIATRIC SERVICES

The inter-relationships between the various components of the mental health service were discussed in Chapter 3.

TABLE 9

Year prevalence, proportion of CPN to total psychiatric services by clinical category

Percentages and rates per 1,000 total population

Clinical category	1976	1979	1982	1985
Schizophrenia	14	52	46	47
Depressions	6	35	40	41
Senile dementia	6	37	25	44
Anxiety states	6	31	36	41
Personality disorder	6	23	36	31
Addictions	7	25	26	24
Other	8	29	34	34
Total	8	36	37	39
(N all services)	(3707)	(4129)	(4522)	(5423)
Rate	14.2	16.4	18.8	22.6
(N CPN service)	(308)	(1489)	(1692)	(2133)
Rate	1.1	5.9	6.8	8.9

Table 9 above shows that the proportion of all psychiatric patients who saw a community psychiatric nurse during each year, increased from 8% in 1974, to 36% in 1979, and remained steady thereafter. Proportions in each clinical group varied over time. In 1974 14% of patients diagnosed as suffering from 'schizophrenia' had some CPN contact during the year; in 1979 and 1985 the figures were 52% and 47% respectively. However, after 1979, the proportions within each individual clinical category moved closer to the total, as the distribution of clinical categories of CPN patients approached that of the services as a whole.

Figures VII and VIII below illustrate the rates and proportions of CPN patients receiving CPN care only on successive point prevalence days. Since 1975, the proportions of the total rose from 59% to 79% in 1984.

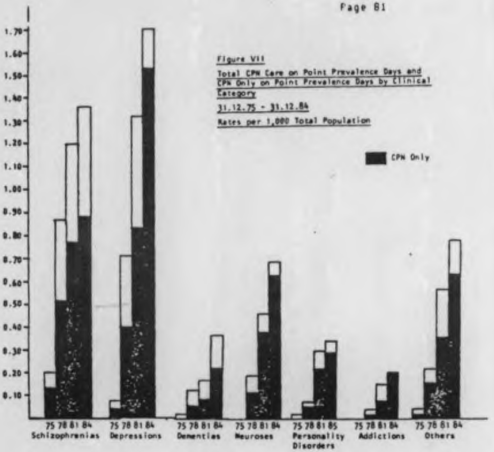


Figure VII
Total CPN Care on Point Prevalence Days and CPN Only on Point Prevalence Days by Clinical Category
31.12.75 - 31.12.84
Rates per 1,000 Total Population
CPN Only
1.70
1.60
1.50
1.40
1.30
1.20
1.10
1.00
0.90
0.80
0.70
0.60
0.50
0.40
0.30
0.20
0.10
75 78 81 84
Schizophrenias
Depressions
Dementias
Neuroses
Personality Disorders
Addictions
Others

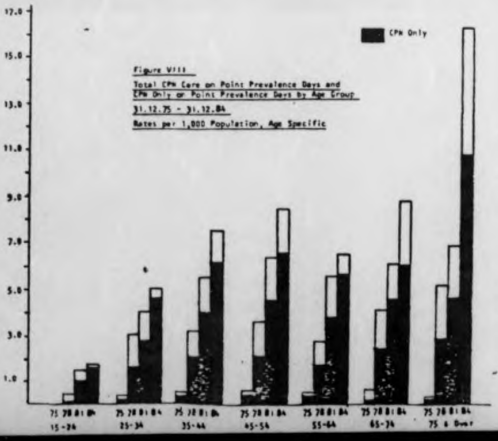

CPN Only
Figure VIII
Total CPN Care on Point Prevalence Days and CPN Only on Point Prevalence Days by Age Group
31.12.75 - 31.12.84
Rates per 1,000 Population, Age Specific
17.0
15.0
13.0
11.0
9.0
7.0
5.0
3.0
1.0
15-24
25-34
35-44
45-54
55-64
65-74
75 & Over

Figure VII shows that since 1975, on point prevalence counts of CPN patients suffering from 'schizophrenia' and 'senile dementia', the proportion who had CPN only care stayed relatively stable. Rates and proportions in other clinical categories rose dramatically.

The age breakdown given in Figure VII illustrates that increasing proportions of clients in the youngest age groups had CPN only care but that there was no clear trend over time in other age ranges.

TABLE 10

CPN only clients on point prevalence days who received no other psychiatric care during the following 365 days.

Numbers and percentages

Point Prevalence	N	%*
31.12.75	29	37
31.12.76	46	47
31.12.77	78	56
31.12.78	168	50
31.12.79	235	47
31.12.80	258	44
31.12.81	312	46
31.12.82	450	57
31.12.83	620	57
31.12.84	623	59

* Percentages of CPN only on point prevalence count

Table 10 gives numbers of clients who received CPN only care on point prevalence days who received no other care during the following year (365 days). It can be seen that there was no

clear trend in percentages over time, though numbers rose. This is surprising, as the move to primary care bases could well have resulted in CPNs 'treating' a larger proportion of clients themselves (many of whom were referred directly from GPs, and were probably in the 'depression' or 'anxiety' categories). That this did not occur suggests that CPNs did not divert clients from the other psychiatric services.

4.6 PSYCHIATRIC SERVICES EXCLUDING CPN

The new investment in CPN services between 1976 and 1985 could be thought to have had some impact on the use of other more traditional mental health services. Register data show that total annual period prevalence rates for contacts involving psychiatrists increased from 13 per 1,000 total population in 1976, to 15 per 1,000 total population in 1981, and to 17 per 1,000 total population in 1985. Rates rose in all clinical groups. The largest increases were in 'senile dementia' (0.36 to 0.58 per 1,000 population), 'addictions' (0.43 to 0.97 per 1,000 population) and 'other' (1.56 to 2.98 per 1,000). Age specific rates per 1,000 in the under 35 age groups decreased (from 20.71 to 16.92 between 25 and 34) and in the 35-64 range they increased slightly. The biggest increases were in the 65-74 (17.02 to 24.20) and 75 and over age groups (17.25 to 46.79). Year prevalence rate for out-patients rose from 9 to 13 per 1,000 population between 1976 and 1985.

Admission rates remained steady between 1976 and 1982, around a mean of 3.76 per 1,000 total population. After 1983 rates rose

each year to 4.39 per 1,000 total population in 1985. The rises occurred wholly in the 65 and over age group, but age specific rates in the 15-64 age range remained steady at around 4.55 per 1,000 population. The mean number of admissions per person each year rose from 1.12 in 1976 to 1.35 in 1985. After 1976 the diagnostic composition of admissions changed. The proportion of schizophrenias fell from 24% in 1976 to 18% in 1984, continuing a trend which had been observed in Salford C.B. since 1968 and was probably the result of increasing use of depot neuroleptic drugs.

The proportion of admissions each year which resulted in a length of stay of at least one year remained steady, around a mean of 7%, between 1976 and 1984; in 1985, it fell to 5.26%. This fall was more likely to have been a consequence of a new policy instituted by the hospital rehabilitation team during 1985 than a consequence of vigorous community service activity. The hospital rehabilitation team were given control over access to long-stay wards, and admission to them was refused until a rehabilitation assessment had been made and deemed the patient suitable for admission to the rehabilitation programme. New long-stay rates - i.e. continuous in-patient care for 1-10 years - rose from 0.59 to 0.90 per 1,000 population between 31.12.1975 and 31.12.1982; the rate then fell to 0.79 at the end of 1985.

4.7 SUMMARY AND DISCUSSION

The data showed a sevenfold increase in CPN year prevalence rates between 1976 and 1985; over the same period, the number of staff increased sixfold. Rates increased in all age groups but the greatest expansion occurred in the over 75 age range, where proportions increased from 5% of the total year prevalence in 1976 to 21% in 1985. The most rapid growth in this age group was found after the establishment of the specialist psychogeriatric service.

Change in the distribution of clinical categories

The change from a service which primarily catered for the care of clients suffering from schizophrenia, to one in which the distribution of clinical categories was similar to that found in the mental health services as a whole, followed the move to primary care and community bases in 1979. Information on the sources of referrals (Grieshaw 1985) shows that in 1984 the proportion of clients referred to CPNs from psychiatrists was 16% whilst the proportion of referrals direct from GPs was 62%. Before the move to primary care, the majority of referrals were from psychiatrists, and consisted mainly of psychotic patients. Data from Worcester and Southampton case registers (Wooff et al. 1987), where CPN services are consultant-attached, showed that CPNs in these areas dealt predominantly with psychotic clients.

It would appear then, that psychiatrists in Salford, and probably from elsewhere, perceived the role of CPNs as predominantly

caring for psychotic clients, and GPs and other primary care workers perceived the role of CPNs as providing care for non-psychotic clients. The resulting CPN case mix in Salford closely resembled the case mix found in the psychiatric services as a whole, which provided CPNs with the opportunity to widen their original roles but also laid the ground for possible conflict between the demands made for the care of at least two client groups - those referred by psychiatrists and those referred by GPs.

The dynamics of prevalence

As epidemiological work on long-stay in patient rates (Fryers op. cit.; Hailey 1971) has shown, there is an important distinction to be made between 'new' and 'old' long-stay in-patients. The same principle applies to the long-term care of people living outside hospitals. The data showed the extent to which numbers and rates of CPN patients in continuous long-term care built up over time. The vast majority of first referrals to the CPN service after 1979 were not in the 'schizophrenia' clinical group, and data on the dynamics of care showed that a substantial proportion of clients referred each year went on to receive long-term (i.e. care for at least 1 year) CPN care. As these 'new long-term' cases built up, there was no corresponding fall in the numbers of 'old' long-term psychotic clients receiving CPN care.

It is clear that unless either the numbers of 'new' long-term patients or the numbers of 'old' long-term patients are reduced,

the service will continue to operate under pressure as each increase in staff appears to bring about a cumulative increase in the numbers of 'new' long-term patients. It is important that this point is understood, as the usual solution to a built up of pressure is to deploy more staff. These data show that staff increases alone will not only fail to improve the situation in the long term, but may even exacerbate the problems.

It is in relation to long-term care that the conflict between demands for care from psychotic and non-psychotic clients is most apparent. Since CPN services began, they have provided long-term care for psychotic clients, and psychiatrists have generally seen this as a service priority. However, nurses themselves appear to have equated caring for non-psychotic clients with increasing 'professionalism' and over the last five years there have been increasing moves to accept referrals direct from GPs and to expand primary care links in order to widen their roles. Indeed, work by Paykel et al. (op cit.) and Marks et al (op cit.) has demonstrated that CPNs can make an effective contribution to the care of neurotic clients, and it is clear from the data presented here that it is these patients who are likely to be referred to CPN care if the CPN service is primary care based and free to accept referrals direct from GPs.

Given that the demands made on GPs and other primary care workers by patients with mental health problems are likely to differ from the demands made on psychiatrists (Goldberg & Huxley op. cit.), it is perhaps inevitable that GPs and psychiatrists will have different perceptions of relative priorities for care.

Strengthening primary care links in themselves may not necessarily result in changing CPN caseloads if links are strengthened by the whole multidisciplinary specialist team; the acceptance of GP referrals by CPNs almost inevitably will result in changes in caseload mix as it is likely that the patients referred directly to CPNs will reflect primary care perceptions of priorities rather than psychiatric team priorities. These different priorities each have their own validity, but planners and managers need to be clear in their objectives for service development.

Observations of work on psychiatric wards (Towell op. cit.; Altschul op. cit.) have illustrated that psychiatric nurses' activities tended to be defined by a variety of 'treatment cultures' and that nurses did not appear to apply any identifiable theoretical framework to their day-to-day activities. It may be postulated that nurses' responses to 'demands' made by patients living outside hospitals will follow similar patterns, and that the conflicts inherent in moves to primary care bases could, to some extent, have been anticipated. Furthermore, the nurses' 'spontaneous and genuine' responses to patients which are permitted by their 'pragmatic, non-intellectual orientation' (Rubenstein & Lasswell 1966) is likely to lead to their responding more to the 'demands' made by highly verbal and responsive neurotic clients than to the less overt 'demands' made by non-verbal, withdrawn psychotic clients.

In times of service constraint, the problems of conflicting 'demands' for care will be severe, and although the 'demands' of

psychiatrists and GPs may balance each other in force and tend to ensure that at least some of their 'demands' are met, the contrasting 'demands' of psychotic and non-psychotic patients are unlikely to result in equal shares of staff time unless administrative arrangements which 'protect' services for psychotic patients are put into practice. The results of observations of actual working practice may go some way towards establishing whether this did indeed happen in the Salford service.

The relationships between CPN and other psychiatric services

The data on first known referrals for psychiatric care showed that after 1979, around 20% of these 'new' referrals occurred via a CPN. The total rates of 'new' referrals to psychiatrists rose over the period which could have implied that the patients GPs referred to CPNs were referred in addition to those patients referred to psychiatrists. That is, that the patients referred directly to CPNs represented an expansion of the boundaries of specialist care rather than CPNs substituting for psychiatrists in the care of 'new' patients.

However, the data show that the rates and percentages of 'new' referrals via psychiatrists fell in the 15-44 age group and that the expansion occurred only in patients aged over 65. It would appear therefore, that after their establishment in primary care bases, CPNs appeared to be substituted for psychiatrists, at least to some extent, as the first contact point with specialist psychiatric services for patients aged between 15 and 64, and

suffering from anxiety states.

In contrast to the declining numbers of patients aged under 65 whose first contact with psychiatric services was with a psychiatrist, there was an increase in the total numbers of people who were referred to psychiatrists. The process underlying this increase in referrals to psychiatrists are not clear. It could be the result of CPNs' perception of 'needs' of some newly referred patients, and being instrumental in their referral to psychiatrists; it could be that GPs referred to CPN and psychiatrist care simultaneously and CPNs responded more quickly, thus becoming the initial contact; it could be that patients were referred to psychiatrists after care from CPNs had failed to produce a remission of symptoms.

Whatever the processes, the total numbers of new patients aged over 35 seen by psychiatrists increased over the period, suggesting that the CPN service did not routinely divert these patients from the other psychiatric services. They might however, have provided care for younger clients who would otherwise have been referred to psychiatrists. It is therefore likely that a substantial proportion of these patients cared for by CPNs only, would have received care from GPs rather than from psychiatrists if the CPN service had been unavailable. What is certain is that the increase in CPN services which occurred over the period did not result in any overall reduction in patients' use of other more traditional psychiatric services.

CHAPTER 5

MENTAL HEALTH SOCIAL WORK SERVICES, CARE REGISTER DATA

As explained previously, population-based data covering the enlarged Salford Metropolitan District, have been gathered from 1976 onwards. Mental health social work care in Salford M.D. is provided by two, separately managed, social work departments:

1. Patch or Area Social Work Teams (Patch SW), which provide services to a wide range of client groups in a designated geographical area, and where social workers have mixed (generic) caseloads, some of which have a 'mental health' component. The Register records those cases designated 'mental illness' cases by social workers, and those cases referred to them by the psychogeriatrician;

2. A specialist mental health work team (Specialist SW) which is based at the local psychiatric hospital, and whose members are attached to various consultant teams including the psychogeriatric team. The Register records all the cases referred to the specialist team.

Both categories together constitute total mental health social work care (MHSW). Details of recording method appear in Chapter 3.

5.1 MHSW YEAR PREVALENCE, 1976-1985

Figure 1X and Table 11 below show that year prevalence rates,

which rose from 3.23 per 1,000 total population in 1976 to 6.27 per 1,000 total population in 1985, almost doubled over a 9 year period. The low year prevalence rate in 1981 was a consequence of industrial action taken by social services staff, and falls were recorded in both 'new episodes' and point-prevalence counts. The cohort effect of the 1981 reduction in new episodes can be seen to have affected the point prevalence rate in 1982, which is lower than might otherwise have been expected.

Figure IX

SALFORD MD

SSW Year prevalence 1976 - 1984

Rates per 1,000 Population

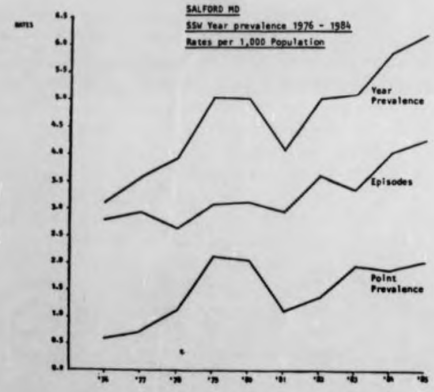


TABLE 11

MHSW Year Prevalence 1976-1985

numbers and rates per 1,000 total population

Year	Point N	Episode N	Total N	Rate
1976	176	671	847	3.23
1977	204	706	910	3.52
1978	296	660	956	3.75
1979	495	767	1262	5.03
1980	479	761	1240	5.01
1981	310	679	989	4.06
1982	338	870	1208	5.03
1983	449	791	1240	5.06
1984	434	978	1412	5.82
1985	488	1016	1504	6.27

It can be seen that pointprevalence rose rapidly for the four years following the creation of the enlarged Metropolitan District of Salford (1974-1979), stabilised, and began a further rise in 1983. 'New episodes' rose throughout the period (with the exception of 1981, reasons for which have been explained earlier), and the increases in year prevalence rates can be seen to have been due almost entirely, to increases in 'new episodes' of care. This suggests that increasing numbers of clients have decreasing lengths of continuous MHSW care.

As Patch team workers had mixed caseloads, it was not possible to arrive at any notional staffing figures which could have related numbers of clients to numbers of staff.

The proportion of total mental health social work care each year dealt with by the specialist social workers is shown below, in Table 12.

TABLE 12

Mental Health Social Work Care, Year Prevalence 1976-85

Proportion of Specialist Social Work care in Total MHSW.

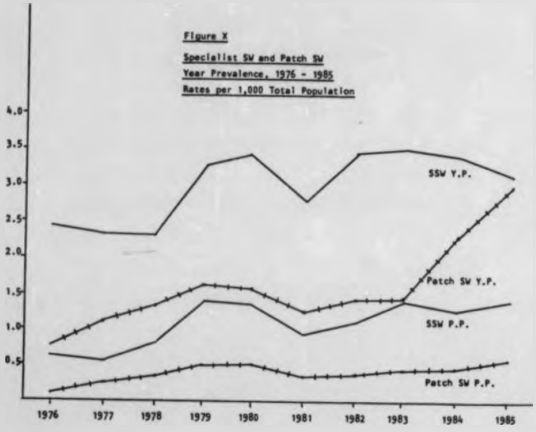
Numbers & Percentages

Year	Total MHSW N	Specialist SW N	%	Staff*
1976	847	644	76	3
1977	910	615	68	4
1978	956	604	63	4
1979	1262	842	67	5
1980	1240	849	68	5
1981	989	678	68	5
1982	1208	857	71	6
1983	1240	879	71	6
1984	1412	833	59	6
1985	1504	766	51	7

* Whole time equivalent as at 1st July each year.

It can be seen that, until 1984, the Specialist consultant-attached social workers accounted for around 70% of total mental health social work care. After 1984, proportions fell by 20%, but rates fell only slightly as Patch team workers increased their recorded mental health work.

The comparison of the components of year prevalence for Patch and Specialist social workers in Figure I below illustrates the increasing contribution to total MHSW rates made by the Patch teams after 1983. In 1983, Specialist SW year prevalence rates were more than double those for Patch SWs; by 1985, the rates, at 3.19 per 1,000 total population for Specialist SWs and 3.08 per 1,000 total population for Patch SWs, were almost equal.



The contribution of point prevalence to year prevalence rates varied over time for both Patch and Specialist social workers. As would be expected when services were being established and extended, the contribution of point to year prevalence rose steadily in the specialist service between 1976 and 1979, from 25% to 44%. It slowly fell to 31% in 1982, but rose again to 45% by 1985. In the patch teams, contribution of point to year prevalence rose from 6% in 1976 to 31% in 1980, and fell

irregularly, to 19% in 1985. Thus the rise in year prevalence after 1983 was due to large increases in Patch team 'new episodes'.

Clients with long periods of continuous care are more likely to appear in a point prevalence count than as 'new episodes'. The contribution of point prevalence to year prevalence was higher (often twice as high), for Specialist social work than for Patch SW, indicating that Specialist SWs were more likely to have long-term involvement with clients, and Patch team workers more likely to provide many short periods of care.

5.1.1 Year Prevalence by Clinical Category

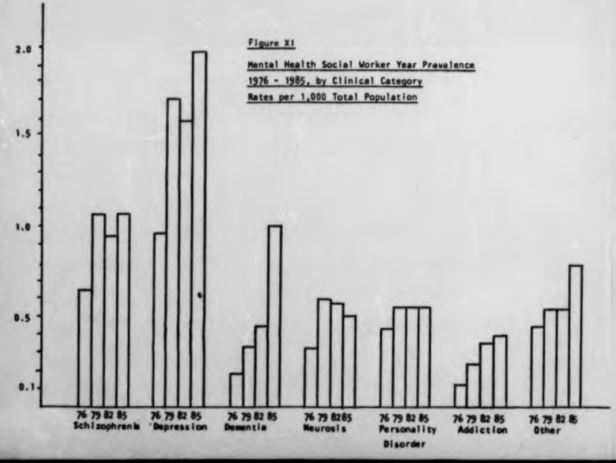


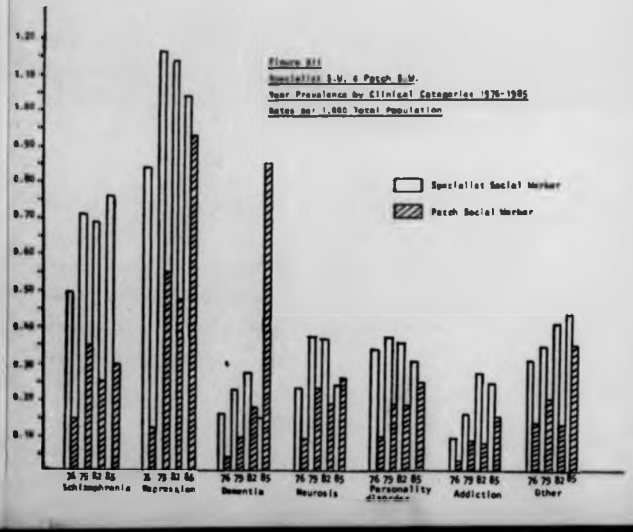
Figure XI
Mental Health Social Worker Year Prevalence
1976 - 1985, by Clinical Category
Rates per 1,000 Total Population

Figure XI shows that the overall expansion of social work care was not equally distributed between clinical categories. Rates fell in the 'neuroses' group, and remained steady in the 'schizophrenia' and 'personality disorders' groups; small increases in rates were recorded in the 'depressions' and 'other' categories. Only two groups showed rises in both rates and proportions - 'senile and pre-senile psychoses' which showed a rise from 0.19 per 1,000 total population and 6% of all cases in 1976, to 1.00 per 1,000 total population and 16% of all cases in 1985, and 'addictions' which rose from 4% to 6% and 0.12 to 0.40 per 1,000 total population between 1976 and 1985.

The distribution of clinical categories and the changes over time for patch team and specialist workers are shown separately in Figure XII below.

In the Specialist service, 'depression' and 'schizophrenia' were the largest clinical categories over the whole period, and varied little around a mean of 33% and 21% of all cases respectively. Clients in the 'Neuroses', 'Personality Disorders' and 'other' clinical groups were the next most frequent at around 11%, with 'addictions' and 'senile and pre-senile psychoses' the smallest groups forming around 7% of all clients. It is interesting to note that proportions varied little over time, and that proportions and rates in two clinical categories which have had considerable media attention in recent months - 'addictions' and 'dementia' - remained small.

In contrast to the Specialist team, rates and proportions for clinical categories of clients referred to the Patch SWs varied considerably over time. In 1976, 'depression' and 'schizophrenia' were the largest categories, and 'senile and pre-senile psychoses' and 'addictions' were the smallest; by 1985 rates and proportions in the 'senile and pre-senile psychoses' category had risen to almost the same levels as those for 'depression'. Proportions, but not rates, for 'schizophrenia', 'depression', 'neuroses' and 'personality disorders' fell after 1979. These differences in the distribution of clinical categories between Specialist and Patch social workers were substantial by 1982.



5.1.2 Year Prevalence by Age Group

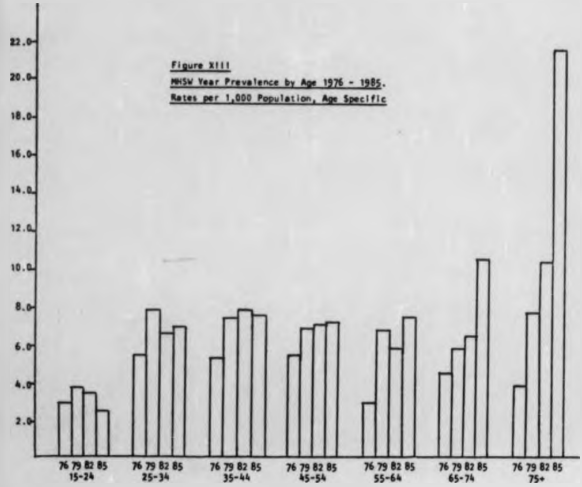


Figure IIII shows how age specific year prevalence rates varied over time. Rates as well as proportions began to fall in the youngest age groups, whilst the oldest age group, 75 and over, showed dramatic rises in both rates and proportions. Care for the elderly accounted for almost the whole of the overall increase in year prevalence rates.

Table 13 shows the clinical categories of clients aged 65 and over from 1982 to 1985, the years during which the great expansion of social work care for the elderly mentally ill occurred.

TABLE 13

Mental Health Social Work Clients Aged 65 & Over: Clinical Categories, Percentages

Clinical categories	1982 %	1983 %	1984 %	1985 %
Schizophrenia	10	10	8	7
Depressions	33	30	28	35
Senile Dementia	33	38	40	41
Anxiety States	5	3	4	3
Personality Disorders	3	5	3	4
Other	15	14	15	10
Total %	100	100	100	100
(N)	(298)	(377)	(487)	(576)

It can be seen that the 93% increase in numbers of clients aged over 65 was not confined to the 'senile and pre-senile psychoses' category. Proportions in each clinical group varied only slightly over time.

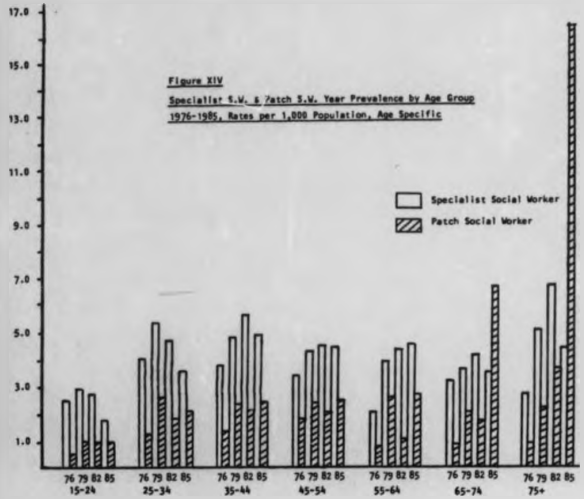


Figure XIV

Specialist S.W. & Patch S.W. Year Prevalence by Age Group 1976-1985, Rates per 1,000 Population, Age Specific

The age distributions of Patch and Specialist SW clients is illustrated in Figure XIV. The bi-modal distribution can be seen for both, but the highest peak for the Specialist team was in the 35-44 age range, and for the Patch teams was in the oldest age group, with less of a peak for young middle aged clients as time went on.

The tendency for Specialist SWs to become involved with younger clients, and Patch SWs to become involved with older clients, increased over time. Thus the increase in total social work care for the elderly mentally ill seen earlier (Figure XIII), was due entirely to work in the Patch teams. Similarly, the decreasing proportions of mental health social work carried out by Specialist social workers (Table 12), were due to increases in the work with elderly mentally ill of the Patch teams and not due to decreases in rates of Specialist social work.

It is important to point out that referrals to Patch teams by the psychogeriatrician were all recorded on the Case Register whether or not they were categorised as 'mental illness' cases by social services staff. Any other referrals were included only if classified as 'mental illness'.

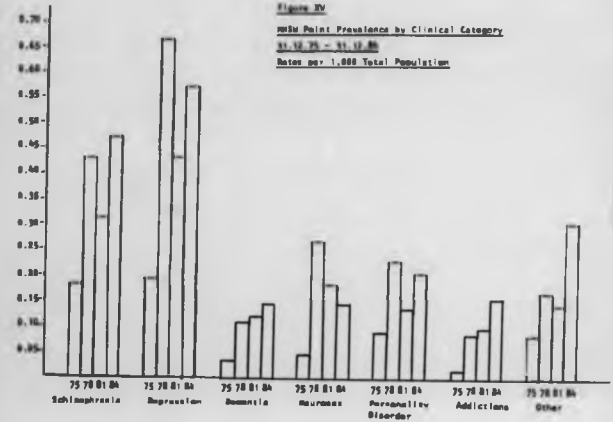
General Psychiatrists do not routinely refer clients directly to Patch teams, as the Specialist social workers would usually do this if appropriate. If general psychiatrists did refer directly to Patch teams, cases would almost certainly be classified as 'mental illness'. In contrast, the Psychogeriatrician, after assessment, refers clients directly to Patch teams if he considers that non-specialist assistance is appropriate. In these cases, clients may well be classified by social services staff as 'elderly' rather than 'mental illness' and in order to monitor and record the impact on services made by the specialist psychogeriatric team, it was decided to include all referrals to Patch teams by the psychogeriatrician on the Register data bank.

The rises recorded by the Register may, therefore, have reflected differences in data collection methods and/or a changes in social service 'labelling' practice rather than reflected overall increases in referrals of elderly clients. Data obtained from the Social Services Department (Ford 1986) show that between the financial years 1981-2 and 1984-5 total referrals rose by 42%. In the 'elderly' category, referrals over the same period rose by 75%. It is therefore likely that the increases in referrals of elderly clients recorded on the Case Register after the establishment of a psychogeriatric service, represented real increases in the workload carried by the Patch teams.

5.2 MENTAL HEALTH SOCIAL WORK POINT PREVALENCE

5.2.1 Point prevalence by clinical category

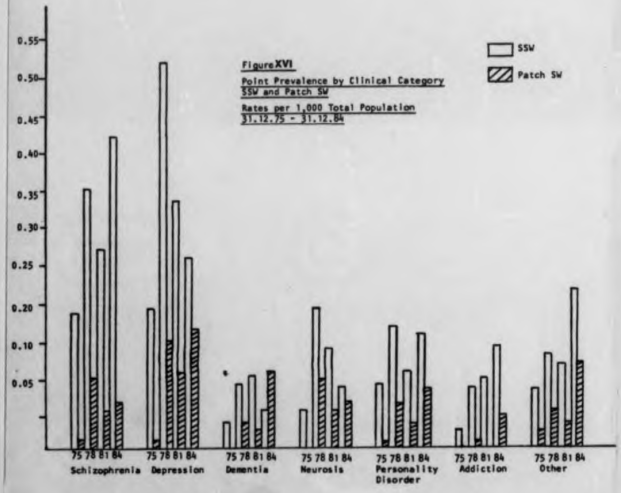
The clinical categories of clients in social work care on point prevalence days between 1975 and 1984 are shown in Figure IV.



Total point prevalence rates for MHSW care rose from 0.47 per 1,000 total population at 31.12.1975, to 2.03 per 1,000 total population at 31.12.1984, and rises occurred in all clinical categories. The largest increases were in the 'senile dementia' and 'addictions' categories, although they together formed only 13% of the 1984 point prevalence. The smallest rates of increase were in 'personality disorders'. The rankings of proportions for clinical categories were the same as in the year prevalence figures, but the excess of 'depression' over 'schizophrenia' was less in the point prevalence counts than in the year prevalence

counts because point prevalence counts include greater numbers of people in long term care.

The distributions of clinical categories for Patch and Specialist social work teams are shown below in Figure XVI. The increasing contribution of the Patch teams to MHSW point-prevalence counts can be clearly seen, though it is by no means clear whether in the past Patch teams saw fewer clients with mental health problems, or merely recorded fewer clients in this category because of lack of awareness of needs, reluctance to label, or for other reasons.



As with year prevalence ratios, changes in clinical categories occurred after 1982. By the end of 1985, Patch teams had over 5 times more clients in the 'senile and pre-senile psychoses' category, and less than half the clients in the 'schizophrenia' group than had the Specialist team. Total rates (3.19 per 1,000 total population Specialist SWs; 3.08 per 1,000 total population Patch SWs) were similar.

5.2.2 Point-Prevalence by Age

Figure XVII

MHSW Point Prevalence by Age, 31.12.75 - 31.12.84

Rates per 1,000 Population, Age Specific

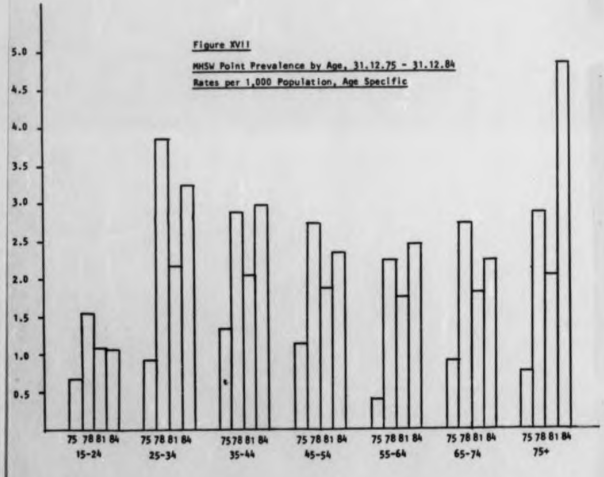


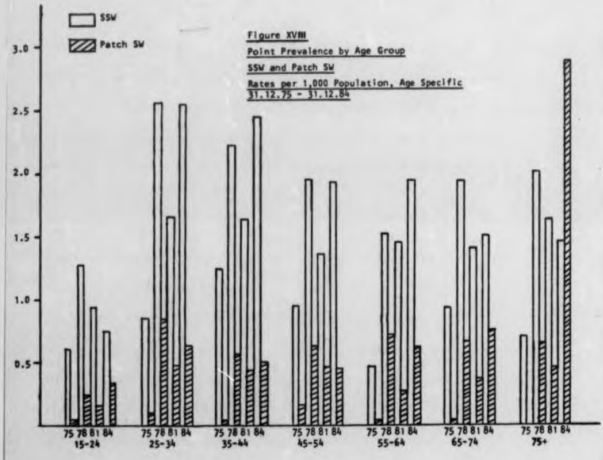
Figure XVII illustrates changes in age specific rates for total MHSW care between 31.12.1975 and 31.12.1984. These changed even more dramatically than those for clinical categories. The smallest rises were 15-24 and 45-54 age groups; the two highest were in the 55-64 and 75 and over groups.

Table 15 compares the situation in 1975 and in 1984.

TABLE 15
MHSW Point prevalence by age
31.12.75 and 31.12.84
Percentages

Age group	31.12.75	31.12.84
15 - 24	15	9
25 - 34	17	20
35 - 44	21	18
45 - 54	20	12
55 - 64	8	15
65 - 74	13	10
75 & over	5	14
Total	100	100
(N)	(176)	(488)

Figure XVIII shows age specific point prevalence rates for Specialist and Patch team workers. Consistent with the increase in Patch team clients with 'senile dementia', there was an increase in numbers, rates and proportions of elderly clients in Patch teams. Prevalence rates for clients aged 65 and over in the Specialist team rose only until 1978, and stayed relatively stable thereafter.



5.3 LENGTH OF CONTINUOUS MENTAL HEALTH SOCIAL WORK CARE

As described earlier, both referrals to and discharges from Patch and Specialist social work care are recorded on the Case Register. In order to appear on a social work point prevalence count, clients must be 'active' cases i.e. they must have been referred before the point prevalence day, but not discharged from care before it. Point prevalence measures of length of care describe the period between the last referral and the point prevalence day.

Table 14 below shows the length of continuous social work care on point prevalence days. Overall, the distribution of clients by length of continuous social work care showed no consistent trend. Around 40% had been receiving continuous social work care for over one year; around 10% had been receiving it for less than 1 month.

Compared with Specialist social workers, Patch teams had higher proportions of clients in very short-term care (under 1 month). The proportion of clients in long term social work care (1 year and over) varied between 20% and 44% for Patch teams and between 28% and 50% for the Specialist team. No clear trends were evident. For **total** NHSW, the proportion of clients in continuous care for 1 year and over varied relatively little.

TABLE 16

Length of Continous MHSW Care on Point Prevalence Days

Percentages

Length of Care			31.12 1975	31.12 1977	31.12 1979	31.12 1981	31.12 1983	31.12 1985
Under 1 month		MHSW	14	6	10	11	10	11
		Patch SW	62	8	11	13	13	14
		Spec. SW	21	6	10	10	9	10
1 < 3 months		MHSW	18	15	15	14	17	14
		Patch SW	25	25	10	13	7	14
		Spec. SW	39	11	17	15	20	14
3 < 12 months		MHSW	27	46	28	45	33	34
		Patch SW	12	37	36	38	36	51
		Spec. SW	21	49	25	46	32	26
1 year +		MHSW	41	32	47	30	40	41
		Patch SW	-	29	43	35	44	20
		Spec. SW	40	34	48	28	39	50
Total	%	MHSW	100	100	100	100	100	100
	(N)		(176)	(296)	(479)	(338)	(434)	(466)
		Patch SW	100	100	100	100	100	100
	(N)		(13)	(85)	(122)	(68)	(101)	(146)
		Spec. SW	100	100	100	100	100	100
	(N)		(163)	(211)	(357)	(270)	(333)	(320)

TABLE 17
Clients in Continuous MHSW Care for Over 1 Year
On Point Prevalence Days 31.12.75 - 31.12.84
By Clinical Category
Percentages

CLINICAL CATEGORY	31.12. 75	31.12. 77	31.12. 79	31.12. 81	31.12. 83	31.12. 84
Schizophrenia	45	32	22	28	29	26
Depressions	18	24	33	31	25	24
Anxiety states	6	8	12	14	11	9
Dementia	6	6	5	5	5	6
Personality Disorder	10	13	13	8	15	13
Other	15	16	13	13	17	22
TOTAL	100	100	100	100	100	100
(N)	(73)	(96)	(224)	(100)	(174)	(178)

Table 17, above, shows the distribution of clinical categories for clients who received continuous MHSW care for one year and over on point prevalence days changed. As proportions in the 'schizophrenia' category gradually fell, proportions in all other categories except 'senile dementia' rose. Proportions in the latter stayed the same. It is important to point out that even though proportions in the 'schizophrenia' category fell, prevalence rates increased.

TABLE 18
Clients in Continuous SSW & Patch Care for Over 1 Year
On Point Prevalence Days 31.12.75 - 31.12.84
By Clinical Category
Percentages

CLINICAL CATEGORY		31.12. 75	31.12. 77	31.12. 79	31.12. 81	31.12. 83	31.12. 84
Schizophrenia	SSW	45	37	23	30	31	32
	PATCH	-	8	12	22	15	7
Depressions	SSW	18	22	35	33	28	24
	PATCH	-	33	36	26	15	20
Anxiety states	SSW	6	7	12	10	7	7
	PATCH	-	17	12	26	22	15
Dementia	SSW	6	7	5	4	2	2
	PATCH	-	-	4	9	15	17
Personality Disorder	SSW	10	13	12	7	15	12
	PATCH	100	17	20	13	17	17
Other	SSW	15	14	13	16	17	21
	PATCH	-	25	16	4	17	24
TOTAL	SSW	100	100	100	100	100	100
	PATCH	100	100	100	100	100	100
(N)	SSW	(66)	(71)	(171)	(76)	(129)	(129)
	PATCH	-	(25)	(53)	(24)	(45)	(42)

The comparison between patch and specialist social work teams shown above in Table 18, demonstrates substantial differences in the distribution of clinical categories of long-term clients. Both groups of social workers had similar proportions of clients in the 'depressions' and 'other' clinical categories; Patch workers had higher proportions with 'anxiety states', 'personality disorders' and 'senile dementias'; Specialist workers had higher proportions in the 'schizophrenia' category.

TABLE 19
MHSH Referrals by Length of Continuous Care
1974 - 1985
Numbers and Percentages

Year of Referral	< 1 month		1<3 months		3<12 months		Over 1 year		TOTAL	
	n	%	n	%	n	%	n	%	n	%
1974	426	57	140	19	102	14	76	10	744	100
1977	423	51	111	13	138	17	155	19	744	100
1978	259	32	128	16	222	28	187	23	796	100
1979	399	40	213	22	297	30	85	9	994	100
1980	415	42	239	25	258	26	66	7	978	100
1981	380	42	181	20	200	22	137	15	898	100
1982	563	49	212	18	254	22	129	11	1158	100
1983	576	48	205	17	297	25	116	10	1194	100
1984	828	56	226	15	284	19	152	10	1490	100
1985	1032	60	237	14	287	17	166	10	1722	100

Point prevalence data show situations as they are at any one time. The dynamics of care are more effectively shown by analysis of ultimate length of care following referral. Table 19 above, shows that, apart from 1977 and 1978, when proportions of those referred for MHSW care who received continuous care for at least 1 year were high, proportions of clients in care for varying lengths of time changed little between 1976 and 1985.

TABLE 20
Specialist SW & Patch SW Referrals by
Length of Continuous Care 1976 - 1985
Numbers and Percentages

Year of Referral		<1month		1 < 3 months		3 < 12 months		Over 1 year		TOTAL	
		n	%	n	%	n	%	n	%	n	%
1976	SSW	320	59	101	20	68	13	45	8	541	100
	PATCH	106	52	32	16	34	17	31	15	203	100
1977	SSW	256	48	76	14	55	16	118	22	535	100
	PATCH	167	57	35	12	53	18	37	13	292	100
1978	SSW	74	16	74	17	153	35	140	32	441	100
	PATCH	185	52	54	15	69	19	47	13	355	100
1979	SSW	167	28	154	26	222	38	42	7	585	100
	PATCH	232	57	59	14	75	18	43	10	409	100
1980	SSW	197	31	193	31	201	32	38	6	629	100
	PATCH	218	62	44	13	57	16	28	8	347	100
1981	SSW	187	31	138	23	169	28	106	18	600	100
	PATCH	193	50	43	11	94	24	31	8	381	100
1982	SSW	268	36	166	22	217	29	90	12	741	100
	PATCH	295	71	44	11	37	9	39	9	417	100
1983	SSW	241	33	154	21	263	36	69	9	727	100
	PATCH	335	72	51	11	34	7	47	10	467	100
1984	SSW	256	35	149	21	232	32	79	11	716	100
	PATCH	572	74	77	10	52	7	73	9	774	100
1985	SSW	319	44	165	20	173	24	77	11	714	100
	PATCH	713	71	92	9	114	11	89	9	1008	100

Table 20 above indicates that higher proportions of referrals led to very short term care in Patch teams than in the Specialist team. However there were few differences in the proportions of clients who became long-term cases.

The numbers of clients referred to Patch teams who received continuous care for 1 year and over remained stable around a mean of 38 between 1976 and 1983, then rose from 73 in 1984 to 89 in 1985. Because the overall increase in Patch team referrals in 1984 and 1985 led to similar increases in short and long term care, proportions remained the same.

As Table 21 below shows, after 1978, the mean length of short term care given by Specialist SWs was at least twice that given by Patch SWs. For Patch teams, the trend was to shorter periods of care; for the Specialist team, the trend was towards longer periods of care.

TABLE 21

MHSW Referrals 1976-1985

Mean length of short-term* care for clients referred to MHSWs

Year	Mean length of care (days)	
	Patch SW	Specialist SW
1976	48.8	37.9
1977	52.4	46.6
1978	51.5	112.2
1979	52.2	98.7
1980	48.6	85.1
1981	35.2	85.0
1982	31.6	88.1
1983	31.2	85.0
1984	26.5	80.4
1985	31.1	66.8

* Length of continuous MHSW care after referral of up to 1 year.

5.4 FIRST CONTACTS WITH MENTAL HEALTH SOCIAL WORK SERVICES

The numbers of inceptors whose first ever contact was a mental health social worker were very low - an annual mean of 47 (or 4% of total year prevalence) between 1976 and 1985. However, this does not necessarily mean that clients with mental health problems did not initially contact the social services department. It is possible that some clients with mental health problems may have made their initial contact with Patch team workers but that they (the clients) were not classified as being 'mental health' cases. There is evidence to suggest that this did happen (Fisher et al. op. cit.; Woolf 1978), but the extent to which it did is not known.

TABLE 22

First NHSN, SSN & Patch Referral

By Clinical Category

Rates per 1,000 total Population

YEAR		Schizophrenia	Depression	Neuroses	Personality disorder	Addictions	Senile dementia	Other	TOTAL	(N)
1976	NHSN	0.27	0.68	0.23	0.29	0.08	0.15	0.28	1.96	(514)
	SSN	0.18	0.53	0.15	0.22	0.06	0.12	0.19	1.46	(382)
	PATCH	0.08	0.15	0.07	0.07	0.02	0.03	0.08	0.50	(132)
1981	NHSN	0.14	0.50	0.19	0.19	0.14	0.19	0.24	1.60	(589)
	SSN	0.09	0.35	0.15	0.13	0.10	0.15	0.20	1.17	(295)
	PATCH	0.05	0.14	0.05	0.07	0.04	0.04	0.05	0.43	(104)
1985	NHSN	0.13	0.85	0.16	0.16	0.13	0.42	0.59	2.44	(585)
	SSN	0.08	0.38	0.08	0.09	0.05	0.06	0.02	0.93	(222)
	PATCH	0.05	0.48	0.08	0.07	0.08	0.36	0.40	1.51	(363)

Table 22 gives the clinical categories of clients who made their first contacts with NHSN services. Total rates rose between 1976 and 1985, but only from 1982. As expected, the rates for conditions which may be considered to require treatment for long periods ('schizophrenia' and 'personality disorders') tended to decline over the first 5 years, and then levelled out. Referral rates in the 'depressions' and 'neuroses' categories did not vary greatly, but there were striking increases in the 'senile dementia' and 'other' categories, and a more gradual increase in the 'addictions' group.

These increases occurred in the Patch teams rather than in the Specialist service. In the specialist team, rates of 'new' referrals fell even though year prevalence rates rose, which emphasised their increasing involvement with chronically disabled clients. The increased 'demands' which contributed to the overall increase in 'new' RHSW referrals occurred in the Patch teams.. The clinical groups which showed the most dramatic rises in referral rates were 'senile dementia', 'addictions' and 'other'.

TABLE 23

First RHSW, SSW & Patch Referral

By Age Group

Rates per 1,000 Population, Age Specific

YEAR		0-14	15-24	25-34	35-44	45-54	55-64	65-74	75+	TOTAL	(N)
1976	RHSW	0.03	2.04	3.28	2.90	2.16	1.77	2.71	3.95	1.96	(514)
	SSW	0.03	1.79	2.52	2.07	1.55	1.15	1.96	2.09	1.43	(375)
	PATCH	-	0.24	0.76	0.83	0.60	0.62	0.75	1.84	0.53	(139)
1981	RHSW	0.04	1.54	2.01	2.40	1.62	1.69	1.90	3.81	1.60	(389)
	SSW	0.04	1.29	1.36	1.63	1.18	1.01	1.44	3.24	1.16	(284)
	PATCH	-	0.24	0.65	0.78	0.44	0.68	0.45	0.56	0.43	(105)
1985	RHSW	0.07	1.00	1.08	1.64	2.12	1.79	5.31	13.08	2.44	(585)
	SSW	0.07	0.64	1.05	1.01	1.20	1.00	1.50	2.26	0.93	(222)
	PATCH	-	0.34	0.83	0.64	0.93	0.79	3.81	10.82	1.51	(363)

The age groups of 'new' MHSW clients are given in Table 23. Increases in 'new' referral rates in the over 65 age groups were confined to the Patch teams. There were also rises in the age groups 15-24 and 15-34 in the patch teams, which presumably reflected increased numbers of clients in the 'addictions' clinical group.

The extent to which the recent influx of clients in the oldest age range will add to the already substantial 'chronic' population of MHSW service users, is a matter for speculation. As there is little prospect of 'cure' for those elderly clients suffering from dementia, it is likely that the pressure on local authority staff to remain in contact will depend upon the life expectancy of this group of clients, and the extent to which other services, both health and voluntary, are able to undertake the care and support of elderly clients and their relatives or supporters.

5.5 OVERLAP WITH OTHER TYPES OF PSYCHIATRIC CARE

Earlier data showed that year prevalence rates of MHSW care had increased over time. Table 24 shows that the proportions of all psychiatric patients who had MHSW care during each specified year also rose - from 23% in 1976 to 28% in 1985. Proportions within each clinical category varied, but a consistent change was the increasing proportion of patients in the 'senile dementia' category. The proportions in the 'anxiety states' category showed no clear trend, but it is possible that the recent fall may be due to the increasing involvement of CPNs with clients in this clinical group.

TABLE 24

Year Prevalence, Proportion of MHSW to Total Psychiatric Services By Clinical Category

Percentages

Clinical Category	1976	1979	1982	1985
Schizophrenia	20	31	27	30
Depression	20	30	27	24
Anxiety States	16	28	23	17
Personality disorder	33	37	31	31
Addictions	24	35	36	31
Senile Dementia	29	30	27	52
TOTAL	23	31	27	28
(N all services)	(3707)	(4129)	(4522)	(5430)
(N MHSW service)	(847)	(1262)	(1208)	(1504)

Table 25, below, shows the numbers and proportions of MHSW clients who were in receipt of MHSW care only on a succession of point prevalence days (i.e. in receipt of no other psychiatric care according to Register definitions).

TABLE 25

MHSW Care ONLY as a Proportion of Total MHSW Care

Numbers and Percentages

Point prevalence	Only MHSW N	Re*	Proportion of total MHSW
31.12.75	105	0.40	60
31.12.76	116	0.45	57
31.12.77	170	0.67	57
31.12.78	319	1.27	62
31.12.79	288	1.16	60
31.12.80	179	0.73	58
31.12.81	197	0.82	58
31.12.82	258	1.05	57
31.12.83	253	1.04	58
31.12.84	304	1.27	62

* Rate per 1,000 total population.

It can be seen that proportions of MHSW only to total MHSW stayed very stable throughout the period.

Table 26 shows the differences between Patch and Specialist social work teams in the proportions of clients who were not in contact with psychiatrists on successive point prevalence days.

TABLE 26

RHSW clients with no current contact with psychiatrists on point-prevalence days

numbers & percentages

Point Prevalence	Patch Team		Specialist Team	
	N	%	N	%
31.12.75	1	1	104	99
31.12.76	28	24	88	76
31.12.77	48	29	121	71
31.12.78	73	23	246	77
31.12.79	63	22	225	78
31.12.80	57	32	122	68
31.12.81	49	25	148	75
31.12.82	67	26	191	74
31.12.83	85	34	168	66
31.12.84	108	35	196	64

* Percentages of all RHSW clients on point prevalence days.

As the Specialist SWs were well established in the psychiatric team, they had ready access to the expertise of other mental health professionals, and the high proportion of Specialist SW only cases was not thought to imply that inappropriate support was being given to these clients. Until the end of 1983, numbers of Patch team workers' clients not in current contact with psychiatrists were low. The increase which occurred, was probably due to increases in referrals of elderly clients from the specialist psychogeriatric team.

There will be a tendency for the most frequent attenders of psychiatric services to appear in a point prevalence count, and the extent to which clients received only RHSW care over longer periods is of interest. Table 27 shows numbers and proportions

of clients who were in receipt of MHSW only care on point prevalence days, who did not receive any other type of psychiatric care during the following twelve months.

TABLE 27

MHSW only clients on point prevalence days who received no other psychiatric care during the following 12 months. Numbers and percentages

Point Prevalence	MHSW N	MHSW %*	SSW N	SSW %**	Patch SW N	Patch SW %***
31.12.75	65	62	65	62	-	-
31.12.76	59	51	50	57	9	8
31.12.77	87	51	87	72	-	-
31.12.78	151	47	133	50	18	6
31.12.79	144	50	138	61	6	2
31.12.80	62	35	62	51	-	-
31.12.81	69	35	69	47	-	-
31.12.82	136	53	103	54	33	49
31.12.83	139	55	96	57	43	50
31.12.84	162	53	122	62	40	37

* Percentage of MHSW only on point prevalence..
** Percentage of SSW only on point prevalence.
*** Percentage of Patch SW only on point prevalence.

It should be noted that not all these clients will have received MHSW care for the whole 12 month period. The figures will include clients treated for shorter periods who were discharged from all psychiatric care.

After 1982, the numbers of Patch team clients who received only social work care rose. The psychogeriatrician referred cases to Patch teams because he felt the kind of care available was appropriate to his clients' needs. The support from general

psychiatrists available to Specialist SWs was not so readily available to Patch social workers and it is not known how far the lack of contact between Patch team clients and staff working in the general psychiatric services was, or was not, appropriate to the clients' needs.

5.6 MENTAL HEALTH SOCIAL WORK SERVICES. CASE REGISTER DATA

SUMMARY AND DISCUSSION

Mental Health Social Work services in Salford were provided by two main agencies. Patch Team social workers carried generic caseloads, classified some clients as being referred for 'mental health' reasons, and the Case Register recorded these cases. It also included Patch SW care given to clients referred by the Psychogeriatric Team whatever their classification. Hospital based, consultant-attached social workers provided Specialist Mental Health Social Work care and worked as part of a multi-disciplinary psychiatric team and all their cases were recorded on the Register.

Service Growth

Over the period 1976 to 1985, total MHSW year prevalence rates rose from 3.23 to 6.27 per 1,000 total population. Point prevalence rates rose over 3 times from 0.67 per 1,000 total population at 31.12.75 to 2.03 per 1,000 at 31.12.84. These rises, however, occurred mainly between 1976 and 1979 in both patch and specialist teams, and (apart from in 1981 when industrial action took place) rates remained relatively stable thereafter.

Age specific rates rose in all age groups with the exception of 15-24 where year prevalence rates fell by 11%. Apart from the youngest age group where raw numbers were very small and where small fluctuations produced large percentage changes which were

probably spurious, the greatest percentage increases were in the three oldest groups of 55-64, 65-74 and 75 & over, where rates increased by 147%, 138% and 441% respectively.

Between 1976 and 1985, Specialist SW year prevalence rates grew by 29%, and those relating to the Patch social work teams rose 3 times over the same period. Patch teams were thus mainly responsible for the overall increase in mental health social work care. Although there had been some increase in Patch team year prevalence rates between 1976 and 1983, in the two years 1984 and 1985, rates more than doubled.

Clients aged over 55 were mainly responsible for this increase, and between 1976 and 1985 age specific rates more than doubled in the 55-64 age group, rose almost 6 times in the 65-74 group and in the 75 and over age group rose 15 times. There is little doubt that these rises represented real rises in workload rather than solely reflected changes in Register recording methods.

Analyses of clinical categories showed that whilst the increasing total MHSW involvement with elderly clients occurred in all clinical groups, the proportion of clients aged over 64 in the 'senile and pre-senile dementia' category rose from 33% in 1976 to 41% in 1985. The only other clinical category which showed increases in both rates and proportions in year and point prevalence counts for MHSW care was 'addictions'. Year prevalence rates in this category rose more than 3 times between 1976 and 1985 but the rise was from a low baseline and the proportion of clients in this clinical group remained small at 6%

of total year prevalence in 1985.

It should be noted that the data presented here did not include the social work input to the specialist drug addiction and community alcohol teams. How far the clients of these specialist teams were the same as those seen by the other MHSWs is not known. However, the community alcohol team's original brief was to work with other staff in order to enhance their (the other workers') skills with this client group, so it is likely that at least a proportion of clients with alcohol problems who were seen by members of the community alcohol team did in fact appear in the prevalence figures presented here.

Changes in the Clinical Categories and Age Distributions of Mental Health Social Work Clients

Throughout the period, at a mean of 32%, 'depression' remained the largest single clinical category in each year prevalence. The proportion of clients in the next highest category, 'schizophrenia', fell slightly from 20% in 1976 to 17% in 1985. The most dramatic proportionate change occurred in the 'senile and pre-senile psychoses' group, which rose from 4% to 16% of the total MHSW year prevalence between 1976 and 1985. The 'other' clinical category, which consists of a large number of different conditions, consistently accounted for around 12% of each year prevalence.

The differences between Patch and Specialist SWs in the distribution of clinical categories in year prevalences became

statistically significant after 1982. Specialist SWs were more likely to have clients in the 'schizophrenia' 'addictions' and 'other' categories; Patch SWs were more likely to have clients in the 'senile and pre-senile psychoses' clinical group, largely as a result of the referral practices of the psychogeriatric team.

The massive expansion of clients in the oldest age group (75 & over) caused a shift in the overall distribution of MHSW clients each year. In 1976 clients aged 75 or over formed 6% of the total number of clients seen - i.e. the smallest proportion; by 1985 that proportion was 23% - i.e. the largest proportion.

First Referrals for Mental Health Social Work Care

The numbers and proportions of inceptors whose first ever contact with psychiatric services was a social worker, were very low, (a mean of 4% of each year prevalence). However, first referrals for MHSW care rose from 1.96 to 2.44 per 1,000 between 1976 and 1985.

Until 1984, first referral rates fell slowly in both the Specialist and Patch teams. After 1984, first referral rates rose in the Patch teams for all age groups except 35-44, but the greatest increases were in the oldest age groups. Rates in the 75 and over group rose from 1.86 per 1,000 total population in 1976 to 10.82 per 1,000 total population in 1985. Increasing proportions of first Patch team referrals were in the 'senile dementia', 'addictions' and 'other' clinical categories.

The patch teams were undoubtedly bearing the brunt of increasing referral rates for elderly clients. One implication for the future, if even a small proportion of these clients need long-term support, is that resource increases will be required if other client groups are not to be neglected.

First referral rates per 1,000 total population in the Specialist team dropped from 1.31 in 1984 to 0.93 in 1985, and indicated that the Specialist team was becoming increasingly involved with existing and re-referred clients. The inauguration of the specialist psychogeriatric team may have decreased the SSW team's involvement with elderly clients, as the elderly component of the 6 general psychiatric social workers' caseloads was replaced by the full-time input of one worker. Since the study took place, another full time social worker has joined the psychogeriatric team.

The differences found between these two different kinds of social work services underline the importance of considering both, when questions of social work support for clients with mental health problems are being considered. Not only did the two services tend to deal with different types of clients, but the relative contribution of each to total MHSW care changed over time.

Discussion

The data show that clients with mental health problems were increasingly being cared for by non-specialist mental health

workers - which could be said to be the model of care propounded by national 'community care' policies. Indeed, if the results of earlier research in Salford remain applicable (Wooff 1978), the proportion of Patch Team clients with mental health problems is likely to be higher than those recorded on the case register.

It must be emphasised, however, that the expansion of Patch Team social work care occurred mainly amongst clients aged over 55, and therefore did not greatly affect the kinds of care being given to younger clients. Data presented in Chapter 2 showed that a minimum of 27% of clients aged between 15 and 65, seen in any one year by the psychiatric services, were chronic/heavy service users and could be said to require long-term support. There was no evidence to suggest that Patch Teams significantly increased their input to this particular group of clients, although this remains a possibility if criteria for classification of case types had changed after 1974 (Wooff op. cit.), and increasing numbers of long-term clients having psychiatric care were being classified under non-mental health categories.

The question then emerges as to whether or not the expansion of Patch Team services for the elderly mentally ill actually prevented any expansion of such care for younger clients with mental health problems, due to the former absorbing all resource increases, or whether services for younger mentally ill clients would have remained static anyway. Certainly, without corresponding increases in resources, local authorities cannot expand their services, and pressures to increase resources can

only ultimately come from voters. Hence the ability to attract resources for the mentally ill is highlighted as being crucial to the development of community care policies. The expansion of care for clients in the 'addictions' category very probably demonstrates this process, as the general public have become more and more aware of the possibility that their children may be involved in some form of drug abuse. Clients in the 'schizophrenia' category have not apparently been so successful in awakening public concern.

The creation of specialist teams has been one of the chief ways in which extra resources for groups of people who do not easily attract resources have been obtained. Resources include special skills and consistent as well as financial inputs, and how far the pressure to create specialist teams is the result of the failure of general service managers to ensure that 'difficult' or 'unpopular' client groups get their fair shares of resources, is open to debate. The Specialist social work team in Salford maintained its involvement with clients treated by general psychiatrists, many of whom fall into these groups. The data presented here suggest that if such a specialist team had not existed, then social work services for 'difficult' or 'unpopular' clients may well have diminished.

CHAPTER 4

4.0 COMMUNITY PSYCHIATRIC NURSING AND SPECIALIST MENTAL HEALTH SOCIAL WORK CARE - A COMPARISON OF CASE REGISTER DATA

There are difficulties involved in making direct comparisons between CPN and total MHSW service statistics because the distinction between specialist and non-specialist status of the two professional groups is not clear cut. Specialist social workers come from a profession whose training and perspective is not exclusively mental health related, but in Salford at least, form part of a team of other professionals concerned to provide mental health/psychiatric care. Their colleagues based in Patch teams deal with all kinds of social problems, some of which are classified as 'mental health' problems.

The position in nursing is somewhat different. Although nurse training is not exclusivly mental-health based, psychiatric nursing, the branch of the profession to which CPNs belong is, and CPNs could therefore be said to belong to a profession whose training and perspectives are concerned solely with mental health. Other nurses working in the community e.g. district nurses and health visitors may also care for people who have mental health problems, though the extent of their involvement in mental health care is not routinely monitored by the Case Register in the same way as is Patch social workers' involvement with clients who are classified as having 'mental health' problems.

Although the contribution of Patch social workers to mental

health care is by no means insignificant, the nurse/social worker data presented in this section will mainly focus on a comparison between data obtained from CPNs and Specialist social workers involved in general psychiatric care, as both these groups of workers work exclusively with people who have mental health problems.

It should be emphasised that the data presented here relate to CPNs and Specialist SWs who worked in general psychiatry and/or as part of the psychogeriatric team. The ways in which other specialist teams such as drug addiction and alcohol addiction work, are managed and organised, preclude the collection of data which record the work of individual professionals within them.

6.1 YEAR PREVALENCE 1976-85

As seen earlier, overall year prevalence rates grew in both services. In 1976 CPN and Specialist SW year prevalence rates at 1.18 and 1.07 per 1,000 total population respectively, were much the same. However, whilst Specialist SW year prevalence rates almost doubled between 1976 and 1985, CPN year prevalence rates increased sevenfold over the same period

Details of staffing levels in the two groups of workers may be found in Chapters 4 and 5. In summary, however, after 1978 the numbers of CPNs working in general psychiatry exceeded those of Specialist SWs for the first time, and by 1985 the number of CPNs (17) was more than double that of Specialist SWs (7).

Differences in individual workers' caseload sizes could also have influenced the comparative rates, and, notwithstanding difficulties of establishing precise denominators each year (the effects of sickness, maternity leave and training secondment are difficult to quantify), an estimate of the mean number of people seen each year by each worker, based on staff in post on 1st July each year, varied very little each year. It was very much the same for both groups of workers - a mean of 113 people seen each year by each CPN and a mean of 118 people seen each year by each Specialist SW. Differences in staffing levels did, therefore, appear to account for the differences found in overall year prevalences.

6.1.1 Year Prevalence by Clinical Category

Table 28 shows that in 1985 the proportions in each clinical category for both groups of workers differed except in the case of 'depression' and 'other'. CPNs had higher proportions than SSWs of cases in the 'senile dementia' and 'neuroses' categories; SSWs had higher proportions than CPNs of cases in the 'schizophrenia', 'personality disorder' and 'addictions' clinical groups.

There were few changes over time in the distribution of clinical categories in the SSWs' year prevalence figures, whereas the move to primary care bases in 1979 coincided with a dramatic fall in the proportion of 'schizophrenia' cases which appeared in the CPNs' year prevalence counts.

TABLE 28

Year prevalence by Clinical Category CPN & SSH

1976 - 1985

Percentages

CLINICAL CATEGORY		1976	1978	1980	1983	1985
Schizophrenia	SSH	20	20	20	20	24
	CPN	40	35	28	19	19
Depression	SSH	34	32	35	32	33
	CPN	24	32	33	36	34
Senile dementia	SSH	6	7	5	10	5
	CPN	4	5	6	5	10
Neuroses	SSH	9	13	11	8	8
	CPN	10	10	12	14	13
Personality	SSH	14	11	11	10	10
disorder	CPN	6	6	7	7	6
Addictions	SSH	4	5	5	8	8
	CPN	3	3	3	4	3
Other	SSH	12	9	12	12	14
	CPN	12	10	11	15	15
TOTAL	SSH	100	100	100	100	100
	CPN	100	100	100	100	100
(N)	SSH	(646)	(604)	(849)	(879)	(766)
	CPN	(588)	(933)	(1624)	(1984)	(2135)

6.1.2 Year Prevalence by Age Group

Table 29 shows that the SSWs saw higher proportions of clients in all age groups under 65 during 1985 than the CPNs, and that CPNs saw higher proportions of clients aged 65 and over. This difference had been maintained since 1976, but after the introduction of the specialist psychogeriatric team the differences in proportions of clients aged 75 and over widened. However, it should be remembered that Patch social work involvement with clients referred by the psychogeriatric team increased dramatically.

TABLE 29
Year Prevalence by Age CPN & SSW
1976 - 1985
Percentages

AGE GROUP		1976	1978	1980	1983	1985
0-14	SSW	-	-	-	-	-
	CPN	-	-	-	-	-
15-24	SSW	16	15	13	11	9
	CPN	8	6	8	9	7
25-34	SSW	20	21	21	18	19
	CPN	17	17	16	15	12
35-44	SSW	17	16	17	16	19
	CPN	19	17	16	16	16
45-54	SSW	17	16	15	15	15
	CPN	19	20	18	15	14
55-64	SSW	11	13	14	13	17
	CPN	15	15	15	15	13
65-74	SSW	12	12	11	14	11
	CPN	16	15	16	15	15
75 +	SSW	6	7	8	12	10
	CPN	5	10	10	13	23
TOTAL	SSW	100	100	100	100	100
	CPN	100	100	100	100	100
(N)	SSW	(446)	(604)	(849)	(879)	(766)
	CPN	(308)	(933)	(1625)	(1904)	(2135)

Given that the differences in the distribution of clinical categories were not prima facie explained in terms of differences in the age structures of client populations, a breakdown of the clinical categories for separate age groups in 1985 is given in Table 30.

TABLE 30

CPN & SSH Year Prevalence 1985

Age by Clinical Category

Percentages

CLINICAL CATEGORY		0-34	35-44	45-54	55-64	65-74	75+
Schizophrenia	SSH	20	33	29	27	15	11
	CPN	17	24	28	29	18	6
Depression	SSH	20	28	30	43	57	37
	CPN	28	31	38	38	40	31
Senile	SSH	-	-	1	2	4	27
Dementia	CPN	-	-	-	2	10	35
Neurosis	SSH	8	9	9	9	5	2
	CPN	20	19	16	14	10	3
Personality	SSH	19	11	5	4	6	-
Disorder	CPN	14	10	4	4	5	2
Addictions	SSH	14	8	12	3	1	-
	CPN	6	6	4	2	2	1
Other	SSH	19	10	13	12	12	23
	CPN	15	9	10	11	15	22
TOTAL	SSH	100	100	100	100	100	100
	CPN	100	100	100	100	100	100
(N)	SSH	(219)	(146)	(118)	(128)	(82)	(73)
	CPN	(402)	(339)	(364)	(286)	(326)	(484)

As Table 30 shows, SSWs' clients aged under 55 had higher proportions than CPNs' in the 'schizophrenia' and 'other' clinical groups, whereas CPNs had higher proportions of 'depressions' and 'anxiety states' in all clients aged under 65. In the oldest age groups, the position was reversed in respect of 'schizophrenia' (CPNs more than SSWs) and 'depressions' (SSWs more than CPNs) but CPNs continued to have higher proportions of clients in the 'anxiety states' category.

6.2 POINT PREVALENCE BY CLINICAL CATEGORY AND AGE

TABLE 31
Point Prevalence CPN & SSW
By Clinical Categories
31.12.79 - 31.12.84
Percentages

CLINICAL CATEGORY		31.12. 79	31.12. 79	31.12. 82	31.12. 84
Schizophrenia	SSW	27	21	26	28
	CPN	50	33	29	25
Depression	SSW	29	32	31	29
	CPN	25	31	32	31
Senile Dementia	SSW	5	4	5	3
	CPN	3	6	4	7
Neuroses	SSW	8	14	10	5
	CPN	1	11	11	12
Personality disorder	SSW	13	12	10	10
	CPN	2	6	7	6
Addictions	SSW	-	2	4	4
	CPN	4	5	7	9
Other	SSW	13	11	11	14
	CPN	10	10	13	14
TOTAL	SSW	100	100	100	100
	CPN	100	100	100	100
(N)	SSW	(1631)	(357)	(356)	(347)
	CPN	(89)	(767)	(1011)	(1316)

The differences between the two groups of workers' distributions of clinical categories on point prevalence counts, given in Table 31 above, follow the same pattern as the distributions in the year prevalence counts. Both groups of workers had higher proportions of clients in the 'schizophrenia' and 'other' categories on their point-prevalence counts than appeared in the year prevalence counts, which reflected the likelihood that clients in long-term continuous care would appear on a point-prevalence rather than a year prevalence count.

The age distributions of CPN and SSW cases were similar to those found in year prevalence counts.

6.3 LENGTH OF CONTINUOUS CARE

The proportions of clients in continuous CPN and SSW care for various lengths of time on point prevalence days are shown in Table 32 below. The trends over time can be seen to have been for the CPN service to acquire not only increasing numbers of clients in long-term continuous care, but increasing proportions of them; whilst the SSW service appeared to deal increasingly with cases over a 2-12 month period. The high proportion of clients in SSW care for 1 year and over at 31.12.79 was the result of a cohort of referrals which occurred during 1978.

TABLE 32

Length of Continuous Care on

Point Prevalence days 31.12.75-31.12.84

CPN & SSW

Percentages

Length of Care		31.12. 75	31.12. 77	31.12. 79	31.12 81	31.12 84
< 1 month	CPN	15	8	6	3	6
	SSW	21	6	10	10	9
1<2 months	CPN	11	5	8	2	9
	SSW	9	7	9	11	11
2<12 Months	CPN	33	52	47	30	27
	SSW	39	53	33	50	43
1 Year +	CPN	42	34	38	64	57
	SSW	40	34	48	28	37
Total	CPN	100	100	100	100	100
(N)		(89)	(201)	(767)	(923)	(1316)
	SSW	100	100	100	100	100
		(163)	(211)	(357)	(270)	(347)

In order to understand further the dynamics of care, point prevalence data have been supplemented by referral data. Table 33 below shows lengths of continuous care after referral, and contrasts the two groups of workers.

TABLE 33
Referrals By Length of Continuous Care
CPN & SSW
Percentages

Year of Referral		<1 month	1<3 month	3<12 months	Over 1 year	Total	(N)	Mean Yrs per Worker
1976	CPN	30	10	41	21	100	(2231)	16
	SSW	59	20	13	8	100	(544)	14
1977	CPN	22	15	35	28	100	(2751)	26
	SSW	48	14	16	22	100	(558)	69
1978	CPN	18	7	31	43	100	(8321	44
	SSW	16	17	35	32	100	(644)	35
1979	CPN	17	10	33	40	100	(10251	34
	SSW	28	26	38	7	100	(698)	8
1980	CPN	37	9	22	32	100	(1043)	25
	SSW	31	31	32	6	100	(494)	9
1981	CPN	42	7	21	30	100	(914)	21
	SSW	31	23	28	18	100	(640)	59
1982	CPN	29	9	33	29	100	(906)	21
	SSW	36	22	29	12	100	(748)	15
1983	CPN	13	16	37	33	100	(1188)	19
	SSW	33	21	36	9	100	(767)	11
1984	CPN	10	19	43	28	100	(1088)	18
	SSW	35	21	32	11	100	(716)	13

Over time, Specialist social workers increasingly tended to shift from very short term care (under 1 month) to care lasting between 3 and 12 months. Proportions in continuous care for between 1 and 3 months remained relatively stable; proportions in continuous care for 1 year and over fluctuated considerably. The CPNs tended to change from very short term care, to care lasting between 1 and 3 months, with proportions of clients in continuous care for between 3 and 12 months, and over 1 year, remaining relatively stable.

Over the whole period the proportion of clients referred for SSW

care who received continuous SSW care for 1 year and over was very much lower than equivalent proportions of CPN clients.

4.3.1 Short-term continuous care

The mean lengths of continuous care for those clients who were discharged within 1 year of referral are shown in Table 34. In 1976 and 1977 (before the CPNs moved into primary care bases), the mean lengths of clients' continuous stays were over twice as high as those of the Specialist SWs. Between 1980 and 1982, the mean lengths of continuous short-term SSW care fell, and rose thereafter to their former level. Apart from inconsistencies in early years, the mean length of continuous short-term care given by SSWs remained constant, at a level above that of CPNs between 1980 and 1982, but below that of CPNs after 1983.

TABLE 34

Referrals with continuous care for less than 1 year
CPN and SSW, 1976-1984
Mean numbers of days

YEAR	CPN	SSW
1976	107	38
1977	114	52
1978	124	112
1979	120	99
1980	67	85
1981	72	85
1982	75	88
1983	124	85
1984	131	80

Long-term continuous care

TABLE 33
Clients in Continuous Care for Over 1 Year
On Point Prevalence Days 31.12.75 - 31.12.84
By Clinical Category, CPN & GSN
Percentages

CLINICAL CATEGORY		31.12. 75	31.12. 77	31.12. 79	31.12. 81	31.12. 83	31.12. 84
Schizophrenia	CPN	70	71	54	40	37	36
	SSN	45	37	23	30	31	32
Depressions	CPN	13	12	23	27	27	27
	SSN	10	22	35	33	28	26
Anxiety States	CPN	-	3	5	10	9	10
	SSN	6	7	12	10	7	10
Neurotics	CPN	-	-	4	3	4	5
	SSN	6	7	5	4	2	2
Personality Disorder/Other	CPN	25	27	25	23	32	33
	SSN	8	14	14	19	22	22
TOTAL (N)	CPN	100 (37)	100 (69)	100 (290)	100 (570)	100 (653)	100 (751)
TOTAL (N)	SSN	100 (66)	100 (73)	100 (171)	100 (76)	100 (129)	100 (129)
No. of 1 yr + per worker	CPN	12	23	24	44	36	44
	SSN	22	18	34	15	21	18

The numbers of CPN clients per individual worker in continuous CPN care for over 1 year on point prevalence days, grew from a mean of 12 at 31.12.75 to a mean of 44 at 31.12.84. In contrast, the Specialist GNs' mean number of clients in continuous care for over 1 year per worker remained relatively stable at around 20, apart from higher numbers found at the end of 1978 and 1979.

Table 35 above shows the distribution of clinical categories of clients in continuous CPN and SSW care for at least 1 year on point prevalence days. The dramatic fall in the proportion of CPN clients in the 'schizophrenia' category after 1979 resulted in the distributions of clinical categories of long-term clients on point prevalence counts of both groups of workers becoming very similar.

Clients who have been in long-term care for many years will tend to be included in the point prevalence figures. Table 36 shows the clinical categories of clients referred more recently - during 1984 - who became long-term continuous service users.

TABLE 36

Referrals with length of continuous care 1 year and over 1984 by clinical category, CPN and Specialist social work

Percentages

Clinical category	CPN	SSW
Schizophrenia	24	27
Depression	34	29
Dementia	5	2
Neuroses	12	2
Personality disorder	4	14
Addictions	4	9
Other	16	16
Total	100	100
(N)	(306)	(79)

Apart from the CPNs' tendency to give more long-term continuous care to clients in the neuroses category than the SSWs, and the

SSWs' tendency to give more long-term continuous care to clients in the 'personality disorder' category than CPNs, the proportions within each clinical category in both groups were much the same in 1984.

6.4 FIRST SERVICE CONTACTS

Specialist SWs, as part of the hospital psychiatric team, were rarely the first professionals giving psychiatric care to be consulted when clients made their first known contact with psychiatric services. When CPNs were hospital-based and consultant-attached (before 1979), they were also unlikely to be the first professionals to be consulted by people making their first-ever contact with psychiatric services. However, after their move to primary care settings, numbers and proportions of inceptions whose first contacts were CPNs, rose dramatically.

The extent to which CPNs contributed to the overall increase in inceptions to the services as a whole, was discussed in detail in Chapter 4. It was considered likely that CPNs may have been responsible for the increasing referrals to psychiatrists.

As a consequence of the way in which social work services were organised, inceptors would have been expected to make their first contacts with Patch team rather than Specialist team social workers. Surprisingly, case register data did not support this expectation. This may have been due to Patch SWs not classifying some clients who later went on to see psychiatrists, as being

'mental health' cases (thus excluding them from the Case Register data collection system). That a proportion of Patch team clients who had not been classified as 'mental health' cases did indeed go on to have some contacts with psychiatrists was shown by Wooff (1978).

TABLE 37
First Register CPN & SSW Referrals by Clinical Category
Percentages and Rates per 1,000 Total Population

Clinical Category		1974	1981	1984
Schizophrenia	CPN	28	11	5
	SSW	13	8	11
Depressions	CPN	27	34	38
	SSW	34	30	37
Senile Dementias	CPN	4	4	4
	SSW	4	13	10
Neuroses	CPN	14	16	19
	SSW	8	13	7
Personality disorders	CPN	8	10	7
	SSW	10	11	7
Addictions	CPN	4	5	3
	SSW	15	8	10
Other	CPN	14	16	22
	SSW	13	17	18
TOTAL	CPN	100	100	100
(N)		(199)	(454)	(708)
TOTAL	SSW	100	100	100
(N)		(382)	(285)	(317)
Rate	CPN	0.76	1.84	2.92
	SSW	1.4[illegible]	1.17	1.31
Percentage of	CPN	65	29	31
year prevalence	SSW	59	42	38

Table 37 above, shows how rates of first referrals to CPN and SSW care rose over the period. The CPNs' increasing involvement with clients in the 'depressions', 'neuroses' and 'other' categories can be clearly seen. The SSWs had increasing proportions of 'new' referrals in the 'addictions' and 'senile dementia' categories. By 1984, the SSWs had higher proportions of 'new' clients in the 'schizophrenia', 'addictions' and 'senile dementia' categories than the CPNs; the CPNs had higher proportions of 'new' clients in the 'neuroses' and 'other' categories than the Specialist SWs.

The proportion of 'new' referrals in relation to year prevalence can be seen to be higher in the Specialist SW service - implying that the CPNs had higher proportions of either chronic or intermittent clients on their caseloads than the Specialist social workers. In view of the nurses' role in maintaining treatment for schizophrenia, this tendency to accumulate 'old' clients is not surprising. However, as has been seen previously, the 'old' clients were by no means all in the 'schizophrenia' clinical group.

Apart from large increases in the 75 and over age range, proportions of 'new' CPN and SSW clients in various age groups changed little over time, and were similar in both services. There was a tendency for SSWs to see slightly higher proportions than CPNs of 'new' clients aged between 15 and 24 (18% and 13% respectively in 1984) and for CPNs to see slightly higher proportions than SSWs of 'new' clients in the 25-34 age range (19% and 16% respectively in 1984).

4.3 OVERLAP WITH OTHER TYPES OF PSYCHIATRIC CARE

The proportions of people using any psychiatric service who received CPN and Specialist SW care are shown in Table 38 below. The change, from minimal CPN involvement with clients in clinical categories other than 'schizophrenia' in 1976, to considerable involvement with clients in all clinical categories in 1985 was striking. In contrast, the Specialist social work service proportionately increased its involvement with clients in the 'schizophrenia' clinical group and reduced its involvement with clients in the 'neuroses' category.

TABLE 38
Year prevalence, proportion of CPN & SSW to total psychiatric services by clinical category
Percentages and rates per 1,000 total population

Clinical Category		1976	1979	1982	1985
Schizophrenia	CPN	16	32	46	47
	SSW	16	21	28	22
Depressions	CPN	6	29	40	41
	SSW	10	21	19	14
Senile Dementia	CPN	6	37	29	44
	SSW	20	21	17	8
Anxiety States	CPN	6	31	36	41
	SSW	12	17	13	8
Personality disorder	CPN	8	23	36	31
	SSW	12	17	13	31
Addictions	CPN	7	25	26	29
	SSW	20	23	29	20
Other	CPN	8	29	30	30
	SSW	17	17	18	31
TOTAL	CPN	8	36	37	39
	SSW	17	20	19	14
(N all services)		(17671	((1291	((5220	(15431
Rate		16.2	16.4	18.8	22.6
(N CPN services)		(3888	((4891	((6492	(7138
(N SSW services)		(4464	(4923	(4897	(7668
Rate	CPN	1.1	5.9	6.6	6.9
	SSW	2.9	3.3	3.9	3.2

As a proportion of all psychiatric services, the SSW service involvement overall stayed relatively steady, but, in spite of considerable staff increases, the proportion of all psychiatric service clients seen by CPNs each year remained much the same after 1979. Register data show that year prevalence rates of contacts with psychiatrists increased from 14.04 to 16.75 per 1,000 total population between 1976 and 1985: CPN year prevalence rates increased 7.54 times (from 1.18 to 8.90) over the same period. Therefore, the contribution made to total psychiatric service year prevalence rates by clients seen by CPNs only, must have increased considerably, and accounted for the fact that their contribution to the total psychiatric service remained steady in spite of large staff increases.

Until 31.12.1978 there were less than 20 clients who were in receipt of CPN and MHSW care on point prevalence days (data for Specialist SW alone, are unavailable). Table 39 gives the numbers on each successive point prevalence count, together with proportions who were aged under 65 and in the 'schizophrenia' clinical category, and those aged 65 and over.

TABLE 39

Clients on CPN and MHSW point prevalence counts

1978-1985

Numbers and percentages

Point Prevalence	N	Aged 65 & over %	Aged < 65 Schizophrenia %
31.12.78	93	27	37
31.12.79	86	19	37
31.12.80	50	14	53
31.12.81	74	19	53
31.12.82	82	35	47
31.12.83	100	35	48
31.12.84	121	32	45
31.12.85	120	45	48

At the end of 1984, 25% of MHSW and 9% of CPN clients were in receipt of both MHSW and CPN care. As Table 39 shows, the majority of clients common to both services were either elderly, or in the 'schizophrenia' clinical group.

Table 40 below, compares the proportions of clients who had only CPN or SSW care on point prevalence days, and who had no further contact with any other services during the following 365 days.

TABLE 40

Clients with CPN & SSW only on point prevalence days
who received no other psychiatric care
during the following 365 days
Numbers and percentages of CPN & SSW only

Point prevalence	CPN		SSW	
	N	%	N	%
31.12.76	46	47	50	57
31.12.78	168	50	133	50
31.12.80	258	44	62	51
31.12.82	450	62	103	54
31.12.84	624	59	122	62

It can be seen that the proportions of CPNs' and SSWs' clients who received no other care during the year following each point prevalence count were much the same and changed little over time. However, although numbers were similar in both groups until 1978, the growth in numbers of CPN clients seen by nurses only was such that by the end of 1984 the numbers of such CPN clients were over 5 times higher than the numbers of SSWs' clients. The beginning of growth in these numbers coincided with the CPNs' move to primary care bases.

The clinical categories of the cohorts of only CPN care and only SSW care at 31.12.84 who received no other psychiatric care during the following 365 days, are shown below in Table 41.

TABLE 41

Clients in CPN only and SSW only care at 31.12.84
who received no other psychiatric care
during the following 365 days.
Clinical Categories
Percentages

Clinical Categories	CPN	SSW
Schizophrenia	14	11
Depression	35	28
Senile dementia	6	3
Anxiety states	16	7
Personality disorder	8	16
Addiction	4	21
Other	15	14
Total	100	100
(N)	(624)	(122)

The differences in the kinds of clients seen by only CPNs and only SSWs in the specified period are clear. CPNs supported clients with 'anxiety states ; Specialist SWs supported clients in the 'personality disorder' and 'addiction' categories. Whilst the proportions of clients in the 'schizophrenia' category are not high in either group, the number (90) of CPNs' clients in this group who had no contact with a psychiatrist is considerable. Whether this represented a group of clients who did not attend for out-patient consultations, were prescribed medication by their GPs, or who were just not given an out-patient appointment, is not known.

6.A COMMUNITY PSYCHIATRIC NURSING AND SPECIALIST SOCIAL WORK SERVICES. CASE REGISTER DATA. SUMMARY AND DISCUSSION

The difference between the CPN and SSW services' total year prevalence rates, were seen to be solely the product of differences in staffing levels, as the mean number of clients seen each year by individual workers was the same in both groups. There were however, substantial differences in the lengths of continuous care given by CPNs and Specialist social workers. There were also differences in the age and clinical categories of their clients.

The SSWs were attached to general psychiatric teams, and the extent of their contacts for periods between 3 and 12 months, with clients aged under 55, and in the 'schizophrenia', 'addictions', 'personality disorder' and 'other' clinical categories, points to a considerable involvement in the acute psychiatric service. The fact that the numbers of long-term clients per social worker stayed relatively stable over the period showed that they did not continue to accumulate long-term clients over many years.

In contrast, the CPNs' work appeared to fall into two main areas. There was substantial evidence to support the proposition that the move to primary care bases and the acceptance of referrals direct from GPs caused a change in the diagnostic composition of their clients. Before 1979, their main involvement was with clients in the 'schizophrenia' clinical category. After 1979, the distribution of their clients' clinical categories became

similar to that of the psychiatric services as a whole, as GPs referred increasing numbers of non-psychotic patients to them, and the numbers of psychotic clients referred to them by psychiatrists fell.

The CPNs could thus reasonably be thought to have become involved with the range of work generally undertaken by GPs in the care of their non-psychotic clients, whilst continuing their original involvement in the long-term care of clients in the 'schizophrenia' clinical group.

It has been shown that a substantial, but decreasing, proportion of clients in CPN care for over 1 year fall into the 'schizophrenia' clinical group. Even though proportions declined over time, it should be borne in mind that prevalence rates rose. As CPNs were expected to provide long-term support, and particularly to maintain clients on their long-term phenothiazine injections, a build-up of very long term cases was inevitable. At the same time, CPNs continued to 'expand' by accepting new clients referred direct from GPs, many of whom were shown to have become long-term users of CPN services in their turn. Under such circumstances, a serious overload on CPN services built up and the service steadily expanded as a consequence.

The issue then arises that if this service expansion cannot be sustained indefinitely, then either:

a) Some other service must 'take over' the long term care of psychotic clients; or

b) Some restrictions on the build up of 'new long-term' cases must be achieved.

An overload on CPN services accompanied by corresponding falls in the use of other psychiatric services such as in-patient beds, or out-patient clinics, would imply the possibility that a redistribution of existing resources might wholly offset the demands made by the 'community' services. In fact, the data show that use of these 'traditional' services actually increased rather than decreased throughout the period studied, although there is evidence that the rate of in-patient admissions and accumulation of 'new long-stay' elderly clients are beginning to fall.

There is a prima facie case for supposing that these increases in care given to clients under the age of 65 by psychiatrists were a consequence of CPNs' exposure to 'demand-led' referrals, as CPNs themselves referred clients on through the system. How far this meant that clients received more appropriate care than they had done in the past is not clear. Other register data show that the decline in the proportion of people admitted in the 'schizophrenia' clinical group was accompanied by an increase in the proportion of people admitted in other clinical categories. However, the extent to which this increasing use of other psychiatric services may also have been the consequence of an increase in service provision (which in itself encouraged the re-definition of criteria for specialist referral), rather than constituted a response to increasing 'needs' is not known.

The provision of social work care poses different, and considerable, problems. It has been shown that the proportion of Specialist SW clients in continuous care for over 1 year remained stable, and as they had little exposure to a 'demand-led' influx of 'new' clients, there was no indication of the service overload so clearly seen in the CPN service. Patch teams are however, exposed to 'demand-led' increases in new referrals, and the evidence presented shows, that in relation to elderly clients, they have indeed experienced increased pressures on their services.

Social Services Departmental managers have evolved a policy whereby the Specialist SWs are expected to provide social work support to people whose mental dysfunction is so severe that they need specialist social work help. Patch SWs are expected to provide the kinds of social work support required when symptoms of mental ill health, even though they may be present, are not of the nature or severity to require specialist mental health social work input.

If there is a 'need' for long-term social work care for any client group, then the issues to be resolved are:

a) Which social work agency, Specialist or Patch, is the most appropriate to give this care?

b) Where is the increase in resource, necessary if long-term care is to be given, to be found?

It was paradoxical that the social workers who would be expected to be least able to recognise signs of mental dysfunction (the Patch team social workers) were usually the first social workers to encounter clients with no previous contact with psychiatric services. It may be thought that some social services clients who have mental health problems and who might benefit from referral to psychiatrists were being 'missed' by the Patch team workers.

Thus, the data show that the very different organisations of CPN, Specialist and Patch social work services pose various problems. On the one hand, a primary care based CPN service was likely to have caused an increase in the numbers of people receiving care from psychiatrists, and a non-medical model of care may have been more appropriate. On the other hand, a mental health social work service where the Specialist workers most likely to recognise signs of mental ill health were the least likely to be the first point of contact with services, may have caused people who might have benefited from specialist psychiatric care to be denied it.

These issues are of fundamental importance but will probably remain unresolved at least in the short term. The first part of this study has aimed to describe, primarily using case register data, how the CPN and mental health social work services related both to each other and to the pattern of other psychiatric services in Salford. The register data suggested that the nursing and social work services operated in different ways. The second part of the study to be presented, will seek, using direct

observational methods, to describe the day-to-day work of CPNs and Specialist SWs in a way that routine service data can not. It is hoped that the insights gained will further inform the debate on possible solutions to the problems of providing community care for the mentally ill as illustrated and discussed in preceding chapters.

CHAPTER 7

METHOD OF DIRECT OBSERVATION

The final part of the study aimed to compare the face-to-face contacts between social workers, their co-workers and their clients, with the face-to-face contacts between community psychiatric nurses, their co-workers and their clients. The prime concern was to describe what workers actually did rather than what they planned to do or what they said they had done. Writers concerned with both psychiatric nursing (Towell op cit., Altschul op cit., Cormack op cit.) and social work (Goldberg & Neill op cit.) have found that theory and practice cannot be assumed to be the same, and it is the practice with which these sections are primarily concerned.

7.1 RECORDING METHOD

The possibility that worker/client interactions could be tape recorded, and interpreted after each interaction took place, was considered to be impracticable, and two other methods of data collection were considered:

a. researcher recording;

b. worker self-reporting.

Advantages of researcher recording

1. Data are recorded by one person only, thus minimising inter-rater differences.

2. Interactions are recorded as they happen, and do not rely upon memory.

3. Interactions recorded by an observer are thus more likely to reflect what did happen rather than what a worker thought happened or intended to happen.

4. The observer is aware of the extent to which the data are comprehensive.

5. The workers' usual work pattern is not interrupted by the need to undertake additional recording work. The imposition of such tasks imposes a considerable extra, and almost always unwelcome, burden on staff.

6. The insights gained by the researcher actually being with the workers and observing interactions in person, assist data interpretation.

Disadvantages of researcher recording

1. The number of observations is limited to the physical capacity of one person. Thus fieldwork has to be spread over a long period, and a longitudinal study of workers' interactions with specific clients, is precluded.

2. There is no way of assessing how far the researcher's presence affects staff/client behaviour.

3. There will be situations in which the presence of an observer will be unacceptable either to the client, or the worker, or both. These are likely to be in the area of sexual counselling, in group work, or when a client's paranoia is likely to be aroused.

One of the main advantages of observations taking place over the same time period is that some notion of the characteristics of clients in a prevalence count can be made. As prevalence data are available from case register statistics in Salford, there is no necessity to use observational data as surrogates for prevalence counts.

Both groups of staff regularly visit their clients in the company of students, and staff and clients are therefore accustomed to the presence of others during interviews. Further, proponents of an interactionist perspective would argue that even if an observer's presence did change behaviours, the observations would remain of value (Douglas 1967; Atkinson 1978). However, the role of researcher as observer-participant (as distinct from participant-observer (Gold 1958)), envisaged in this project, demanded that the researcher's presence should be as inconspicuous as possible, and should minimise interference with the dynamics of worker/client interactions. In order to minimise the possibility of the researcher's presence contaminating the interaction she intended to:

1. Make clear to clients her role as observer/recorder of the

worker's activities;

2. To physically distance herself from the client and worker, and avoid eye contact with either throughout the interaction.

There remains the possibility that the workers' usual methods of work may be changed as a result of research observation. There was no possibility that the researcher could observe interactions without the knowledge of workers and clients, and any other methods of observation would also be liable to induce behaviour changes.

In view of the advantages outlined above, and the fact that the main purpose of the study was to compare the work of two different professions, which introduced the possibility of inter professional differences in perception and interpretation as well as intra professional differences, if self reporting mechanisms were used, it was decided that the researcher would adopt the role of observer-participant used by Cormack (op. cit.) and Altschul (op. cit.) in their studies of nurse/patient interactions on wards.

It is argued that the presence of a researcher was no more likely to affect usual work patterns than the awareness that a self reporting schedule must be completed, and that, in any case, each group of workers would have to react differently to being observed in order to render comparisons invalid. Further, as other recently published work (Bladden, op. cit.; Paykel et al., op. cit. and Goldberg and Neil op. cit.) had been based on staff self reporting methods and substantial differences between

self-reported and observer-reported data had been noted by Pritchard (op. cit.), it would seem important to test the use of a different method of gathering data.

7.2 RECORDING INSTRUMENT

Both the 'Nursing Process' (Crow op cit.) and the 'Case Review System' (Goldberg & Fruin op cit.) provided frameworks which aimed to clarify and integrate the contexts of various activities which take place between workers and clients. The components of the two systems have been seen to be similar in their concentration upon the identification and solution of problems, and have helped practitioners to review their work systematically. The nursing process and the case review system both emphasised the importance of placing each 'activity' in an overall context. The instrument which was developed to record interactions with clients was, therefore, based upon these frameworks in order to assist the researcher to systematise her observations and to place them in the context of the workers' past and future involvements with individual clients.

As the comparative aspects of this study were its prime focus, and the nursing and social work frameworks were seen to complement each other, the same recording instrument was used to record the content and content of interactions with individual clients undertaken by both groups of workers. Detailed descriptions of the nature of group interactions were considered to be beyond the scope of the present study. The researcher did however, wish to describe the extent and nature of CPNs' and SSWs' interactions with other workers.

7.2.1 The context of each interaction

Information on the context of each worker/client interaction consisted of the following:

1) Clarification of the length of time workers and clients were known to each other;
2) A record of the place of contact and its duration;
3) A record of the presence or absence of others;
4) A record of others with whom the worker was in contact concerning each client;
5) A statement of reason(s) the contact took place;
6) A statement of what was achieved or learned as a result of the contact;
7) A statement of what steps the worker expected to take immediately following each contact;
8) A statement of overall objectives of care.

Ideally, a statement and validation of clients' 'needs' in the form of problems to be solved would have provided additional contextual material. However, the complexities of establishing the range and severity of clients' and their families' problems was such that an adequate problem assessment could not be undertaken within the resource constraints of the project. A limited solution to this difficulty was considered to be the collection and analysis of the range and severity of clients' psychiatric symptoms, and details of the method used appear below.

The contextual data outlined above were recorded following a

mixture of highly structured and open-ended questions, the responses to which were recorded either immediately before, during or immediately following each interaction. The only exception to this method occurred in respect of CPNs' clients seen at injection clinics, where the pace of activity was so great that contextual data had to be collected and recorded at the end of each clinic session.

The method of eliciting the above items of information may be summarised thus:

	Questions/Observations	
	Open ended Item no.	Highly structured Item no.
Before interaction	5	1 ; 4
During interaction		2 ; 3
After interaction	6 ; 7 ; 8	

Responses to the highly structured items 1 and 4 were obtained after the researcher read out prompt lists of items, and recorded positive or negative answers to each item.

7.2.2 The interactions themselves

A variety of theoretical frameworks have been developed which aim to facilitate the interpretation of face to face interactions (Argyle 1981). As the strategy of presenting an overview of CPNs' and SSWs' everyday work was adopted in the present study, detailed descriptive data on the range of social skills used by both groups of workers was precluded, and it was decided to adapt methods used by other researchers who had adopted similarly broad descriptive strategies.

Sladden (op. cit.) asked CPNs to complete a simple yes/no checklist to record activities, which precluded the possibility of assessing the balance of interactions, as the degree of emphasis placed on each item recorded could not be assessed. Paykel et al. (op. cit.) attempted to overcome this difficulty by introducing broad time measurements for each checklist item. This method was attempted by the researcher, who found the task of assigning total time in minutes to each item to be beyond her competence. The range of topics covered and the techniques used in all but the most simple interactions were far too wide, and the sequences too fragmented to be accurately recorded by her in minutes.

It was therefore decided to try a method which, whilst allowing the balance of the interaction to be summarised, would also be simple to record. A method based on that used by Marks, Goldberg and Hillier (1979), who classified the utterances of general practitioners during patient consultations, was tested and

developed. Each utterance (sentence) made by the worker was classified according to a checklist of topics, using a simple stroke system. Utterances were further classified into one of the following categories:

a. clarifies/elicits information;
b. gives advice/information;
c. supports/sympathises;
d. other.

This recording method was found to be easily achievable when the range of topics in the checklist was contained on a single page, and arranged in hierarchical order on the page. In the event of any uncertainty caused when utterances were not clearly focussed on one topic only, (e.g. discussions on the need to find alternative accommodation because rent arrears had accrued might conceivably be coded under 'accommodation' or 'financial problems' topic headings), the topic item recorded was the one which appeared highest in the hierarchy. In fact, the use of the hierarchy was rarely required as the topics discussed were generally quite clear.

However, it was found that some therapeutic activities were appropriately recorded following agreement between researcher and worker, and after each interaction a checklist was read out, and a record of whether activities had taken place or not was made. It was also found to be practicable to time 'personal services' and 'practical assistance' items. A summary of the relative use made of certain interpersonal procedures was also agreed by the

researcher and worker at the end of each interaction. The time the contact began and ended was recorded so that mean contact times and 'grouped' distributions could be established.

Categories of activities, topics, and procedures, were drawn from other studies of social work and community psychiatric nursing, (Bladden; Paykel et al.; Goldberg & Fruin; Goldberg & Neill, all op cit.) and were tested and amended during pilot studies. The data collection schedule (see Appendix 3) was piloted and amended between February and May 1983. Data collection began in June 1984 and ended in August 1985.

The contents of the staff contact schedule were based as far as possible on the model of the client contact schedule. Pilot work showed, however, that such a structure was over ambitious as staff contacts frequently took place for very short periods, and were not always conducted on a face to face basis, which prevented the researcher from witnessing the whole interaction. Attempts to relate inter-worker contact to specific clients also failed, because the detailed enquiries necessary to establish contextual information interfered with the pace at which work could be carried on to such an extent, that the enquiries were abandoned. The information actually gained, was, therefore, considerably less detailed than was originally envisaged.

7.3 CODING METHODS

The contents of each schedule were translated into codes and stored and retrieved by the researcher using a Delta 4 database

and a micro computer. As can be seen from the schedule, the highly structured sections of the questionnaire were pre-coded to facilitate the coding process. Replies to open-ended questions which were recorded verbatim at the time of the observation, were coded into various categories by the researcher. The categories used were those decided upon by the researcher using a combination of topics and structure which as far as possible reflected categories used to record the worker/client interactions. A list of the categories used appear in Appendix 4. In order to minimise the numbers of errors or changes in coding practice, responses to open-ended questions were coded twice, and any discrepancies checked and re-classified where appropriate.

7.4 SAMPLING

Observations were limited to CPNs and Specialist SWs working in general psychiatry, thus nurses and social workers attached to regional units, rehabilitation and psychogeriatric teams were excluded. District nurses, and social workers working in patch teams, also provide services to people suffering from mental illness, but time constraints were such that these aspects of mental health work had also to be excluded from the study.

Out of a CPN department with an establishment of 17 full-time nursing staff, 11 nurses carried full caseloads and were thus eligible for inclusion in the study. A random sample was drawn of 10 nurses, one from each community base, half having completed the one year full-time ENB community psychiatric nursing course.

The six social workers attached to general psychiatric teams all took part in the study.

Most CPNs (Brough 1983) and SSWs worked to a weekly routine although some group and special activities (for example, psycho-sexual counselling), took place at less frequent intervals and are thus excluded from the study data. It was thought that the observation of one week's activity for each staff member would adequately represent the main kinds of work with individual clients undertaken by the two groups of workers. Observations took place between June 1984 and August 1985. It should be noted that observations of SSWs began in January 1985, after the establishment of the psychogeriatric service. The measure of statistical significance used, unless otherwise stated, was the X2 test.

7.5 DESCRIPTION OF CLINICAL STATE

7.5.1 Choice of Measuring Instrument

The data on incidence and prevalence of psychiatric service use provide basic information on the proportions of the general population who make contact with psychiatric services. The kinds of broad clinical categories generated from case register data may be considered sufficiently detailed and accurate for these purposes (Jones et al. 1984), however, for a variety of reasons, register diagnostic data by themselves are less useful when more detailed descriptions of the clinical states of patients are required. As the diagnoses recorded on the register are those

made by the consultant psychiatrists dealing with each case, the diagnostic practices are not standardised. Neither does a diagnostic category alone, indicate the severity and total range of symptoms which may be present at any one time.

The main purpose of obtaining detailed data on the clinical states of clients, was to describe in a standardised way, the range and severity of symptoms present at the time the workers' study contacts took place. A second possible use of these data was to clarify the extent to which the diagnostic data recorded on the case register reflected the diagnostic data generated by a standardised measuring instrument.

Various psychiatric interviews have been developed which aim to describe, in a standardised way, the range and severity of various symptoms of mental dysfunction. The ways in which these relate to each other are discussed by Goldberg and Huxley (op. cit.).

The most widely used instrument in international studies and in the U.K. - the Present State Examination (Wing et al. 1974) has been developed and tested on people who had already been referred to psychiatric services. In order to satisfy the Present State Examination (PSE) criteria a symptom must be definitely present in order to be rated. Individual symptoms are grouped into syndromes and, via descriptive categories, into CATEGO classes which relate to International Classification of Diseases rubrics (1977). Thus, detailed or grouped data may be used to give various levels of descriptive data, and an Index of Definition

(ID), based on hierarchical principals and the number and type of symptoms recorded, is used to define 'case threshold' and 'severity' levels.

There were, however, three issues which needed to be borne in mind concerning the suitability of the instrument for the purposes outlined above.

1. There was some doubt about the extent to which the reliability of ratings of symptoms such as anxiety or depression found in hospital patients would extend to the general population, and some CPN and Specialist SW clients may have had little or no contact with hospital psychiatric services.
2. There were no criteria included which allowed the allocation of diagnoses of 'personality disorder', and 'organic' illness.
3. The interview schedule was designed to be used by psychiatrists, and although various studies had found that suitably trained non-psychiatrists could satisfactorily administer the questionnaire, there was some evidence that non-psychiatrists tended to rate higher levels of symptoms than psychiatrists (Copeland et al. 1975).

Notwithstanding these limitations, the PSE interview appeared to be the instrument which most closely satisfied the requirements of the study, and the researcher was trained in its use by Dr. C. Dean, Consultant Psychiatrist, Manchester University Department of Psychiatry, during August 1983. The researcher further familiarised herself with the schedule by conducting interviews with a sample of patients newly referred to one of the Salford

consultant psychiatrists during March 1984.

7.5.2 Sampling Techniques

As discussed earlier, the decision to observe and record the day to day work of each worker over a period of one working week was based on the premise that this method would allow an overview of the ways in which members of the two professions related to clients and other staff to be assembled. Pilot work had established that CPNs were likely to contact more clients during the course of one week than Specialist SWs, and that the total number of Specialist SW client contacts likely to be observed during the study could be expected to be less than 100. In order to obtain a balance between the desirability of large numbers, and the time constraints imposed on the study, the researcher decided to conduct PSE interviews on every 10th client contacted by CPNs and every 5th client contacted by Specialist SWs. It was anticipated that these data would provide an overview of the clinical states of the two client groups.

In view of the fact that the PSE interview related to symptoms experienced by clients in the immediately preceding past (within 1 month of the interview date), it was planned to complete all the interviews during the week immediately following that in which the observations took place. Thus it was planned that a one week period of observation would be followed by completion of the relevant PSE interviews the next week.

CHAPTER 8

RESULTS OF OBSERVATIONS

8.1 ORGANISATION OF WORK

During the study period various differences between the administrative/management arrangements relating to the two groups of workers were observed .

8.1.1 Intra-Professional Supervision/Support

There was no established system of work supervision/support for the CPNs. As will be seen, there was some informal opportunity for case discussions with a small group of interested workers, but CPN managers had made no formal provision either for help with individual cases or for overall caseload management. In contrast, the Specialist SW Team Leaders had a responsibility to provide regular supervision of individual cases and to undertake responsibility for overall caseload management.

In both services a 'Referral Form' was filled in for each newly referred client (except for those making simple enquiries only) which formed the basis of an individual file. The Specialist SWs' Team Leaders required (although the extent to which this requirement was fulfilled in practice was not investigated in this study) detailed records of the progress made with individual clients to be kept as part of the supervision process. Apart from very occasional special 'inspections' by the CPN Manager, the ways in which the nursing records were kept were unsupervised

and unstructured.

Organisation of the working day.

The CPNs worked a 9 a.m. to 5 p.m. day. Occasional evening work was additionally undertaken by most nurses. All but one health centre had two CPNs working together. There were no arrangements made to cover for emergencies or to systematise the arrival of new clients, and GPs often sent patients directly to the CPNs' offices after their consultations had finished. The 3 CPNs who were based in a community 'clinic', did, however, arrange to interview some new clients referred to them by GPs at specified times, and called in to the surgeries to which they were 'attached' to pick up the names of newly referred clients who were then visited at home.

The Specialist SWs also generally worked a 9 a.m. to 5 p.m. day. However, 24 hour cover was arranged by means of an 'on call' system. During the day, emergencies and client self-referrals were dealt with by 'duty social workers'. All members of the Specialist SW team each took their turn, together with one other back-up social worker and one team leader, on a 'duty rota'. The social workers usually used their duty periods (if there were few 'emergency' or 'casual' contacts) to write up their case notes and catch up on their correspondence. Apart from those referrals which arrived via the duty system, assessments/interviews with 'new' clients took place at pre-arranged times.

CPNs rarely made specific appointments to visit their clients,

whereas Specialist SWs almost always did. When questioned, the CPNs gave various explanations for this practice, and cited the fact that they had to cover 'emergencies' and could not therefore make fixed appointments to see clients, as they might be unable to keep them. They also argued that "it is impossible to predict how long a client will need so I can't make appointment times".

The researcher considered that a further factor may have been the medical/health tradition, particularly strong in health centres, which usually requires patients to wait until staff are able to see them rather than structure staff work so that patients are not inconvenienced - for example, GPs and district nurses rarely make specific appointment times for their home visits even when non-urgent visits are being made.

8.2 THE WORKERS IN THE STUDY

Nine CPNs were Registered Mental Nurses, one was Enrolled. All but one nurse had received basic training at the local mental hospital, and all had had some post-basic training. Five had successfully completed a one year full-time Community Psychiatric Nursing Course (one of these, the equivalent course for S.E.N.), one was a Nurse Therapist. Apart from one nurse, who had been working in the community for less than 3 months, all had a minimum of 2 years community experience, and many had much more than this.

All Specialist SWs had obtained the Certificate of Qualification in Social Work (all from different polytechnics throughout the

country), and Approved Social Worker (University of Manchester Department of Psychiatry) qualifications. Five of them had obtained their social work qualifications after completing various kinds of higher education, 4 of whom had first degrees. Two had been in post for just over 3 months, one for just under one year; all the rest had worked in Salford as specialist mental health social workers for at least 1 year and all had previous experience of working in area or patch teams.

8.3 INDIVIDUAL CLIENT CONTACTS

When accompanying many CPNs, the researcher sometimes had to explain the purpose of her presence and ask the client's permission to allow her to record the interaction herself. Nurses often introduced her to clients as "a colleague" or said "I've got somebody with me to-day", and did not in the researcher's opinion always give clients a genuine opportunity to refuse her presence. In some cases, the researcher was unable to intervene without implying criticism of the worker, and opted to allow the interaction to take its course without the client being given a real opportunity to ask her to leave. The Specialist SWs always explained clearly the purpose of the researcher's presence and phrased the question, asking the client's permission for her to attend the interview, so that pressure to accept her presence was minimised. One social worker insisted on asking clients' permission whilst the researcher was not present, which minimised the pressure to accept even further.

8.3.1 Number of contacts in the study

Two hundred and eighty three CPN and 78 MHSW individual contacts were included in the analysis. When clients or workers wished the observer to withdraw, data on the context and future plans for care only were recorded. Table 42 shows the numbers and proportions of missed contacts and it can be seen that a significantly higher proportion of the Specialist SWs' clients refused the researcher's presence (P<0.01). Ways in which these refusals may have affected the data are discussed below.

TABLE 42
Number of Contacts in Study

	CPN	SSW
Missed Contacts	1	4
Context and Future Plans Only	9	17
All Interaction Observed	274	61
Included in Study	283	78

During the period of observation, 10% of the CPNs' clients were seen twice and 1% were seen more than twice (not always by the same nurse). Equivalent proportions for the SSWs (always seen by the same social worker) were 14% and 4%. Only 3 clients appeared in both the CPN and SSW sample.

The length of time clients had been in each worker's care is shown below in Table 43.

TABLE 43

Duration of care from individual workers

Percentages

Duration	CPN	SSW
No Previous Contact with Worker	13	6
Previous contact but < 3 months	30	44
" 3 < 6 Months	9	21
" 6 < 12 Months	5	10
" 1 Year & Over	42	18
Total	100	100
(N)	(283)	(78)

Although the CPNs saw a higher proportion of new clients, the difference was not statistically significant. The proportions in individual workers' care for longer periods to some extent reflected the lengths of time workers had been in post - one CPN and 3 SSWs had been in post for under one year and could not possibly have accumulated long-term clients. Information concerning length of care and turnover for each service as a whole appears in earlier chapters which analyse case register data.

8.3.2 Age Groups and Clinical Categories

The age groups and clinical categories of CPN and SSW clients are shown in Table 44 below. The 'schizophrenia' category includes those with 'unspecified psychotic illnesses'. It can be seen that the CPNs saw over twice the proportion of clients in the 35-44 age group than the SSWs, and all this excess was accounted for by clients in the 'schizophrenia' clinical category. Neither diagnostic nor age differences reached the 5% level of statistical significance. The higher proportion of SSW contacts in the 25-34 age range were in the 'schizophrenia' and 'personality disorder' clinical groups; in the 45-54 age range they were in the 'schizophrenia' and 'depression' categories. The excess of people over 65 in the CPN sample was probably due to observations of half the CPNs taking place before the specialist psychogeriatric team became operational.

TABLE 44

Clients Contacted, by Age Group & Clinical Category

Percentages and Total Numbers

Age Group		Schizophrenia		Depression		Anxiety		Personality disorder		Dementia		Other		Total	
		CPN	SSN	CPN	SSN	CPN	SSN	CPN	SSN	CPN	SSN	CPN	SSN	CPN	SSN
0-14	%	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	n													(1)	(-)
15-24	%	3	6	1	4	-	1	1	1	-	-	1	-	5	13
	n													(15)	(10)
25-34	%	6	9	3	3	2	1	1	5	-	3	1	-	12	20
	n													(34)	(16)
35-44	%	15	5	4	5	2	3	1	-	-	-	1	1	23	14
	n													(66)	(11)
45-54	%	11	14	2	5	3	1	1	-	-	-	1	1	18	22
	n													(50)	(17)
55-64	%	9	5	5	9	1	3	-	-	-	-	1	-	15	17
	n													(43)	(13)
65-74	%	7	-	5	1	1	-	1	3	1	-	-	-	15	4
	n													(42)	(3)
75+	%	2	-	2	1	-	-	-	-	2	1	1	1	7	4
	n													(21)	(3)
N.K.	%	2	-	-	-	-	-	1	-	-	-	1	4	3	4
	n													(10)	(5)
TOTAL	%	54	35	22	28	9	9	5	9	3	4	6	10	100	104
	n	(152)	(31)	(63)	(22)	(27)	(7)	(13)	(7)	(10)	(3)	(18)	(8)	(283)	(78)

8.3.3 The range and severity of clients' symptoms

As explained in Chapter 7, it was decided to supplement case register diagnostic information with more detailed and standardised clinical descriptive data obtained from the Present State Examination interview (Wing et al. op. cit.).

Out of a total of 28 CPN clients eligible for interview (every 10th contact), 7 people were excluded from the analyses for various reasons. One client answered affirmatively to every single question on the schedule and was excluded because her answers were considered to be unreliable; 1 client could not be contacted for interview; 1 client appeared to be demented, had a language difficulty, and could not answer the questions adequately; 2 contacts were with relatives only; 1 was for joint marital therapy; 1 client had already been interviewed in the SSW sample some weeks previously. Twenty-one CPN interviews were completed and are analysed below.

Fourteen out of a total of 15 eligible client interviews (every 5th contact) were included in the SSW analysis - one client had refused to be interviewed. One PSE interview included in the CATEGO analysis was conducted by a psychologist, following the emergency admission of a client who was eligible for interview by the researcher.

The CATEGO program allocates clients into groups which correspond closely with I.C.D. rubrics. The process works on a hierarchical principle and allocates each individual into one class only. The

single exception to this rule is the case of class O?, where the borderline nature of the condition is such that another class is also allocated on the basis of the non-psychotic symptoms present.

TABLE 45

Grouped CATEGO classes
Frequencies

CATEGO classes	CPN	SSW
Schizophrenic &, Paranoid psychoses (S,O,P)*	8	10
Manic psychoses (M)	3	1
Depressive psychoses (D)	-	-
Other depression (R & N)	4	-
Anxiety states (A)	3	-
Other (I,ON)	3	3
TOTAL	21	14
* inc. O?	3	4

Numbers were small, and as Table 45 shows, the SSW clients interviewed mainly belonged to the 'schizophrenia' and 'paranoid psychoses' group, whereas the CPN clients were spread throughout the CATEGO classes. The distributions were not normal, and the difference between the two groups of clients as measured by the Mann Whitney U Test was not statistically significant. As the clients who were classified O? were assigned a second catego class, a further statistical test was performed in which the

second CATEGO class was substituted for O?. The distribution of classes within the two groups became more similar, as all but one of the O? second classes were in the 'Other depression' group, and 1 SSW client moved into the 'anxiety' group.

Index of definition (ID) scores, arranged hierarchically, reflect the severity of clients' symptoms. The higher the score, the more 'severe' the symptoms. Scores of 4 and below are regarded as 'sub clinical'.

TABLE 46
PSE 'Prevalence' ID scores
numbers and percentages

	CPN		SSW	
ID Scores	N	%	N	%
8	2	9	4	29
7	4	19	1	7
6	5	24	3	21
5	4	19	2	14
4	1	5	-	-
3	1	5	3	21
2	3	14	1	7
1	1	5	-	-
T	21	100	14	100

The Mann Whitney U test found no statistically significant difference between the two groups of clients, and 71% of both groups could be said to have experienced active clinical symptoms within one month of the worker/client contact.

8.3.4 Sources of Referral

TABLE 47
Referral Source
Percentages

Source	CPN	SSW
Psychiatrist	20	24
Ward Staff	-	41
Social Workers	3	15
CPNs	41	-
Primary Care Staff	25	-
Client/Family	6	5
Other	5	14
Total	100	100
N	(283)	(78)

Table 47 shows how client referral sources varied between the two groups of workers (P<001). It is important to point out that this Table refers to the sources of referral to each individual worker rather than the sources of referral to the departments as a whole. The absences of CPN referrals from ward staff, of primary care referrals to SSWs, and of referrals between the two groups of workers were striking. It is possible that some of the referrals from psychiatrists to CPNs were generated from 'ward rounds' and that nurses interpreted the process differently from the SSWs. Even if this was indeed the case, and the two categories (psychiatrist and ward staff) were combined, the overall specialist mental health team/other agencies split varied significantly (P<001) between the two groups of workers.

The vast majority of people (75%) referred from one CPN to another fell into the psychotic clinical group, and were in receipt of phenothiazine injections. Most of these clients would probably originally have been referred for CPN care by psychiatrists. Over 60% of all CPN psychotic clients were referred by other CPNs; 19% were referred by psychiatrists. Sixty-four per cent of clients referred to CPNs by primary care staff (88% of these were GPs), were in the 'depression/anxiety' clinical group.

Seventy nine per cent of the referrals to SSWs from ward staff originated from 'ward rounds'; half those referred by 'social services staff' were from non-specialist mental health workers and 71% of the referrals from 'other known' sources were from day care staff/agencies. These 'other' agencies referred clients mainly in the 'psychotic' and 'depression/anxiety' categories. All referrals from one SSW to another were of 'psychotic' clients.

8.3.5 Place of contact and persons present

Although Table 48 below, shows that similar proportions of clients were seen at home and in day care settings by both groups of workers, overall, place of contact varied significantly (P<001). CPNs saw more clients in a primary care setting than SSWs, and SSWs saw more people on wards. The majority of clients seen in social workers' offices were seen when the SSWs were 'on duty'.

The tendency for CPNs to see more clients alone than SSWs (P<025) held true even when they saw them at home and in primary care offices. Similar proportions of CPN and SSW contacts took place in the presence of relatives; higher proportions SSW client interactions took place with relatives only, and in conjunction with other workers. Overall, differences were statistically significant (P<001).

Although similar proportions of clients were seen at home by both groups of workers, there were considerable differences according to clinical category. Thirty-five per cent of the CPNs' 'schizophrenic' clients were seen at home, compared to 67% of their other clients (P<001). Equivalent proportions for social workers' clients were 48% and 39% respectively and the difference was not statistically significant. The majority of CPNs' 'schizophrenic' clients were seen at the 'injection clinics', most of which were held at health centres.

TABLE 48
Place of Contact by Persons Present
Percentages and Total Actual Numbers

Persons Present		Place of Contact																			
		Ward			Day Care			G.P.		SW Office		Primary Care		Home			Other		Total	
		CPN	SW		CPN	SW		CPN	SW	CPN	SW	CPN	SW	CPN	SW		CPN	SW	CPN	SW
Client Only	%	1	14		11	6		5	-	-	11	25	3	25	1	5	4	6	70	56
	(N)																		(200)	(44) (0)
Relative Only	%	-	-		-	-		-	-	-	1	1	-	3		6	-	-	4	0
	(N)																		(11)	(6) (0)
Client and Relative(s)	%	-	1		1	-		-	-	-	1	3	1	18	1	7	-	1	23	22
	(N)																		(64)	(17) (0)
Client and Other Workers	%	-	-		-	5		-	-	-	1	1	-	2		-	-	1	3	8
	(N)																		(8)	(6) (0)
Other	%	-	1		-	-		-	-	-	1	-	-	-		3	-	-	-	5
	(N)																		(-)	(4) (0)
D.K.	%	-	-		-	-		-	-	-	-	-	-	-		1	-	-	-	1
	(N)																		(-)	(1) (0)
Total	%	1	17		11	11		5	-	-	17	30	4	48	4	2	5	9	100	100
	(N)	(4)	(13)		(31)	(9)		(15)	(-)	(-)	(13)	(84)	(3)	(136)	(3	3)	(14)	(7)	(283)	(78) (0)

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4.3.4 Workers' client contact networks

TABLE 49

Workers' Contact Networks for each Client* Percentages**

Contacts	CPN	SSW
Psychiatrist	66	97
Other CPN	31	31
Other MHSW	12	17
Other Mental Health Staff	13	67
Other SSD Staff	13	22
Non-Health Professionals	5	20
Primary Care Team	62	25
Client's Household	44	43
Other Relatives/Friends	24	47
Other	2	29
N	(203)	(78)

* Persons with whom the worker was in contact concerning each client.

** These categories were not mutually exclusive therefore percentages do not add up to 100.

It can be seen from Table 49, that SSWs had extensive contacts with members of other professions within the psychiatric team. In contrast, CPNs were over twice as likely to be in contact with each other than to be in contact with mental health staff other than the psychiatrist. Overall, SSWs had wider contact networks for each individual client than CPNs, though CPNs had more extensive links with primary care workers. The mean number of

contacts per client was 2.7 for CPNs and 3.9 for SSWs.

Compared to other clients, for those with 'schizophrenia', CPNs were more likely to be in contact with a psychiatrist - 55% and 77% respectively (P<001), and other CPNs - 16% and 44% (P<001). With the exception of members of the client's household and ward staff, Specialist social workers were more likely to be in contact with all other agencies for their schizophrenic clients, and significantly more likely to be in contact with non-mental health professionals - 41% and 8% (P<001) .

8.3.7 Purpose of Contact

The breakdown of purposes given in Table 50, shows that SSWs cited a mean of 1.5 purposes for each contact; CPNs cited 1.3. CPNs mainly intended to administer physical/behavioural treatments, and to learn about and observe symptoms/behaviours. SSWs intended to learn and/or observe and give information/advice on a wide range of topics.

TABLE 5b
Purpose of Contact by Topic
Percentages of Recorded Clinical Contacts
(N = 282, CPN; N =72 SSW)

Topic		Purpose																			
		Learn		Encourage		Advice		Treatment		Verbal Therapy		Pers. Services		Support		Multiple		Other		Total	
		N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S	N	S
Treatment	1 (N)	6	4	-	4	1	4	45	-	3	7	1	1	-	-	2	-	-	-	89 (166)	20 (15)
Symptoms/ Behaviour	1 (N)	35	12	-	-	1	5	1	1	-	-	-	-	-	-	-	-	-	-	23 (94)	19 (14)
Physical Symptoms	1 (N)	3	1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	3 (9)	1 (1)
Relationships	1 (N)	2	9	-	3	1	1	-	-	-	1	-	-	1	-	-	-	-	-	2 (10)	15 (11)
Administration	1 (N)	1	3	-	-	3	3	-	-	-	-	1	-	-	-	-	-	-	-	7 (19)	3 (4)
Life Style	1 (N)	-	7	-	-	1	5	-	-	-	-	-	1	-	-	-	-	-	-	2 (7)	13 (10)
Social Life	1 (N)	-	1	-	1	-	1	-	-	-	-	-	1	-	-	-	-	-	-	- (1)	3 (4)
Welfare	1 (N)	-	7	-	-	1	0	-	-	-	-	-	7	-	-	-	-	-	-	1 (2)	21 (16)
Professional Relationships	1 (N)	-	3	-	11	-	3	-	-	-	1	-	-	1	-	-	-	-	-	1 (2)	17 (13)
History	1 (N)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	- (-)	- (-)
Support	1 (N)	-	4	-	1	-	-	-	-	-	-	-	7	-	-	-	-	-	-	7 (26)	7 (5)
Other	1 (N)	2	19	-	1	1	-	-	-	-	-	-	1	1	-	1	-	-	-	11 (36)	24 (18)
Total # Topics Recorded		50 (140)	70 (52)	1 (0)	21 (17)	10 (29)	31 (23)	47 (133)	1 (1)	2 (6)	9 (7)	2 (7)	11 (8)	10 (27)	1 (1)	3 (8)	1 (2)	1 (3)	-	139 (365)	140 (111)

N: All purposes were recorded, therefore percentages do not add up to 100

* SS CPN = Non-specific assessment
(#) SSW = Non-specific assessment

Five per cent of the CPNs', and all the SSWs' 'other' learning related to 'assessment' where the topic was unspecified, or when the assessment was described in generic terms - for example "to find out what his problems are". The social workers were over twice as likely as the nurses to describe their assessments in a generic rather than specific way.

It is not known how far the CPNs' use of the word 'support' and the SSWs' use of the word 'encourage' represented real differences of meaning. The fact that most of the SSWs' 'encouragement' concerned the formation of professional relationships might imply a particular social work concept. However, even if 'support' and 'encourage' were combined (i.e. treated as if they meant the same), than the SSWs intended to give more support/encouragement than the CPNs.

For their schizophrenic clients, CPNs' purposes were more likely than for their other clients, to relate to the following topics - give treatment - 46% v 34% ($P<.001$), to observe psychiatric symptoms - 64% v 47% ($P<.001$). Specialist social workers were more likely to be concerned with lifestyle and coping skills (18% v 10%), 'welfare' (33% v 15%) and support (11% v 4%) for their schizophrenic clients but none of these differences reached the 5% level of statistical significance.

8.3.8 Contact duration

The mean number of individual client contacts per worker per week, was 28 for CPNs and 13 for SSWs. The mean weekly total time spent in individual client contacts was 454 minutes for CPNs and 315 minutes for SSWs. The CPNs, therefore, spent a higher proportion of their time in individual client contact than the SSWs.

TABLE 51

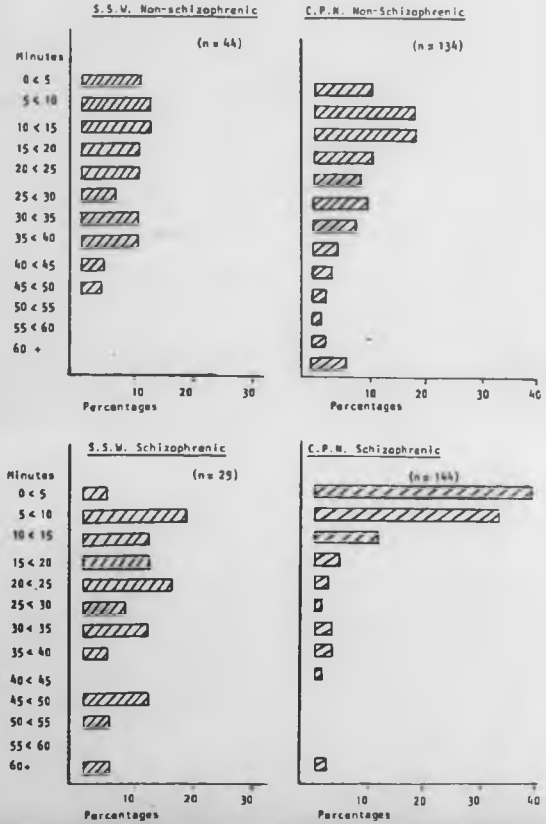
Mean Contact Duration by Clinical Category

Clinical Category	Mean Contact Time (Minutes)	
	CPN	SSW
Schizophrenia/Paranoid Psychoses	9	25
All Depressions	26	28
Anxiety States/Other Neuroses	31	37
Other	16	19
Total (N)	16 (283)	25 (751)

Table 51 shows that the shorter CPN mean individual client contact time was attributable to the very short mean individual contact time for clients in the 'schizophrenia/paranoid states' clinical category. Figure IV111 shows the distribution of individual contact times for this group of clients, compared to the rest of the group. It can be seen that CPNs spent significantly less time with each individual client in the 'schizophrenia' category, than they did with others, and that over 70% were in contact for less than 10 minutes. In contrast,

Figure XVIII

Contract Duration



SSWs were more likely to spend longer with these clients than with others, although it should be borne in mind that the number of SSWs' clients in the 'schizophrenia' was low.

8.3.9 Verbal interactions

Only 3% (N=9) of CPNs' interactions were not observed and recorded by the researcher whereas the verbal interactions of 19% (N=15) of SSW contacts were not observed or recorded. Of the 15 SW contacts, two clients did not wish the researcher to be present on 3 occasions each, and one client refused on 2 occasions. Three clients thus accounted for half the missing observations. These three clients, plus a further 2 who refused, were very upset and disturbed at the time of contact, and there is no way of knowing how far the SSWs' interactions with these clients followed a different pattern than others which were observed and recorded. Four contacts were missed for practical/logistical reasons and one because the client did not wish to discuss her problems with anyone but the social worker. There was no reason to suppose that the interactions with this latter small sub-group of clients were significantly different from others observed.

Topics were divided into four structural elements:

1. Asks questions; elicits information;
2. Gives advice/information;
3. Gives support/encouragement/sympathy;
4. Neutral (none of the above)/general conversation.

Significant variations (P<001) occurred between the the groups of workers in the overall structure of their verbal interactions and in three out of the four elements when these were considered individually. Both CPNs and SSWs gave similar amounts of 'support' (8% and 7% respectively) and advice and information when speaking to their clients (43% and 45% of all utterances respectively). The social workers asked more questions than the nurses - 42% compared to 35%, (P<001) and CPNs used 'general conversation and neutral comment' over twice as much as SSWs - 13% and 6%, (P<001). Even when 'general conversation' was excluded from the 'neutral comment' category, the CPNs' use of 'neutral comment' remained significantly greater (P<001) than that of the SSWs.

TABLE 52

Workers' Verbal Interactions by Topic
Percentages of all Utterances

Topics	CPN	SSW
General Conversation	7	2
Medication	12	4
Symptoms/Behaviour	18	14
Physical Symptoms	9	3
Treatment Explanation	3	7
Administrative Arrangements For Treatment/Care	17	7
Social Life/Networks	6	5
Self Care/Coping	4	6
Finance	2	11
Accomodation	1	8
Inter-personal Relationships		
Family	10	14
Other	2	4
Psycho-social History	3	4
All Other Topics	4	10
Total	100	100
N Utterances	12,736	4,268
N Interactions Observed	273	61

The distribution of topics discussed is shown in Table 52 above. As none individually, formed more than 2% of the total, five topics (bereavement, work, legal, anti-social behaviour, and sex) which were specified on the data collection form, were incorporated into the 'other topics' category. That 'work' was so little discussed was surprising, and perhaps reflected the attitude that because the prospect of finding work was so remote generally, there was little point in exploring work issues with this particular group of clients. No record of the numbers of clients who had a job was kept, but as the study progressed, the researcher became aware of the fact that a working client was the exception rather than the rule.

Whilst there was some degree of overlap in the topics discussed, and both groups discussed psychiatric symptoms/behaviours extensively, there was a statistically significant difference in the overall distribution ($P<0.01$). Almost 50% of the CPNs' utterances covered three topics - 'psychiatric symptoms/ behaviours'; 'treatment administrative arrangements'; and 'medication'. Two topics - 'physical symptoms' and 'family relationships' - accounted for a further 20% in total and all the remaining topics accounted for only 30% of all CPN utterances. These five topics dominated the nurses' interactions in all four elements, although the rank orders varied.

The SSWs discussed a wider range of topics and this held true in all four elements. Most of their questions were about family relationships (19% of all questions), closely followed by

enquiries about psychiatric symptoms/behaviours (17%). Most advice (16%) concerned financial matters. Between 10% and 12% of all advice given was about psychiatric symptoms/behaviours, treatment explanation, administrative arrangements for treatment, accommodation and family relationships. A breakdown of each element into topics appears in Appendix 9.

When topics were combined into two types - 'medical' (medication; symptoms/behaviors; physical symptoms; treatment explanation and administrative arrangements for treatment) and 'social adjustment' (social life; self care; finance; accommodation; inter-personal relationships; psycho-social history and 'other'), the differences between the two groups of workers and the way in which they related to clients in different clinical categories were clearly seen. Fifty-nine per cent of CPNs' and 28% of SSWs' utterances fell into the 'medical' type; 32% of CPNs' and 62% of SSWs' utterances fell into the 'social adjustment' type.

Compared to their non-schizophrenic clients, CPNs were slightly more likely to discuss 'medical' topics (63% and 67% respectively) with their 'schizophrenic' clients, SSWs were less likely to discuss 'medical' topics (46% and 26% respectively). Thus, the difference in emphasis between the two groups of workers (CPNs tended to discuss 'medical' topics, whilst SSWs tended to discuss 'social adjustment' topics), became more extreme in respect of their interactions with clients with 'schizophrenia'. The mean number of CPNs' utterances with each 'schizophrenic' client was 31.4, and with each other client was 62.9. Equivalent utterances for SSWs' individual clients were

68.6 for those with 'schizophrenia' and 70.6 for others.

8.3.10 Specific activities and techniques

TABLE 53

Clients in Receipt of Specified Activities
Percentages*

Activities	CPN	SSW
Counselling/Other		
Verbal Therapy	22	72
Clinical Investigation	3	-
Medication Change	2	4
Drug Administration	46	-
Transport Provision	2	6
Behaviour Therapy	3	-
Practical Assistance/ Personal Services	7	21
Other	4	6
N	280	75

*These categories were not mutually exclusive therefore percentages do not add up to 100.

After each interaction, workers and researcher agreed upon whether any of the above activities had taken place or not. The breakdown in Table 53 illustrates the differences between the two groups (P<001). It can be seen that the active therapeutic technique mostly employed by the CPNs was the administration of medication and that of the SSWs was counselling. The CPNs undertook 'counselling' in 22% of their contacts; the social workers gave 'practical assistance' or undertook some personal service in 21% of theirs.

The definitions of various types of 'verbal therapeutic' techniques are many and varied, and, in order to avoid confusion, no attempt was made to define 'counselling' precisely. A record that 'counselling' had taken place was made if any kind of verbal therapy had taken place, and the recording method did not incorporate any qualitative measures.

The clear differences shown above, were even more marked for clients suffering from 'schizophrenia'. Drug administration, as would be expected, figured highly - for 80% of these CPN client contacts. Significanly fewer 'schizophrenic' clients were counselled - 9% v 37% (P<.001). Fifty-five per cent of social workers' 'schizophrenic' clients received verbal therapy but this was significantly lower than for their other clients (P<.025).

The data in Table 33 showed whether or not a particular activity had taken place. In addition, after each contact, agreement between worker and researcher was reached concerning the extent to which various techniques had been used.

Figure XIV, below, illustrates the differences in emphases of the two groups of workers, according to the clinical category of the clients. In respect of 'non-schizophrenic' clients, social workers were more likely than CPNs to examine clients' relationships, undertake some service or task, and offer support, reassurance and encouragement. CPNs were more likely to show disapproval, adopt a directive approach, undertake physical or behavioural treatments and to allow or encourage ventilation of

emotions.

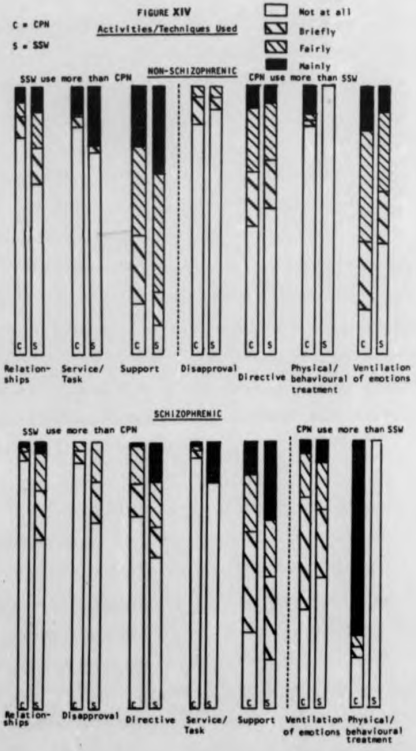


FIGURE XIV
Activities/Techniques Used
C = CPN
S = SSW
Not at all
Briefly
Fairly
Mainly
NON-SCHIZOPHRENIC
SSW use more than CPN
CPN use more than SSW
C S
Relation-ships
Service/ Task
Support
Disapproval
Directive
Physical/ behavioural treatment
Ventilation of emotions
SCHIZOPHRENIC
SSW use more than CPN
CPN use more than SSW
C S
Relation-ships
Disapproval
Directive
Service/ Task
Support
Ventilation of emotions
Physical/ behavioural treatment

The picture changes when the techniques followed in respect of 'schizophrenic' clients are illustrated. It can be seen that even though other activities took place, the main techniques used by CPNs was the administration of physical treatments. They were also more likely than SSNs to allow or encourage ventilation of emotions.

As SSNs did not give any physical or behavioural treatments, it was inevitable that they used other techniques more extensively than the nurses. However, the wide range of 'main' techniques used by SSNs contrasted with the CPNs' who 'mainly' used physical treatment methods in over 70% of their contacts with this client group. The SSNs' 'main' use of various techniques did not differ between their 'schizophrenic' and 'non-schizophrenic' clients, whereas there was a statistically significant difference in the 'main' techniques used by CPNs in their interventions with 'schizophrenic' and 'non-schizophrenic' clients.

The CPNs' emphasis upon the administration of medication in their interactions with their 'schizophrenic' clients confirmed the observer's subjective impression of shortcomings in CPNs arrangements for the long-term care for these clients and their families. The observer noted that in the 'injection clinics', questions about symptoms, were often made using the language and tone associated with an ordinary social enquiry. A tendency to avoid upsetting clients and to re-assure them, rather than acknowledging and discussing strategies for dealing with problems, was also observed. The presence of 'active' symptoms at the time of PSE interview, confirmed that either the CPNs were

unaware that their clients were experiencing symptoms, or if they were aware of them, they had decided that medical intervention was inappropriate.

The CPNs' greater use of 'ventilation of emotions' and 'behavioural treatments' in their interactions with 'non-schizophrenic' clients also confirmed the observer's impression that CPNs tended to adopt a re-active counselling stance by showing some reluctance to discuss their clients' emotional/relationship difficulties in depth and by their use of intuitive counselling approaches. In contrast, the SSWs were observed to use structured methods to help their clients to clarify their problems and to work out strategies for dealing with them.

8.3.ii Workers' perceptions of outcomes

In answer to the question "what did you achieve or learn from this contact?", both groups of workers tended to summarise what they had learned rather than what they had achieved. For example, even when some activities (such as drug administration or provision of advice), had actually been observed by the researcher, these were not, on the whole, mentioned as achievements, and the researcher found herself 'prompting' achievements. The data presented in Table 54 are therefore limited to an analysis of perceptions, that is, what the workers said they had learned.

TABLE 54

Perceptions of outcome
Percentages of Client Contacts*

Topics	CPN	SSW
Psychiatric Treatment	16	17
Psychiatric Symptoms/ Behaviours	58	40
Physical Symptoms	11	7
Clients' Relationships	15	36
Treatment Administrative Information	5	8
Life-Style/Coping	11	17
Social Contacts	5	13
Welfare	3	11
Professional Relationships	5	7
Psycho-social History	4	4
Other	2	7
N Interactions Recorded	280	74

* Up to 4 perceptions were recorded therefore percentages do not add up to 100.

CPNs said they learned a mean of 1.3 things after each contact, whereas SSWs learned a mean of 1.7. CPNs and SSWs learned similar amounts about psycho-social histories, even though the CPNs had more new clients. CPNs learned more than SSWs about psychiatric and physical symptoms; SSWs learned more about every other topic than CPNs. The differences between the two groups was statistically significant (P<001).

The relationships between purposes and outcome are examined in Table 55 below. It can be seen that, with the exception of 'support', where SSWs' purposes and achievements co-incided exactly, and 'other' (each of which was general 'assessment', the results of which were presumably specified under topic headings), both groups of workers learned much more than they set out to achieve about every topic. Overall, both learned three times more things than they cited under 'purposes' although this proportion varied according to topic. The proportion of actual learning to purpose was highest for CPNs in the 'life-style' topic, followed by 'relationships' and 'treatment administrative information'. Proportionate to purpose, SSWs learned most about 'physical symptoms' and 'relationships', even though the latter was the second most frequent specific topic mentioned as a purpose.

TABLE 55

Purposes and outcomes of contacts - learning

Percentages of Client Contacts*

Topic	CPN		SSW	
	P	O	P	O
Treatment	4	20	4	28
Symptoms/Behaviour	26	50	12	32
Physical symptoms	3	12	1	7
Inter-personal relationships	2	16	9	42
Administrative information	1	7	3	15
Life style/coping	-	12	7	19
Social life/networks	-	5	1	16
Welfare	-	4	7	27
Professional relationships	-	6	3	18
Psycho-social history	-	4	-	4
Support/encouragement	-	-	4	4
Other	7	2	19	3
Total Contacts	282	280	75	74
Mean per contact	0.5	1.5	0.7	2.3

8.3.17 Steps to be Taken Immediately after Contact

TABLE 56

Next Steps Involving Others

Percentages of Client Contacts*

Agencies/Staff	Close & Refer On CPN	SSW	Consult/ Involve CPN	SSW	Inform CPN	SSW
Psychiatric Health	2	-	15	20	4	4
Social Services Dept. (Mental Health)	-	-	-	3	-	-
Primary Care & Other Health	1	-	4	-	2	-
Social Services Dept. (None Mental Health)	1	1	1	3	-	-
Other Local Authority Depts.	-	-	-	4	-	-
Financial Agency	-	-	-	4	-	-
Voluntary Agency	-	1	1	3	-	4
None Professional	-	-	1	4	-	-
Other	-	-	-	4	-	-
Total	4	3	23	45	7	5

N Clients CPN 280; SSW 78

* Up to 4 'next steps' were coded, therefore percentages do not add up to 100.

As Table 56 shows, SSWs were more likely to consult/involve others in the care of their clients (P<001). They also intended to consult widely outside the health service. CPNs not only intended to consult health service personnel when they did consult, they also intended mainly to consult doctors (psychiatrists in 72% of all consultations with specialist psychiatric services, and GPs in 78% of primary care staff consultations) rather than other workers: this was not true of

the social workers.

Workers expected to take further steps themselves following 88% of CPN and 96% of SSW contacts. Table 57 outlines the actions specified.

TABLE 57

Workers' Own 'Next Steps'
Percentages of Client Contacts*

Anticipated Action	CPN	SSW
Non-specific	3	7
Support/Maintain	10	16
Further Assessment/Observation	16	16
Give Physical/Behavioural Treatment	36	-
Check on 'Compliance'	2	5
Do a Task	11	12
Give Verbal Therapy	5	27
Close Case (Without passing on)	2	9
Other	2	2
N	280	71

Mean number of 'next steps' per client CPNs 0.88; SSWs 0.91.

* Up to 4 'next steps' were coded therefore percentages do not add up to 100.

The wider range of options intended to be used by social workers was again evident as was the CPNs' association with 'administration of medication', and the SSWs' association with 'verbal therapy'.

8.3.17 Overall Objectives

At the end of each observation, and following their considerations of the 'next steps' they would take, the workers were asked to give their overall objectives for each client. An analysis of their replies appears below in Table 38.

The two groups of workers stated remarkably similar objectives in regard to 'cure' (i.e. relief of symptoms), and 'services'. The CPNs' tendency to see objectives in terms of 'maintenance' rather than 'change' contrasted sharply ($P<.001$) with the SSWs whose main objectives were to effect 'change' in day to day coping, client/family coping strategies and inter-personal relationships.

Compared to their objectives for their other clients, for those with 'schizophrenia', CPNs were less likely ($P<.025$) to cite 'cure' (21% v 8% respectively), and 'change' (22% v 10%; $P<.025$). They were more likely ($P<.001$) to cite 'maintain' (13% v 39%) and to express objectives in terms of services (26% v 53%). There were no statistically significant differences in the Specialist social workers' objectives for their 'schizophrenic' and non-schizophrenic clients.

TABLE 58

Overall Objectives

Percentages of Client Contacts*

Overall Objectives		CPN		SSW
Cure				
Prevent Symptoms		14		14
Change				
Client/Family Coping Strategies	6		15	
Life Style/Daily coping	6		18	
Inter personal Relationships	2		15	
Other	1		10	
Total		16		59
Maintain				
Functioning	24		6	
Support Relatives/Carers	1		-	
Total		26		6
Monitor/Observe				
Symptoms/Behaviours	3		-	
Clients' Problems	2		9	
Other	1		1	
Total		6		10
Services				
Independence & Autonomy	7		14	
Prevention of I/P Care	21		19	
Maintain Treatment	4		3	
Other	8		5	
Total		40		41

N = CPN 279; SSW 78

* Up to 4 Overall Objectives for each client were coded, therefore percentages do not add up to 100.

8.4 WORK WITH GROUPS

CPNs worked with groups more than the SSWs. In conjunction with the local Schizophrenia Fellowship Group one social worker had organised a 'drop-in' club which met for one afternoon each week. During the course of the study another social worker, working with the CPNs attached to the local health centre, finalised arrangements to open a 'drop-in' club which also met for one afternoon each week. Two SSWs (one of whom, already mentioned, had organised a 'drop-in' club) also participated in weekly 'ward group' meetings at which ward staff and patients discussed issues which caused concern in the day-to-day management of the ward, as well as specific problems patients had that they wished to discuss with the group. No other SSW work with groups took place during the study.

In contrast, all but one CPN took part in a group activity although not all of them met during the weekly period of observation. CPNs who worked together at health centres usually shared the tasks of organising and running the groups. Three CPNs jointly ran a weekly relaxation group which took place at one hospital. This group varied in size, but generally, approximately 12 people, many of whom had been referred to the CPNs by a general practitioner, met and performed relaxation exercises generated from a tape. The exercises were followed by a cup of tea and some socialising. One CPN, in conjunction

with a psychiatric hospital pharmacist, ran a weekly group in a GP's office, which aimed to help patients who wished to reduce their dependence upon psychotropic drugs. This group meeting (observed by the researcher) was attended by two members who were advised about possible physical effects of withdrawal, and encouraged to adhere to a personal jointly negotiated withdrawal programme. Both members were successfully following their drug reduction programmes.

Nurses at two health centres each ran small social groups (involving a maximum of around 10 members), which were attended by variously mentally disabled members. The prime aim of these groups was to provide social contact in a sheltered environment. Membership of these groups was largely static and although members sometimes went on various 'outings' together there was no evidence of any attempt to integrate members into ordinary social activity, to improve social skills by using role play or other therapeutic techniques, or to link with any local voluntary groups. Indeed, one of these groups took place in an area which had a local weekly 'drop-in' group, but there appeared to be no liaison concerning the operation of these two groups between the staff involved: neither were any CPN clients seen during the study period informed of the existence of the 'drop-in' club. As mentioned earlier, CPNs from one health centre were involved with an SSN in organising and attending a new 'drop-in' group. Two CPNs working from another health centre organised and facilitated a 'relatives' support' group which allowed relatives of elderly dementing clients to ventilate their emotions and give each other support through sharing their experiences. There was no fixed

pattern to the various groups, each being a response to demand felt by each group of CPNs, and premises were acquired on an ad hoc basis. There was also great variability in the amount of skilled professional input given.

8.5 WORKERS' STAFF CONTACTS

Table 59 shows the pattern of staff contacts at 'formal' (i.e. pre-arranged) meetings, which took place during each observation period. Once again, the differing emphases of primary care links for CPNs and specialist service links for the SSWs were evident, although overall, both groups of workers attended similar proportions of meetings. Although one of the 6 primary care meetings was not timed, those that were, took much less time (a mean of 39 minutes) than the 'ward rounds' (a mean of 163 minutes for SSWs; 96 minutes CPNs).

TABLE 59

Workers' 'Clinical' Meetings with Other Staff
Mean per Worker

Worker(s)	CPN	SSW
Psychiatrist Only	0.3	-
Psychiatrist & Others	0.1	0.3
Primary Care	0.6	-
Ward Round	0.4	1.2
Other	0.7	0.8
Total	2.1	2.3
N meetings	22	14

Table 60 gives details of the less formal contacts which took place over the observation period, but which nevertheless formed an integral part of an overall work pattern. These data do not include the usual social contacts which occured but represent people with whom workers consulted and discussed issues relating to their work. They do not include persons/agencies contacted by letter - an activity in which the social workers were frequently involved.

TABLE 60

Staff Contacts outside Formal Meetings/Ward Rounds
Mean per Worker

Staff	CPN	SSW
Psychiatrist	1.8	1.0
CPN	0.9	0.7
Social Work	0.9	1.7
Other Mental Health	1.2	5.7
Primary Care	1.8	0.5
Administrative	2.2	2.7
Other	1.0	4.5
Total	9.8	18.7
N Contacts	98	112

CPNs contacted psychiatrists and primary care staff, both informally and in meetings, more or less equally; they had limited contacts outside the health service. The SSWs' contacts were mainly with members of the specialist psychiatric team and persons/agencies outside the health service. Within the specialist team, CPNs tended to contact psychiatrists only, whereas the social workers had extensive contacts with other team members also. Both groups of workers contacted administrative staff relatively frequently, a point which emphasises the role played by clerical staff in co-ordinating and effecting service delivery arrangements. Overall, Specialist social workers had twice as many contacts with other staff than the CPNs.

8.6 OBSERVATIONS - SUMMARY AND DISCUSSION

8.6.1 Organization of Work

Apart from the major difference in location - primary care and a community base for the CPNs and hospital bases for the SSWs, other differences emerged in the ways the two groups of workers were managed and organised their work. There was little or no 'clinical' supervision or support of the CPNs' work from within their own profession, nor was there any 'caseload supervision'. There appeared to be little structure in the nurses' methods of recording their work. The lack of a 'duty' system and of a systematic referral procedure were associated with the practice of calling on clients without prior arrangement.

Various explanations were given for this latter practice (for example, "You can't make appointments to see people because you don't know how long each person will take." "You don't know what will crop up and it's better not to make appointments than to break them." "You often want to go round without warning anyway just to see what they're up to."). When asked why they thought the social workers made appointments, a typical reply was "because they only discuss things like finance and it's easier to know how much time you need for things like that".

These responses could be interpreted in several ways - the first, that CPNs did not feel that their interventions with clients should or could be sufficiently structured to enable them to keep to a timetable; the second, that the CPNs' conception of social

workers' work with clients did not include a 'casework' element; a third, that CPNs just hadn't thought of a solution to the problem; a fourth that CPNs did not see the practice as a problem at all - a manifestation of a perspective prevalent in the health service that staff time is valued more highly than patients' time, and/or that priority is given to acute or urgent cases.

In contrast, the SSWs' work was more structured and incorporated supervision of work with clients and caseload management from social work team leaders. This supervision demanded or encouraged detailed compilation of case files. The SSWs channelled emergency/casual referrals through a 'duty' system. They structured their work so that they and their clients almost always made and kept specific appointments. This is a likely manifestation of a social services perspective which is rooted in valuing 'casework' with individual clients more highly than valuing being able to respond to 'emergencies'.

The CPNs' ability to respond to urgent calls on an individual basis is highly valued by G.P.s (DHSS 1978), landladies (Hunter op cit.) and presumably by clients and families who are likely to prefer a familiar worker to an unfamiliar one in the event of a crisis. In order to achieve this level of immediate response, the making and keeping of non-urgent appointments took second place. The SSWs' administrative arrangements were such that they gave priority to making and keeping routine appointments with clients, as a consequence of which urgent or casual requests for assistance were met on a team basis rather than on an individual basis.

This difference in emphasis upon and response to 'urgent' and 'non-urgent' cases, has been identified as one of the main factors which inhibits the development of teamwork between GPs and social workers in primary care settings (DHSS 1978). The data presented here indicate that similar differences in perspective existed between social workers and community psychiatric nurses.

8.4.2 Intra-professional supervision/support

This study was not concerned to investigate the process of supervision within either profession, and, because the discussion which follows concentrates upon provision of supervision for nurses, it should not be assumed that the supervision received by social workers was beyond reproach. The point being made is that the casework model of social work, based on psychotherapeutic principles, demands that support/supervision is made available to individual workers. There appears to be no such tradition within psychiatric nursing, where supervision of work has, in the past, been based upon 'discipline' (Harries 1976). When the performance of nursing tasks is based upon 'procedures', the need for 'discipline' as opposed to 'enabling support' might be argued. If, however, nurses are expected to make judgements and implement therapeutic change, their main need is for 'enabling support' (Menzies 1960).

The CPNs in Salford moved to primary care and community bases in 1979. They had clearly been placed in a position which implied that they were expected to make judgements. Their managers had

not, however, implemented changes in the style of supervision to complement this expectation. In spite of the CPNA's (1983) well argued case for the kind of supervision which contributes towards staff development, there is evidence that, thus far, such supervision systems have not developed to any appreciable extent anywhere(Skidmore & Friend op cit.). Differences in arrangements for 'clinical' and 'caseload' supervision between CPNs and Specialist social workers in Salford are, therefore, likely to be found in other districts.

It is postulated that one of the factors contributing to the slow development of supportive supervision for CPNs is that there are only limited opportunities available for nursing officers to develop these supervision skills because:

a. Many nursing officers have not yet had the opportunity to acquire the basic counselling/assessment/judgmental skills they are supposed to advise upon;

b. The shift of emphasis from 'discipline' to 'support and development' inherent in the implementation from such a system requires the kind of management training which has traditionally not been available within the nursing profession.

It must be concluded, therefore, that any large scale training initiatives will need, at least initially, to incorporate trainers from outside the nursing profession. There is also the wider question of whether all nursing supervision, whether on wards or in community settings, should shift its locus from

'discipline' to 'support and development'.

8.6.3 Teamwork

It was likely that the different physical bases of the two groups of workers affected the professional networks of each. The primary care bases of the CPNs inevitably improved the possibilities of communication between them and members of the primary care team. They did indeed have more extensive links with primary care workers (mostly GPs) than the SSWs. However, it may have been that this improvement was achieved at the expense of communications with members of the specialist psychiatric team.

Although some contact with psychiatrists was maintained, data on referral sources, contact networks, place of contact, next steps and formal and informal staff meetings, all indicated that, in the case of CPNs, contacts with members of the specialist psychiatric team other than psychiatrists were much more limited than those of the SSWs. This lack of contact was disturbing because it reduced the capacity of the CPNs to contribute to the care/treatment/management of their clients when they had spells of in-patient care. During the period of the study only one CPN was observed to contribute significantly to the 'care plans' discussed at 'ward rounds'. Thus continuity of care and consistent treatment plans were virtually impossible to achieve, and most CPNs had no involvement whatsoever in their clients' in-patient care and treatment. Indeed, the CPNs were heard to complain that they sometimes did not even know that their clients

had been admitted or discharged.

The more extensive primary care links of the CPNs did not offset their tendency to work more in isolation than the SSWs. Although the mean number of formal 'clinical' staff meetings was similar for both groups of workers, the amount of time spent in these meetings was significantly less for CPNs - mainly due to the relative brevity of the primary care 'clinical' staff meetings.

In relation to all other parameters which indicated the amount of contact with other staff, (persons present at contact, contact networks, next steps, and informal staff contacts) CPNs were significantly more likely than SSWs to work alone. That this tendency was also accompanied by lack of formal clinical support/supervision from within their own profession leads to the conclusion that the CPNs worked in an isolated and therefore unsupported position. This mitigated against the development of their existing skills and against the acquisition of new skills and perspectives. There seems little doubt that the move from being consultant-attached to being GP-attached, increased the CPNs' isolation.

The specialist social workers were very much part of the specialist psychiatric team, contributed to in-patient 'care plans' and continued the 'plans' on patients' discharge. In spite of the close relationship with hospital based staff, their contacts with professionals outside the health service were extensive. In contrast, their relationships with GPs and other primary care workers were poor.

One reason for this might have been the SSWs' involvement with 'acute' psychiatric care as distinct from involvement in long-term psychiatric care. Whilst GPs' patients receive care from specialists, it is quite usual for communications between the two to be restricted to referral and discharge letters. Close personal contact between specialist and primary care workers would therefore be unusual. There would also be logistical difficulties if 6 specialist workers were expected to liaise with all GP practices. There was, however, little evidence that there were extensive personal contacts between Patch team workers (who would be more likely than the specialist workers to be involved in long-term psychiatric care) and primary care team workers.

Although individual studies have shown that social workers and GPs can co-operate successfully (for example, Goldberg & Neill 1972), there is a considerable literature which demonstrates the many conflicts which exist between the two professional groups (DHSS 1978; England 1979; Huntington 1981). It is therefore considered likely that the lack of contact between Specialist social workers and GPs was, at least to some extent, due to differences of perspective and organization. That the SSWs in Salford had largely overcome these differences with psychiatrists may have been due to the unique history of co-operative working in Salford, and may thus limit the extent to which these conditions apply in other areas.

Challis & Farlie (op. cit.), however, found that many of the

social services departments they surveyed had specialist hospital- based teams, although the extent to which social workers and psychiatrists worked in collaboration rather than conflict is not known. It may well be that because psychiatrists may be more aware than GPs of the relevance of non-medical models of care, and specialist mental health social workers may be more aware than their other colleagues of the relevance of medical models of care, that the two groups of workers have learned that they can co-operate successfully.

A report of a Salford project which aimed to design and implement a mechanism for multi-disciplinary generation of care plans and reviews of people with long-term mental health problems has highlighted the fact that there was little co-ordination between the various members of particular professional groups (Whitehead 1981). The National Schizophrenia Fellowship has been instrumental in drawing attention to the lack of co-ordination or consultation between patients, relatives and professionals (Priestly 1979). There can be little doubt that:

a. The needs of long-term clients and their supporters are complex and likely to change over time;

b. That the co-ordination of services - that is, collaboration and teamwork between professionals and clients - is the only way in which these complex and changing demands can be optimally met.

9.4.4 Differences in skills/techniques and perspectives

Perhaps the most striking difference between the two groups of workers was the mean number individual client contacts which took place within one week (28 for CPNs; 13 for SSWs). Even though this was partially accounted for by a high proportion of very short contacts made with clients suffering from 'schizophrenia', CPNs spent a greater amount of time each week in individual client contact. They also spent more time in client groups. SSWs on the other hand, spent more time than CPNs in contact with clients at 'ward rounds' where individual in-patients were interviewed and plans for their 'treatment' were discussed by a multi-disciplinary specialist team.

Teamwork demands time as well as commitment, and it is perhaps a further indication of the CPNs' 'health' perspective and SSWs' 'social service' perspective that the nurses opted for single-handed direct client contact rather than the time-consuming collaborative approach favoured by the social workers.

Seventeen per cent of SSW clients refused the researcher permission to observe and record the contents of worker/client interactions, and the SSW sample size was reduced to 61. Eight of these refusals involved four patients (2 of whom were seen three times) who were extremely disturbed at the time of contact and it can not be known how far the exclusion of these interactions affected the overall picture. Neither is it known how far the presence of the researcher affected the interactions

observed. Notwithstanding these limitations, the differences found between the CPNs' and SSWs' interactions with individual clients were consistent with differences found in other variables.

Striking differences in the use of skills emerged. The CPNs' capacity to give injections was one obvious difference, another, perhaps less expected difference in view of the fact that CPNs are espousing a widening role in the care of psychiatric patients, was the CPNs' comparative lack of use of counselling/verbal therapy skills. The definition of the various ranges and levels of 'verbal therapy' is a tortuous process, and for this reason no attempt to delineate particular methods was made. However, it was possible to reach worker/observer agreement as to whether verbal therapy of any kind had taken place and the social workers used this technique extensively - in 72% of all their contacts, whereas CPNs 'counselled' less than one quarter of their clients.

Another major difference between the nurses and social workers was their management/care of clients with symptoms of anxiety. Although little use was made of formal behaviour therapy programmes by the nurses during the study period, advice was given about methods of coping with these symptoms/behaviours. Clients were invited to attend relaxation groups set up by the nurses themselves, they were advised to use relaxation tapes and were encouraged in their efforts to overcome their symptoms. SSWs were never observed to give this kind of information or advice.

Another difference, which was not clearly demonstrated by the data presented, was the amount of time SSWs spent mobilising other services for their clients. This activity was to some extent indicated in the data showing staff contacts outside formal meetings in which the social workers were more than twice as likely as CPNs to be engaged. There was, however, a considerable amount of activity (not measured by this study) in which contacts were made by letter with such outside agencies as DHSS, Housing Departments and organisations providing hostel accommodation. Another example of 'resource mobilisation' was a one-day Welfare Rights Conference which the members of the psychiatric social work department were organising to raise the awareness of 'welfare' issues in all disciplines within the hospital as a response to their (the social workers') concern that patients were not always receiving sufficient or correct information concerning payment of benefits whilst in in-patient care.

Data on workers' purposes, contact networks, interactions, activities, techniques, perceptions and next steps, all indicated that the CPNs and SSWs employed different skills and perspectives in their work. The CPNs related mainly to doctors (psychiatrists and general practitioners), and discussed mainly 'medical' topics such as symptoms, medication, treatment arrangements. 'Counselling' and 'verbal therapies' were used in less than one quarter of contacts.

In contrast SSWs, although they also discussed symptoms and

treatment arrangements, engaged in such wider ranging discussions with their clients. They were concerned with family relationships, various 'welfare' issues such as finance and housing, and clearly applied their social science knowledge base to their work. That their perspective was that of the client functioning in the context of ordinary community, rather than within medical networks, was emphasised by the fact that even though the social workers were hospital-based, the data (contact networks, interaction content, informal staff contacts and next steps) indicated considerable involvement with non-medical networks. This compared with the CPNs' two main areas of contact - specialist psychiatric services and primary care service staff, which were not only both in the medical/health context, but related specifically to doctors.

There were indications that underpinning the differences in the kinds of help/care given by the two groups of workers was a difference with regard to their adoption of a re-active or pro-active therapeutic stance. There was a marked measure of agreement between CPNs and SSWs concerning overall objectives for relief of symptoms and independence from service. There were significant differences in their objectives for 'maintenance' and 'change'. SSWs were over three times more likely than CPNs to see 'change' as an overall objective. The greater proportion of CPN clients in the 'psychosis' clinical group did not wholly account for this difference. Although 71% of the SSWs' clients for whom 'maintenance' was the overall objective were in the 'psychosis' group, this objective applied to only 18% of their total 'psychotic' clients. In contrast 'maintenance' was the

declared objective for 43% of CPNs' psychotic clients.

It may have been that the nurses' orientation towards 'maintenance' and the SSWs' orientation towards 'change' reflected their clients' needs. This supposition was supported by the fact that CPNs received referrals direct from GPs, and were involved in the long-term care of psychotic clients, whereas the SSWs were actively involved in 'acute' psychiatric care. However, the results of the PSE interviews did not support this supposition and equal proportions (72%) of CPN and SSW clients were found to have symptoms above the sub-clinical level. Even if the researcher, as a non-clinician, had reported higher levels of symptomatology than a psychiatrist (Copeland et al. op. cit.), that would not have accounted for the fact that no statistically significant difference in the range of the two groups' clients' symptoms was found.

8.6.3 Care of clients with 'schizophrenic' illnesses

Evidence suggested that the CPNs had different perspectives on and expectations of 'schizophrenic' and 'non-schizophrenic' clients, and the care given to the former group had more 'medical model' content than was incorporated into care given to clients in other clinical categories. Continuity of medication has been identified as a major factor in the prevention of 'relapse' in clients suffering from schizophrenia, and the value of the CPNs' contribution in continuing care and support of these clients cannot be over estimated. They also encouraged clients to attend for medical review, and as recent work in Salford has found, a

substantial minority of clients do not receive a medical review if they do not attend an out-patient clinic (Whitehead 1987). Further, both their health centre base and their personal relationships with their clients combined to make the nurses much more 'approachable' than psychiatrists if clients or their relatives needed advice.

However, 60% of the contacts with 'schizophrenic' clients took place at 'injection clinics' held mainly in health centres, and contact times were very short indeed. Although 22% of all CPN clients received some kind of counselling, only 9% of psychotic clients or their families were given any verbal therapy. It could be argued, and indeed was by most CPNs, that this was a response to client needs and that most clients were stable and well settled in the community. The extent to which this may have been so will be discussed later, but it is suggested that the CPNs, for a variety of reasons, were unlikely to have been aware of the full extent of all their psychotic clients' needs .

Observation suggested to the researcher that the practice of administering medication, (often without a home visit for many years) at health centre 'injection clinics' was not conducive to a proper assessment and discussion of clients' mental states, social functioning or welfare needs. The nurses explained that the rationale behind such a method of 'treatment' was that by attending the clinic clients showed that they were taking responsibility for their own health just like 'normal' patients. It was also considered to be an 'efficient' method of 'treating a large number of people. A further view was that some clients

didn't want a home visit and that to insist upon one would amount to unjustifiable interference.

In the opinion of the researcher clinic contact times were often too short to allow nurses time to assess all but the most severe psychiatric symptoms. She observed that the nurses often used the language and tone of a purely social rather than clinical enquiry, and did not, in her opinion, encourage clients to discuss any difficulties they may have had, thus limiting the nurses' abilities to recognise signs of the presence of psychotic symptoms, social/family dysfunction, and the extent to which various 'welfare' benefits may be required. The fact that PSE results showed that many clients had active symptoms should not be overlooked either, as it underlines the need for regular and detailed medical review. The researcher's PSE interviewing experience has convinced her that specific questioning is likely to be a necessary 'assessment' technique if the full range of clients' symptoms are to be discovered. She encountered no clients who thought the questions intrusive - rather, they appeared to be glad to be able to discuss their difficulties with someone.

The study data showed that when CPNs gave injections, this tended to be the main activity undertaken, and other accounts of CPN activities have reached similar conclusions. Hunter (op. cit.) found that patients and relatives expressed disappointment that the administration of injections was associated with the 'stopping of conversation' with the CPN. Sladden (op. cit.) found that clinic contact times were seven times shorter than

community visit times, and concluded that the range of information which nurses could derive solely from contacts at the clinic was very restricted. She also gained the impression that although nurses showed that they could identify relationship difficulties within families, they did not apparently know how to deal with them, and mobilised various defence mechanisms to escape from the problems.

The influence of family life on the course of schizophrenia (Brown et al. 1962 & 1972) and the evidence of the burdens on families caring for a psychotic member (Grad & Sainsbury 1968; Creer & Wing 1974) are also well known, and there can be no doubt of the need for therapeutic counselling and for practical help for families, as well as for clients themselves.

Apart from psychiatrists, the CPNs were the only other specialist workers who undertook long-term responsibility for the care of this group of clients and CPNs' contribution was primarily to ensure the maintenance of regular medication. The conclusion that there remained considerable unmet needs for other kinds of specialist help cannot be escaped. Specialist social workers were observed to provide much of that help, though their numbers were limited, and the policy of the Social Services Department was that care should be transferred to Patch teams when 'acute' symptoms subsided. The contribution made to the long-term care of these clients by Patch team workers was not investigated in detail, but other evidence suggests that mental health problems do not have a high priority in generic social work departments (Neill et al. 1974; Little & Burkitt op. cit.; Rowlings 1979).

The case register data given in Chapter 5 also confirm that the long-term mental health care given in patch teams was limited, and was largely confined to elderly clients.

Analyses of work undertaken as part of a family intervention study in Salford (Tarrier 1987) confirms that CPNs' main contribution to the care of these clients is to ensure maintenance of medication. It also confirms that Specialist social workers work intensively with patients and their families after discharge from in-patient care - but that this intensive follow-up is given to only a proportion of all in-patients.

The intensive work of the type undertaken in the family intervention project was not routinely undertaken by service personnel. The results obtained by Tarrier and Barraclough (1987) indicate that further training in these methods is required if the benefits of this kind of intervention are to be fully realised. Specialist social workers would appear to be likely candidates for this kind of training, but there is no possibility that further social work support for these clients and their families will be available unless staffing levels are increased. The final report of the Salford Schizophrenia Care Co-ordination Project (Whitehead op. cit.) also confirms that the more detailed assessment of 'needs' carried out under the auspices of the Project has revealed a requirement for more specialist social work input which cannot be met if staffing levels do not increase. When clients have long-term difficulties, it is all too easy for staff as well as clients and their families, to settle into a routine which maintains a status

quo. The researcher felt strongly that there should be a more positive approach to the care of these clients and their families, so that optimum levels of functioning are promoted and maintained.

The discussion thus far has concentrated upon unmet needs for the long-term care of people in the 'schizophrenia' clinical category. Case register data analysed for the Salford Mental Illness Planning Team showed that people in the schizophrenia clinical category accounted for only half the number of 'chronic' service users aged between 15 and 64 identified over a 9 year period. If the assumption is made that all long-term service users have a variety of unmet needs, then the implications for the mental health services are such that urgent attention must be paid to the development of systems which co-ordinate care over many years.

8.6.6 Support to primary care

The CPNs were observed to work in a primary care setting rather than a hospital setting - one quarter of the interactions observed involved clients referred directly to the nurse by a GP. The Specialist social workers rarely related to primary care workers and did not receive referrals directly from GPs.

It is not known what the GP referral criteria were, but there is evidence to suggest that for many of the patients identified by GPs as suffering from 'minor psychiatric disorders', psychotherapy would be likely to be their 'treatment' of choice (Shepherd et al. 1966). Goldberg and Huxley (op. cit.) cited psychological help, drug therapy and environmental modification as the three principal modes of treatment open to primary care physicians and recalled the views of the World Health Organization (1961) which noted certain general needs such as 'a tolerant attitude, dependability, continuity, and interest....and attention to the needs of close relatives of the patient'.

CPNs undoubtedly gave such psychological help - they were observed to 'listen with understanding and consideration to the patient's difficulties, and to dispense sympathetic explanations, reassurance, advice and support' - a description of 'simple psychotherapy' put forward by a Working Party of the College of General Practitioners (1958). They monitored drug therapy and organised relaxation groups, but were not observed to become much involved in the exploration of the needs of relatives, or in environmental modification.

The CPNs could thus be thought to be appropriately involved in the therapeutic care required by many GPs' patients. However, it is important to ascertain the criteria operated by GPs for referral for CPN care. Goldberg and Blackwell (1970) found that GPs needed special training to improve their 'case-finding' techniques, and the crucial 'filtering' role played by GPs by virtue of their virtual monopoly on referral for specialist psychiatric care, was discussed by Goldberg and Huxley (op. cit.). It therefore appears likely that GPs may refer, at least some, patients to CPNs in the expectation that the nurses will assist them in the performance of their 'filtering' role.

The nurses' probable greater experience of people who have mental illnesses may be thought to equip them to undertake this 'filtering' role. The researcher has reservations. The present study found no evidence to suggest that nurses had received adequate training in the assessment of mental dysfunction. In their traditional ward bases, nurses have little need to develop the kinds of assessment skills required by professionals whose responsibilities encompass a 'filtering' role. It may be that due to their great experience of mental illness and its manifestations, that some nurses have developed sufficient skills to enable them to carry out a 'filtering' role with more 'success' than GPs. That, in the opinion of the researcher, is not sufficient to justify such a practice continuing in an uncontrolled way.

Haphazardly developed individual competence is no substitute for

a legitimized professional competence. Service development should not be dependent upon 'the luck of the draw'. More research is required to investigate GP direct referral criteria, and to establish whether psychiatric nurses' professional training equips them to adequately perform a 'filtering' role. These arguments have a wider relevance currently, as the proposals made in the Cumberlege Report (1986) are being debated.

Medical officers of health have been aware of the correlation between social conditions and health status since the mid-19th century. More recently there have been two reports of major studies which remind us that forty years after the inauguration of the national health service the correlation remains (Whitehead 1987; Black 1980). That psychiatric symptoms and social dysfunction are inextricably entwined is even more widely recognised than the general health/societal correlation, and the lack of contact between primary care and specialist social workers found in this study was disturbing. Low Specialist social work staffing levels could be identified as a cause of this lack of contact, but conflicting social work/medical perspectives were also likely to have been implicated.

The researcher suggests that the ways in which these conflicts have been resolved in the past, have fallen into two main categories. One solution frequently adopted has been 'avoidance'. Social workers and doctors avoid each other (Wanner Report op. cit.). They do not generally work on a day-to-day basis together, and they operate within separate administrative structures.

A second solution has been to issue 'challenges', and each group has tried to compensate for perceived deficiencies. Doctors, particularly GPs, are having their collective consciousness raised to the relationship between social and health dysfunction. They are, however, not routinely trained to respond to social problems in any way except referral to other agencies, or by prescribing 'medical' solutions. Prescriptions of tranquillisers have consequently soared. It is no wonder that the arrival of CPNs, to whom they can refer and receive an instant 'response', is widely welcomed by GPs. In contrast, social workers are generally castigated for their lack of awareness of 'medical' problems. They have responded by 'specializing' in particular 'health' client groups. The irony of this specialization is that the workers whose training and experience are the most likely to equip them to be able to recognise 'medical' problems, are rarely to be found in Patch teams, where this expertise would perhaps enable them to refer for medical help appropriately. Additionally, the argument against non-medical personnel undertaking 'filtering' roles, applies to social work as well as psychiatric nursing.

Some possible solutions to these problems will be discussed in the final chapter.

CHAPTER 9

FINAL DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

9.1 COMMUNITY PSYCHIATRIC NURSING AND SPECIALIST SOCIAL WORK PRACTICE

The objective of this study was to compare the work of CPNs and Specialist social workers in Salford. The major differences found are summarised thus:

1. Teamwork. CPNs were more likely to work alone than were Specialist SWs. When they did work with others, the CPNs' formal and informal contacts focussed primarily on doctors (psychiatrists and GPs). The Specialist SWs had extensive contacts with other members of the specialist psychiatric team, with non-health professionals and with informal carers. They had few contacts with members of the primary care team.

2. Skills and Techniques. The therapeutic technique mostly used by CPNs was the administration of medication. They also gave advice, both to individuals and in groups, about methods of coping with symptoms of anxiety and undertook some verbal therapy. The principal therapeutic technique used by social workers was counselling/verbal therapy. The social workers also gave practical help and mobilised resources provided by non-health agencies.

3. Content of Verbal Interactions. CPNs used more general conversation than Specialist SWs; Specialist SWs asked more

questions than CPNs. Both gave similar amounts of advice and support. Sixty-three per cent of CPNs' discussions concerned symptoms and treatment, compared to 36% of SSWs' discussions. Fifty-nine per cent of MHSWs' discussions were about social adjustment, compared to 30% of CPNs' discussions.

Although there was no intention to assess the quality of work, it is of relevance to note, that other work (Hunter op. cit.; Sladden op. cit.; Skidmore & Friend op. cit.) confirmed the shortcomings in CPNs' interviewing and counselling skills observed by the researcher. It is also noteworthy that, although the CPNs saw many clients who had symptoms of anxiety, their usual treatment methods were the provision of relaxation tapes/classes and encouragement and advice about managing symptoms. They were rarely (with the single exception of the Nurse Therapist) involved in the design or implementation of specific behavioural programmes.

4. Care of Clients in the Schizophrenia Clinical Category. CPNs spent significantly less time in face to face contact with individual clients in the 'schizophrenia' clinical category than did the Specialist SWs. The data suggested that CPNs took a predominantly re-active stance with this group of clients. Specialist SWs appeared to adopt a predominantly pro-active stance to these and all their clients.

The main differences in the organisation of CPN and Specialist SW services were:

1. Main Base. CPNs were based either in health centres or in a community clinic. Specialist SWs were hospital based.

2. Team Membership. Although CPNs worked less with others than the Specialist SWs, they related more to primary care workers than to psychiatric teams. Specialist SWs worked as members of consultant led psychiatric teams.

3. Supervision/Support. CPNs received no formal caseload supervision from members of their own profession. They relied solely on informal, mostly peer group, support networks. Specialist SWs received formal supervision and support from their team leaders. They also received "support" from their membership of the psychiatric team.

4. Duty System. CPNs did not operate or take part in a duty system. They worked a 5 day week from 9 a.m. to 5 p.m.. New referrals or emergencies were dealt with on an ad hoc basis. Specialist SWs took turns to man a 24 hour duty system which dealt with emergencies (both in and out of office hours) and any ad hoc callers.

5. Appointments. Apart from injection clinics which were held at fixed times, usually in health centres, CPNs did not usually make fixed appointments to see their clients. Neither did their clients usually make fixed appointments to see the CPNs. The SSWs almost always made and expected their clients to make fixed appointments.

9.2 ROLE AND PROCESS

The literature reviewed in Chapter 1 illustrated a general pre-occupation with questions concerning role rather than process. This study has been primarily concerned with process rather than role, and it is considered that, in a complex mental health service, professional role prescriptions as traditionally described - i.e. in terms such as 'assessment', 'treatment' and 'follow-up' - must inevitably overlap to a large extent. Thus, a pre-occupation with role alone, will confuse rather than clarify perceptions of contributions made by various professional groups to the overall mental health service network. The contention here is that a description of the processes by which various professional groups act out their roles will be more likely to illustrate the ways in which the day-to-day work carried out by various professional groups overlap or are distinct, and how they fit into the overall service pattern.

9.3 THE RELEVANCE OF A THEORETICAL/CONCEPTUAL BASIS TO DAY-TO-DAY WORK

The data presented in this study, (derived from both the case register and from direct observation of day-to-day work) suggested that the CPNs applied a variety of concepts (biological, behavioural, psychotherapeutic), to their work, and that, in contrast, the Specialist SWs' work was underpinned by two distinct conceptual bases (social and psychotherapeutic).

By administering drugs, observing their clients' 'mental states',

and by encouraging clients to attend for medical review, the CPNs mainly applied a biological model to their care of 'schizophrenic' clients. By monitoring the effects of medication, providing a sympathetic listening ear and by advising on relaxation techniques, they also applied biological, psychotherapeutic and behavioural models to their work with other clients. The facts that the nurses' own professional contact networks centred round doctors (psychiatrists and GPs), that specific behavioural programmes and pro-active counselling were not much employed, and that nurses received little intra-professional 'clinical' supervision/support all suggest that the biological model was the most frequently applied.

The Specialist SWs' efforts to ensure adequate finance and housing to enable their clients to function within non-medical social networks, and their frequent application of verbal therapies, were evidence of the social and psychotherapeutic concepts they applied to the care of all their clients. The facts that their contact networks outside the health service were as wide as those inside the health service, and that their managers gave 'clinical' supervision and support, provided further evidence of their underlying social and psychotherapeutic theoretical perspectives.

The professions/semi-professions [illegible] of medicine, clinical psychology and social work have their roots in the biological, behavioural and social sciences respectively. Each of these sciences has an established, if constantly refined, theoretical/conceptual basis and body of knowledge. Day-to-day

decisions and actions can thus be based upon a given set of concepts and can therefore be, to some extent at least, standardised and anticipated. In other words, one can broadly anticipate which particular conceptual base and body of knowledge a clinical psychologist is likely to apply to his or her work.

A distinct and standardised theoretical/conceptual base which informs community psychiatric nursing (thus allowing others, health or social services professionals, or planners, to anticipate the kinds of day to day activities in which psychiatric nurses are likely to engage), has yet to be established. Psychiatric nurses have traditionally applied theoretical models which others have developed and refined, and it is this which is both the strength and weakness of community psychiatric nursing.

The strength of the CPNs' present position is that they are likely to have acquired a basic working knowledge of the perspectives and skills of other professionals, and have particular knowledge of biological models. It is argued here that this level of theoretical/conceptual knowledge properly allows them to assist in the process of negotiating and monitoring how clients/patients respond to the various kinds of treatments/help prescribed and administered by other professionals. Training in the application of various concepts (for example, their present training in the administration of drugs), would allow nurses to undertake therapeutic interventions prescribed by others.

It is considered unlikely that the present entry requirements, basic training or experience of psychiatric nurses, or indeed of any one professional group, could ever be considered to be rigorous or lengthy enough to provide them with all the theoretical and knowledge bases of the medical, behavioural and social sciences. The weakness of the CPNs' position then, is that, in the absence of a distinct theoretical base which underpins all nursing activities, assessment skills based upon a thorough knowledge of a relevant conceptual base and body of knowledge cannot be developed except by undertaking some other kind of professional training. Such training is, in the author's view, required to legitimize, at least as far as other professionals are concerned, the assessment for and prescription (as distinct from the application) of any therapeutic intervention.

It follows then that, unless further training, experience and qualifications which make legitimate their rights to prescribe medical, behavioural or psycho-social therapies are acquired, nurses therapeutic activities should be limited to monitoring the progress of treatment, or administering treatments/therapies prescribed by members of other professional or semi-professional groups.

9.4 THE RELEVANCE OF PROFESSIONALIZATION

A medical qualification, by law, legitimates the prescribing of medicines. Social workers have statutory duties and powers governing enforced admission to mental hospitals and the care and

protection of children and elderly people. There is no professional boundary backed by the force of law which limits the 'right to prescribe' behavioural, social or psychotherapeutic interventions, and these 'rights' have become the main battleground between the professions. Each professional group, for example, psychologists, social workers and nurses, formulates and excercises its own legitimation process, and this process of legitimation is one of the limits to the extent to which each group is seen to be successful in claiming professional or semi-professional status.

The movement to claim professional status for nurses is, therefore, inextricably involved with this process of legitimation of 'limits to competence' and 'the right to prescribe' various treatments. The existence of legal barriers to nurses' claims to medical prescribing rights have limited the extent to which they have advanced claims in this area. However, changes in the law advocated in the Cumberlege Report (op. cit.), show that even this barrier is in the process of being breached. CPNs have, however, advanced on the fronts of the behavioural and social sciences, and, as CPNs themselves claim their 'rights to prescribe' behavioural and social 'treatments', so the potential for conflict with psychologists and social workers grows.

It is the differences between the nurses' own, and other professions' perceptions of the legitimacy of their claims to various 'prescribing rights' which lie at the heart of the present conflicts, and conflicts there are (Macleod op. cit., Dingwall op. cit.), between psychiatric nurses, particularly

community psychiatric nurses, who have advanced the most 'claims', and the various professions involved in the provision of mental health care. In contrast, the conflicts between social workers, doctors and clinical psychologists are likely to be the result of perceived conflicts of the relevance of each others' theoretical/conceptual frameworks rather than conflicts concerning each others' limits to competence.

The ways in which these conflicts are resolved are of crucial importance to the development of community care networks. The social workers' avoidance of primary care teams is one probable result of ideological conflict; the rationale behind the move by CPNs from hospital to primary care bases is not clear, although these moves appear to be increasingly undertaken. One hypothesis generated by this study is that the move into primary care and the acceptance of referrals from sources other than psychiatrists are ways in which:

1. The conflict between CPNs and other members of the specialist psychiatric team is reduced by avoidance (the withdrawal from other specialist staff whose perceptions of the CPNs' competence to intervene, may not be equal to those of the nurses themselves);

2. Joining a group (i.e. primary care staff), who value their expertise more highly than do their specialist colleagues increases the nurses' self esteem;

3. The desire to widen their traditional psychiatric nursing

role is achieved because a primary care base offers the freedom to undertake a wide variety of tasks, as many of the constraints which operate in hospital settings do not apply in primary care settings.

9.5 SKILLS AND PROFESSIONALISM

There is the danger that the association of distinct skills with one professional group only, will restrict the development of appropriate care networks for the following reasons:

a) Shortages in any one professional group would prejudice the formulation or completion of overall treatment/care plans;

b) The pace at which local authorities and health authorities progress towards shifting responsibilities for caring for mentally disabled people will vary throughout the country. If clients' and their families' welfare is not to be dependent solely upon this progress, both health and local authorities must be free to employ people who have requisite specialist skills. If those skills are exclusively possessed by single professional groups, the restrictions upon the appointment of particular professional groups (e.g. health authorities can not employ social workers) will mean that districts who are unable to reach a satisfactory level of agreement between health and local authorities will be unable to provide the full range of services required.

Although the disadvantages of separately funded health and social

service agencies' different capacities for growth, and the difficulties this engenders joint-service planning and development, and the difficulties caused be the restrictions on the professions each agency can employ, could be overcome by their forcing a single administrative unit, the difficulty posed by particular professions' monopolies of various skills would remain.

There is a dilemma here for the established mental health professions. In contrast to the health service, which has traditionally employed members of established professions, voluntary agencies, such as Lifeline, which have become increasingly involved in the direct provision of care have demonstrated the advantages of the freedom and flexibility of an organisation which bases its care networks on skills rather than professions. It is argued that if clients' and their supporters' needs have been established, and the mental health professions as currently recruited, trained and organised cannot meet those needs, then some mechanism which allows health and local authorities to purchase the requisite skills rather than purchase professionals, who may not necessarily possess the requisite skills, should be developed.

This does not imply the wholesale jettisoning of professional boundaries, as professional groups which ensure their members possess relevant skills, will ensure their own survival, but there will also be skills such as 'groupwork' skills, 'psychotherapeutic' skills, 'behaviour therapy' skills which may be possessed by members of any professional group. It should be

borne in mind that 'prescribing', implementing, and monitoring various 'treatment programmes' require different levels of theoretical/conceptual understanding which provides the framework for a 'grading' system to be designed.

If conflict between professional groups is such that it results in each group striving for professional excellence, and that excellence is relevant to clients' and their supporters' needs, then the conflict may be considered to be conducive to good professional practice. This study suggested that certain inter-professional conflicts had been resolved by avoidance. Specialist social workers and GPs were seen to have avoided each other; CPNs were seen to have avoided members of the psychiatric team. The former 'avoidance' is likely to have resulted in inappropriate referral for CPN care when referral to a social worker may have been more appropriate. The latter 'avoidance', which resulted in CPN attachment to primary care teams, is likely to have increased the numbers of clients being referred to a CPN who might more appropriately have been referred to a psychiatrist or a psychologist. It also is likely to have been instrumental in the CPNs' drift away from caring for psychotic clients, and their absence of involvement in the construction of in-patient and post-discharge care plans.

It is the researcher's opinion that the present distrust and competition between professional groups concerning the legitimacy of claims to various levels of competence will continue until some system of validation of claims which is independent of each individual professional group is established and implemented.

Inter-professional teamwork in psychiatry, has generally been confined to in-patient care (though it frequently does not involve any real collaboration with patients), and has been conducted at 'ward rounds'. The solution to the problems of professional 'competition' based on conflicts posed by differences in theoretical perspectives, (which results in clients receiving whatever care is offered by the first professional contacted, rather than the professional(s) who have the skills to meet clients 'needs') proposed here, is that all people referred for specialist psychiatric care should be assessed by a multi-professional team, rather than by members of individual professions.

The different theoretical/conceptual 'models' which 'explain' the phenomena of mental 'illness' discussed in Chapter 1, and the differences in the ways CPNs and Specialist SWs care for their clients, clearly demonstrate the multi-factorial nature of mental ill-health. If assessment of problems is carried out by team members who have different theoretical approaches, and these are explained to clients and carers, then there should be a basis for a jointly negotiated care plan to be established. It is suggested that this model should be used at initial assessment, and for systematised periodic review, and not only if a client requires in-patient care. It is further suggested, that in order to facilitate such a team approach, members of specialist psychiatric teams should share accommodation with each other, and not physically maintain groups based upon professional demarkation. The roles of the managers of each profession could

thus change their emphasis from 'administration' to the promotion of professional excellence.

9.6 CARE OF THE LONG-TERM MENTALLY ILL

The data presented showed that, apart from psychiatrists, the only other mental health professionals involved in the provision of long-term psychiatric care outside hospitals, were the CPNs. Although a 'diagnosis' of 'schizophrenia' may be held to imply that long-term psychiatric care is required, case register data showed that clients in other clinical categories were also long-term psychiatric service users. There is thus a substantial proportion of clients (30% of all those aged between 15 and 64 who contacted the services in any one year is the estimate) using the general psychiatric services (which in Salford and in many other places, are organised to give 'acute' care), who have long-term needs. The run-down of large mental hospitals will add to the already substantial proportion of clients who need long-term care, and there can be no doubt of the need to provide co-ordinated long-term specialist services outside hospital, for these clients.

9.6.1 CPN services - the drift away from caring for psychotic clients

Case Register data showed that the composition of CPN caseloads changed. In 1976 clients in the 'schizophrenia' clinical category accounted for 40% of all clients seen in that year, whereas in 1985, the proportion was 19%. Proportions of clients

in the 'schizophrenia' clinical group who received continuous CPN care for at least 1 year reduced from 78% at the end of 1975 to 33% at the end of 1985. The observational study data showed that not only had the composition of nurses' caseloads changed in emphasis, from psychotic to non-psychotic clients, but the mean amount of time spent caring for individual psychotic clients was less than two thirds that spent caring for individual non-psychotic clients.

Thus the CPNs' move away from caring for 'schizophrenic' clients, to caring for clients in other clinical categories, was considerable. The CPNs represented the main new investment in community services which had taken place over the study period, and the data presented in this study confirm that in Salford the dangers foreseen by the Select Committee (House of Commons op. cit.) - that new resources might be used for more 'attractive' client groups - have come to pass in Salford.

9.6.2 The dynamics of the shift

The processes which underlay this shift in emphasis require a study in themselves, but several clues have emerged which will be considered here. The composition of CPNs' caseloads changed after their move from hospital to health centre bases. The proportion of CPN referrals which came direct from GPs rose, and in 1984 accounted for 62% of all referrals compared to 16% from psychiatrists. Psychiatrists tended to refer psychotic clients, and GPs tended to refer non-psychotic clients. Thus the increase in numbers of GP referrals brought about an increase in the

proportions of non-psychotic clients on CPNs' caseloads. Case Register data from Southampton and Worcester, where CPNs worked as part of the specialist psychiatric teams and were not exposed to the kinds of direct referrals from GPs that the Salford CPNs were, showed that the proportions of clients aged between 25 and 54 in the 'schizophrenia/paranoid states' and 'affective psychoses' categories were substantially higher in Southampton and Worcester (Wcoff et al, 1987).

It is argued here that a move to primary care bases and exposure to direct referrals from GPs will, if uncontrolled, tend to lead to resources flowing to more 'attractive' client groups. When that exposure is accompanied both by lack of clear statements of policies/priorities and lack of professional support and caseload supervision, the drift away from care of the most 'difficult' client groups is likely to be unstoppable.

9.4.1 Care of clients with chronic psychiatric difficulties

It was not the purpose of this study to evaluate the kinds of assessment/treatment/care offered to clients with long-term difficulties, but the findings have far reaching implications for the ways in which services for this client group should be organised. The data showed that, apart from contacts with psychiatrists and day centre/hospital provision, the only other long-term support and treatment for long-term clients and their families was given by CPNs. No other professional group undertook long-term care of these clients or their families.

The 'needs' of this group of clients and their families have been well documented over the past decade. Pressure groups such as Schizophrenia Fellowship have been instrumental in raising public and professional awareness of these needs. Work has shown that the ways in which families behave and function can trigger symptoms, and has shown how highly skilled work with families can reduce relapse rates (Brown et al. op. cit.; Tarrier & Barrowclough op. cit.).

In 1985, an experimental scheme funded by D.H.S.S., which aimed to develop administrative mechanisms which would facilitate the provision of such treatment and care, was set up in Salford (other schemes were also set up in Hackney and Southampton). It quickly became apparent that the only long-term care plans which had been made in the past, were for medical care in the form of administration of medication. Such other long-term treatment/care as had been provided e.g. day care, was not part of an overall jointly negotiated plan, but was the result of treatment/care initiated by each individual agency after referral. There was no automatic review mechanism in operation except that governing the prescribing of long-acting phenothiazines, which, following instructions from CPN managers, required medical review at 6 monthly intervals. These 6 monthly reviews did not always involve a face to face contact between a psychiatrist and a client. Medication was sometimes prescribed as a consequence of psychiatrists requesting and receiving reports from CPNs.

The implications of the arguments concerning the desirability of

establishing limits to professional boundaries, supported by data obtained as a result of direct observations, are that whilst it may be reasonable to expect CPNs to carry out and monitor the progress of medical treatments such as the administration of long-acting phenothiazines and to encourage clients to maintain treatment and attend medical reviews, it is unreasonable to expect them to either identify the need for, or give, other specialist help, such as changing family behaviour patterns, organising ways in which clients may achieve independence from their families, or improving social-skills, to clients and their families, unless they have had the benefit of highly specialised training and experience.

Rehabilitation services have tended to concentrate their efforts upon the long-term in-patient population, and ironically, the 'acute' services have traditionally provided care for the chronically mentally-ill living out of hospitals. Whilst 'acute' services may be appropriate from time to time i.e. if symptoms or other problems become 'acute', long-term assessment/treatment/care plans ought to form the basis of the care offered to these clients and their families or supporters. The complexities of their needs, and the changes of needs over time, are such that assessments and care plans need to be negotiated between client, family, and a multi-disciplinary professional team which can provide the wide range of help associated with psychological, occupational therapy and specialist social work professions. These plans should be regularly monitored and reviewed if clients' and their supporters' needs are to be successfully met.

9.6.4 Skills and personnel shortages

The prevalence of schizophrenia and non-specific psychotic illnesses alone is such (around 900 i.e. 3.75 per 1,000 total population in 1985 in Salford) that there is no doubt that skills (for example, the kinds of skills identified in family intervention studies - measurement of expressed emotion and the construction and implementation of treatment/management programmes; the provision of social skills training; assisting families to support the independence rather than the dependence of a disabled member) required at all levels of specialisation, to provide adequate care for people with long-term psychiatric difficulties and their families, are in short supply. If each Salford client/family's care plan was negotiated/updated by the whole team once each year, then approximately 75 would have to be completed each month. Given that these plans then need to be implemented and monitored, the implications for increased staffing levels are considerable. For example, the Salford service has 6 Specialist social workers and no community occupational therapist. There is no conceivable way that these staffing levels can support the kind of service network needed for this client group. Further, case register data showed that people in the 'schizophrenia' clinical category formed less than half the total of people who were 'chronic' service users, and it can be assumed that better long-term co-ordination of care is also required for people in diagnostic groups other than that of 'schizophrenia'.

9.7 CARE FOR THE ELDERLY

The establishment of a multi-disciplinary psychogeriatric team in 1984 ensured that services to this vulnerable group of clients were 'protected'. However, initially, only 1 social worker worked in the team, and during its first year of operation SSW year prevalence rates for clients aged over 65 actually fell. The work of the social worker and the 4 CPNs attached to this team was not observed during the study and the data discussed here must therefore be confined to case register data.

The most striking finding was that Patch team social workers accounted for the whole of the increase in mental health social work care for clients aged 65 and over. As large increases occurred only after the establishment of a specialist psychogeriatric team, and after a standardised assessment by a psychogeriatrician had been made, it is likely that referrals from this source were appropriate, and accounted for much of the increase. The implications are that social services resource increases are necessary in order to cope with increasing demands being made by the elderly population.

In contrast to their colleagues working in general psychiatry, the CPNs worked as members of the specialist psychogeriatric team and did not accept referrals directly from GPs. This latter restriction was not welcomed by GPs, who had had ready access to CPN services before the establishment of the psychogeriatric team. However, the rationale for such a restriction is important to discuss here because of its relevance to the issue

of CPN attachment to primary care teams.

A review of the accuracy of assessment before referral for a consultant psychogeriatrician's opinion (Stout 1985), had shown that only half the cases referred by GPs had been correctly identified as having 'psychological' problems (124 out of 244). Furthermore, of the 124, only 89 required care from a CPN, and in 35 cases, case management would have been more appropriately undertaken by social workers or clinical psychologists. Stout found that the majority (106 out of 128) of those elderly clients referred for his opinion by the primary care attached CPNs were in need of a specialist supervisory service. He concluded that "the current appropriateness and accuracy of referral from this source (GPs) is low and this is especially true of cases with little or no psychopathology who may form the majority of GP to CPN direct referrals." Thus, the psychogeriatrician argued that, in order to 'ration' scarce resources effectively, direct referral to CPNs by GPs should be discontinued as clients either needed a specialist service which included a psychogeriatrician's expertise (in which case they should be referred directly for consultant opinion), or many clients referred by GPs to CPNs were being referred inappropriately and would be more appropriately cared for by members of other professions.

Case register data show that the rate at which 'new' long-stay in-patients aged 65 and over accumulate has begun to fall in spite of the exposure of such previously unmet needs. Much of the burden of caring for these clients has fallen upon the shoulders of non-specialist services, but the evidence points to

the fact that the strict policy of conserving the scarce specialist resources so that they are used where they are most needed, has resulted in an increased capacity of families to cope with the care of very disabled relatives.

9.8 CARE FOR ACUTELY 'ILL' CLIENTS

Care for acutely 'ill' clients is more easily organised than care for people with 'chronic' difficulties. Their needs co-incide with a hospital-based model more closely than the needs of people with chronic difficulties. Case register statistics showed that admission rates rose, lengths of stay rose slightly, day-care and out-patient attendances increased. The proportion of admissions accounted for by patients in the 'schizophrenia' clinical category fell throughout the study period, and the 'success' of CPNs in maintaining patients on their medication is likely to have played a part in this reduction. Such a reduction had in fact been observed since case register statistics became available (after 1968) and before the introduction of CPN services in 1973. It is likely, however, that the introduction of the CPN service reduced the numbers of patients who discontinued their medication.

Observational data showed that the Specialist social workers worked very much as part of the general psychiatric team, and hence, very much as part of the 'acute' service. They did, however, appear to become involved in 'treatment' largely after patients had been admitted for in-patient care. As a consequence, they contributed to ward 'case management' plans,

which they then continued to implement after discharge if this was considered appropriate. Because CPNs spent very little time on wards, and did not attend 'ward rounds' as a matter of course, they were not observed to contribute much to ward 'case management' plans, and certainly did not continue them when their clients were discharged from in-patient care.

Thus, unless the SSWs had had previous knowledge of in-patients' home circumstances, they were in no position to contribute social information to ward staff unless they paid visits after patients admissions; the CPNs who were frequently the first mental health professionals contacted, did not contribute their knowledge of pre-admission circumstances because their contact with ward staff was virtually non-existent.

How far this lack of opportunity for SSWs to make initial social assessments was implicated in the continued rise in admission rates for non-psychotic clients is not known. However, if the inappropriateness of GP referrals (to CPNs and the the consultant psychogeriatrician) found in elderly clients was also found in younger clients - and it is virtually certain that GPs did not refer appropriately (Goldberg & Huxley op. cit.) - it is likely that some clients at least, had ended up being admitted when early social work intervention may have obviated this necessity.

The fact that CPNs did not routinely attend 'ward rounds', at which discharge plans were discussed, is also likely to have resulted in some patients being discharged without the support of a CPN when that would have been appropriate. Indeed, the work of

Paykel et al. (op. cit.) showed that follow-up by CPNs of patients who had been treated for neurotic symptoms, resulted in a high degree of patient satisfaction, good outcome and a reduction of patient costs. Marks et al. (op. cit.) have also shown how with specialised training nurses can effectively implement behavioural psychotherapeutic treatments for clients with symptoms of anxiety.

9.9 CARE OF THE MINOR MENTALLY 'ILL'

Because of the lack of contact between primary care staff and Specialist social workers, it is unlikely that SSWs were involved in caring for this group of clients unless they had been referred for a psychiatrists' opinion. Although the PSE results had shown that around one third of the SSWs' clients had sub-clinical symptomatology it was virtually certain that this was because they were in the process of recovering from a more serious psychiatric 'illness'.

In contrast, the primary care base of the CPNs, and the fact that they received referrals directly from GPs, increased the likelihood that they were involved in caring for people whose symptoms were not serious enough to warrant referral to a psychiatrist. Observational data showed that some kinds of help appropriate to the needs of mildly mentally ill which might have been given by GPs, was, in fact, given by the CPNs - for example 'simple psychotherapy', and advice and reassurance concerning the management of anxiety symptoms. However, the PSE results showed that around seventy per cent of their clients had symptoms above

the sub-clinical level, and case register data showed that many of the clients originally referred to them eventually received some kind of specialist psychiatric help. The possibility remains, therefore, that some of the clients referred directly to CPNs may well have received more appropriate care if they had been referred directly for consultant psychiatrist opinion, for social work or for psychological help. As GP attachment appears to be increasingly undertaken by CPNs, there is an urgent need to establish what GP referral criteria are, and to assess the medical, social and psychological 'needs' of the patients they refer before any further GP attachments take place.

In any mechanism which 'filters' patients who may or may not benefit from referral to specialist psychiatric services, it is important that the processes by which clients are assessed and the criteria for referral which are applied, are clearly delineated and understood. Goldberg and Huxley (1980) showed that family doctors needed special training to detect, reliably, signs of mental illness amongst their patients, and it may be that GPs have delegated this role to CPNs who are attached to primary care settings. Further research into the criteria GPs operate for referral for CPN or psychiatrist care is needed.

The data in this study showed that CPNs intended to refer on to psychiatrists more than to any other professional group. They intended to make few referrals to psychologists or social workers, and their contact networks with psychologists and social workers were limited. How far this was a manifestation of the nurses' main orientation being the medical model of care, or how

far it was the result of the legal barrier which prevented them from prescribing medicines (whereas such a barrier did not prevent them 'prescribing' behavioural or social treatments), must be a matter for further study. Either way, referral direct to a CPN, if the latter is acting as a 'filter' for all clients who may have psychiatric/behavioural/emotional problems, may result in clients being denied the opportunity of 'expert' behavioural or social help if they are not being referred on to psychologists or social workers.

The problems of the limitations of the application of single theoretical perspectives to problems which are multi-factorial have been discussed above. The choice presently facing people who have health and/or social problems and who wish to obtain professional help, is either to contact their GPs and/or to contact their Patch social work teams. There is now little doubt that all health, and particularly mental health, problems are related to some extent to social factors, but two separate organisations are responsible for providing appropriate services.

General practitioners are not trained to recognise and deal with social distress; social workers are not trained to recognise and deal with physical health problems although many of their clients have such problems (Rickards et al. 1976). The patient/client is thus presented with the choice of:

a. Contacting a GP who cannot be expected to provide expert social help;

b. Contacting a social worker who cannot be expected to provide

expert medical help;

c. Contacting both a GP and a social worker, neither of whom is likely to work in conjunction with the other.

The solutions which have been suggested in the past have been based upon the premise that medical workers can be trained to 'recognise' signs of social distress and refer appropriately, and that social workers can be trained to 'recognise' signs of physical ill health and refer appropriately. It is the author's view that the solution which would meet patients'/clients' needs to have their medical and social problems dealt with together, is that of replacing the present two main points of first contact (primary care centre, and patch social work team) with a single resource centre which offered joint medical/social assessments and co-ordinated responses to multiple problems. GPs should not delegate their medical diagnostic skills to non-medical personnel. Doctors are unlikely ever to achieve sufficient competence to assess social problems, and social workers are unlikely ever to achieve sufficient competence to diagnose medical problems, and it is a waste of resource to try to achieve the impossible. It follows that the training effort should be directed to improving GPs' own clinical skills rather than being directed to improve their ability to recognise social dysfunction, and the social work training effort should be directed at improving their social assessment and intervention abilities, and not to enhancing their abilities to recognise signs of physical illness - such special training should be given to specialist rather than generic workers.

It is recognised that such a solution to the problems of 'filtering' for appropriate specialist referral demands a radical departure from customary health and social services practice. There would also be difficulties in conducting joint medical/social assessment of patients/clients when one professional might usually devote less than 5 minutes to such an assessment, and the other may well devote 30 minutes. **It is suggested, however, that such collaboration should be attempted on a pilot basis.** Accounts of attachments of social workers to general practices have shown that their skills are required (Huntington op. cit.; Goldberg and Neill op. cit.), but if GPs are unable to filter for medical symptoms effectively (Goldberg and Huxley op. cit.), they are even less likely to be able to filter effectively referrals for social work help. It is suggested that the difficulties encountered in organising such a system will be fewer than the difficulties which flow from the existing organisation of services, which attempts to provide for a set of medical/social needs (which have been shown to be interdependent) by setting up two wholly separate structures.

9.9.1 Support to primary care workers

Assuming that some kind of adequate 'filtering' arrangements are operational, there will be a substantial proportion of primary care patients who may well need the kinds of therapeutic help which existing primary care staff can supply. The provision of sympathetic explanations and support such as were observed to be given by CPNs is one which should be considered. Another, was the provision of relaxation classes at which groups of people

were encouraged to relax together with the aid of relaxation tapes. How far these kinds of help need the expertise of a trained psychiatric nurse is arguable, but it is the author's contention that instead of providing this kind of care directly, the psychiatric nurses could well have been employed to raise the consciousness of other primary care staff, of voluntary groups, and of health promotion professionals to the needs for and possibilities of such provision. This would enable the CPNs to undertake other tasks which needed their specialist training. It is suggested that all members of the specialist psychiatric team could provide other generalist colleagues with such 'advisory' support.

9.10 SKILLS CONSOLIDATION AND TRAINING

The enhancement of Specialist social workers' therapeutic skills to enable them to undertake 'family intervention' therapy was discussed in relation to the care of clients with chronic psychiatric problems. The problems arising from the fact that the Patch team social workers, who were less likely than the Specialist social workers to be able to recognise symptoms of psychiatric disturbance, but who were more likely to be the first social workers contacted by clients, would be solved if the solutions of joint medical-social primary assessment suggested earlier was adopted.

The Select Committee on Community Care pointed out that asylum, protection and support, is still required for many people. The skills for which psychiatric nurses are particularly valued by clients, their families and other workers i.e. their knowledge the diagnostic significance of various symptoms/behaviours, the relationships between psychiatric and physical symptoms, and of 'managing' acutely disturbed patients, need to be re-enforced, enhanced and more highly valued rather than lost in the rush to acquire new skills. The CPNs in Salford were seen to have made little use of their skills in 'managing' the behaviours of disturbed patients. This may have been because their attachment to primary care teams involved them in less contact with acutely disturbed clients than would have been the case had they had more involvement with the specialist psychiatric team, and/or because the ways in which CPN services have developed have not stressed the use of these skills.

Even though it is considered to be unrealistic to expect basic psychiatric nurse training to encompass all the depth of skills displayed by members of other professions, the need for nurses to improve their interviewing and counselling skills became apparent. Since the completion of the study, CPNs and other psychiatric nurses in Salford have begun to systematise their work by applying the 'nursing process'. Whilst this and other systematic models of enquiry provide checklists of items to be considered, the processes by which information is elicited, recorded and acted upon must also be studied and improved. It is not known how far community psychiatric nurses in Salford are in

any way typical of community psychiatric nurses elsewhere, but there is no reason to suppose that they are in any way untypical, and it is important to note that a need to improve CPNs' interviewing, and counselling skills has been found by other research workers.

There were no statistically significant differences found between the ways in which CPNs who had, or who had not completed the Joint Board of Clinical Nursing Studies' CPN course interacted with their clients. At the time the study took place, these courses did not incorporate any skills training, but concentrated upon a re-orientation approach. The course at Manchester Polytechnic has since included a counselling skills element within its programme in recognition of the needs for training of this kind. It is suggested that, until psychiatric nurses decide how far CPNs and other psychiatric nurses' roles and skills should overlap or be distinct, the present vacuum in skills training for nurses will remain. It is the author's view that basic interviewing, assessment and counselling skills should be taught to all health professionals and therefore should be taught to all psychiatric nurses. It is thought that the need for this training is so widespread and so urgent that a programme of skills training which uses non-nurse trainers must be set in motion forthwith.

9.11. SUPERVISION, SUPPORT AND CASELOAD MANAGEMENT

In contrast to Specialist social workers' managers, CPNs' managers had, in the opinion of the researcher, failed to provide an adequate support or professional development structure for CPNs. They had also failed to clarify the objectives of the CPN service and did not exercise any control over the size and nature of the caseloads carried by individual CPNs. Feedback from a meeting with CPN managers throughout the North Western Region in 1986, suggested that these shortcomings were widespread.

Much has been written of the need to widen the perspectives of ward based psychiatric nurses, and in the North Western Region various levels of re-orientation training needs have been identified. There has, however, been little attention paid to the training needs of nurse managers, and as this group of people will bear heavy responsibilities for managing the transfer of nursing care from hospitals to the wider community, it is imperative that training programmes be devised and implemented which will equip them with the knowledge and insights necessary for them to meet this changing responsibility.

Although in the researcher's opinion, managers should provide supervision and support to all psychiatric nurses, the relatively isolated position of CPNs (and all nurses) who work in community settings demands that special attention to their support needs should be given. Ward based psychiatric nurses work within well defined, not to say restrictive, management structures, thought

by Menzies (op. cit.) to be operated to avoid the stresses of decision-making. Many CPNs in Salford, and in other areas (Butterworth 1981) moved into community work directly from working on wards, without any specialised community training and were implicitly required to make decisions rather than carry out procedures. Nurses moved from a highly structured working situation to one which provided little in the way of guidance or support.

The dangers of this situation were pointed out by Bennett (1978) who wrote that "independent community psychiatric nurses or, for that matter, other professional staff working alone in the community, do not have established ways of containing (that) anxiety other than by admitting the sick person to hospital or by "closing the case"." The observations made in this study suggest that two further mechanisms may have been developed to contain anxiety - the first, to retain cases for long periods when admission is clearly not appropriate, but when lack of progress makes closure of a case a difficult option to justify, and second, the development of an informal peer group support structure i.e. support from other members of the CPN service.

The fact that managers of psychiatric nursing and community psychiatric nursing services have allowed or even encouraged unsupported community work to take place, implies that either they do not accept that support is necessary, that they do not see support as sufficiently important to justify spending their budgets upon it, or that they do not know how to provide it. It is the author's view that not only is caseload supervision needed

to provide support and guidance but the support gained from working as part of a team also provides the opportunity for personal and professional growth. Isolated, independent working will, over the years have a de-skilling effect in that old skills/knowledge, acquired, for example, whilst working as part of a specialist team, will be lost (after 15 years of isolated community work, nurses' knowledge of current medical, behavioural or social interventions is likely to be deficient), and new skills and insights will fail to develop because there is no structure in which they can grow. Nurses will thus lose the very skills and experience for which they were originally valued by primary care team workers.

The majority of psychiatric nurse managers will have had little experience of working outside hospitals themselves. Training programmes should include such experience, and should also include exposure to the ways in which other mental health professionals working outside hospitals function. This kind of re-orientation training will provide a background for the further skills training which will be necessary if managers are to be able to provide the kinds of professional support needed if nurses are to be assisted in their handling of individual cases. A manager who has not developed counselling skills of a high order him or herself, will not be able to provide supervision of CPNs' own counselling activities with individual clients. It is proposed that as these and other skill resources will be scarce within the nursing profession, that both managers and CPNs will require training to be given by non-nursing staff. Managers' own needs for support and professional development

should also be recognised and provided for.

The dynamics of prevalence were such that most of the psychotic clients referred for CPN care tended to remain on their caseloads for long periods. However, each year, a proportion of newly referred non-psychotic clients (most of whom would have been referred directly by GPs) also became long-term clients in their turn. The pressures on caseloads therefore can be seen to take some time to build up, but if, as a result of this pressure, additional staff are employed who also take on more 'new' cases rather than support existing clients only, each new increase in staff will in its turn contribute to increased pressure in the future. It is suggested, that adequate supervision and support of CPNs' management of individual clients will also assist in the process of caseload management, as the systematic progress reviews demanded by such supervision will assist the decision-making process as to whether or not to close cases. It is also a managers duty to ensure that the professional activities he/she manages are under some kind of managerial control. Without caseload supervision, it is difficult to see how this management responsibility can be discharged.

In contrast to the CPN service the SSWs' caseloads and the proportion of long-term clients being cared for remained relatively stable throughout the study period. It is noteworthy that the SSWs were not exposed to demand-led referrals and were supervised and supported both by senior members of their own profession, and by membership of the specialist psychiatric team.

Colleagues working in Patch Teams were, however, exposed to increased demands for their services, particularly with regard to elderly people, though how far the support and supervision given to Patch SWs effectively controlled these increasing demands cannot be discussed with any authority here. Fisher Newton & Sainsbury (1984) in their study of patch team mental health social work care found that the supervision processes as practiced in Derbyshire did indeed tend to control caseload sizes but that the differing sets of criteria which operated between various area offices and between 'intake' and 'long-term' teams meant that this control was not systematically geared to clients' needs. The social work problem may be that Patch teams and Specialist teams may be operating different criteria for long-term involvement with clients.

9.12 CONCLUDING COMMENT

In conclusion, it must be said that much of the preceding discussion has centred upon the community psychiatric nursing service - a service in which the greatest amount of new investment has taken place in the last 10 years. Service developments have not always occurred as the result of careful consideration of the issues and principles involved. 'Needs' have been perceived and initiatives taken; enthusiasts have pursued and publicised these initiatives. The growth of the CPN service has been unplanned - there is no authoritative information on just how fast it has grown but there is little doubt that the growth has been considerable.

Much has been expected of CPNs. The Hospital Advisory Service saw the CPN as being "probably the most important single professional in the process of moving care of mental illness into the community" (House of Commons op. cit.). CPN services were originally perceived to provide continuity of care for people with chronic psychiatric conditions and the fact that existing services did not provide such continuity of care was perceived in many districts. How far the Salford service is typical of services in other districts is not known, but it is certain that in Salford at least, CPN services have moved away from caring for psychotic clients. It is however, possible to discern a trend towards primary care attachment, and the provision of social and behavioural 'treatments', which imply that the original purposes of the service have been lost as nurses have seized the opportunity to escape from the confines of hospitals and to explore and exploit their skills in an atmosphere of freedom. If one of the prime objectives of the mental health services is to **enable rather than disable** its clients, then there is surely a case for postulating that managers should **enable rather than disable** their staff.

Many of the issues raised in this work have direct relevance to the ways in which nursing services are managed. The uncontrolled nature of the expansion of CPN work has demonstrated the need to change existing nurse management styles. **Future expansion of CPN services should be limited by the extent to which managers can demonstrate their capacity to manage them.** It follows that there must also be an expansion of skills training courses for nurse managers.

The latest policy document concerning mental health services, Care in the Community, was published in 1981. The statement of general policy for the future accepted the validity of the concept of community-orientated care and treatment, and affirmed a belief in a policy of integration rather than isolation, the development of more locally based services, and a shift in the balance between hospital and social services care. The logic that implies workers who have different theoretical perspectives and training are 'doing the same things' just because they work outside rather than inside hospitals - a logic which many health staff appear to accept - will serve policy-makers, planners and managers ill.

CPNs and Specialist SWs were observed to employ differing skills and perspectives to their work which were complementary. They should not be considered to be interchangeable with each other. This view has also been expressed by Hunter (1980), Priestly (op. cit.) and MacLeod (op. cit.). Feedback obtained locally suggested that this view was likely to co-incide with that of the majority of social workers; but that, apart from their perception that social workers dealt with financial and housing matters and they (the CPNs) did not, many CPNs felt that they did much the same kind of work, but that they (the CPNs) knew more about mental illness. Priestly (op. cit.) and Macleod (op. cit.) also found that nurses themselves tended to think that there was little difference between social workers and CPNs, but that other mental health professional staff were likely to perceive differences between the two. It is essential that staff and

planners understand that, although roles may overlap, the processes by which roles are acted out may not. There was a substantial difference between the 'simple psychotherapy' practiced by the nurses, and the highly skilled formulation of clients' problems and solutions to that which formed the basis of the Specialist social workers' counselling activities. It is therefore imperative that consideration is given to process as well as role when service networks are being planned and operated, and that appropriate systems, which ensure that the kinds of skills at present possessed by social workers are made more widely available to the mental health services, should be developed.

If realisable plans for the care of mentally impaired people outside the confines of hospital in-patient care are to be made and successfully implemented then the range and complexity of 'prescribing', administering and monitoring competences of various professional groups must be established and accepted by the professions involved in the care networks, the referrers to, and consumers of services, alike.

GLOSSARY

Community Psychiatric Nurse (CPN).

Specialist Mental Health Social Worker (SSW or Specialist SW).

Patch or Area Social Work Team Social Worker (Patch SW).

All Social Workers (patch and specialists) who work with clients with mental health problems (MHSWs).

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Appendix 1

SALFORD PSYCHIATRIC REGISTER

CONFIDENTIAL

Date of Attendance _____ Agency Number _____

Type of Case _____

Surname _____ Christian Names _____

_____ Religion _____ NK ☐

Date of Birth [D | M | Y] NK ☐ Sex M F

Address _____

Place of Birth _____ NK ☐ Agency No. _____

I.Q. Verbal _____ NK ☐ I.Q. Performance _____ NK ☐

Previous Contact with Psychiatric and/or Subnormality Services —
Out-Patient ☐ In-Patient ☐ Day Patient ☐ M.H.D. ☐ None ☐ NK ☐

*No. of Siblings (a) born _____ (b) alive _____

(c) Patients birth order position _____ NK ☐

Domestic Unit Alone ☐ Natural Parents ☐ Foster Parents ☐

Adoptive Parents ☐ Siblings ☐ Family of Marriage ☐

With independent grown children ☐ NK ☐ Other specify _____

Family History of Psychiatric Care in the following — Parents ☐ Children ☐

Siblings ☐ Spouse ☐ Grandparents ☐ None ☐ NK ☐

Other specify _____

General Practitioner _____ NK ☐ *School _____ NK ☐

Marital Status Single ☐ Married ☐ Widowed ☐ Cohabiting ☐

Separated or living apart ☐ Legally Divorced ☐ NK ☐

*Mother's Marital Status (under 15 yrs.) Single ☐ Married ☐ Widowed ☐

Cohabiting ☐ Separated or living apart ☐ Legally Divorced ☐ NK ☐

Present Occupation _____ NK ☐

Husband's or Supporter's Occupation _____ NK ☐

Highest Educational Attainment and Trade/Professional Qualifications _____ NK ☐

P.1.(A)

Provisional Diagnosis

Please tick as many categories as necessary

1. Schizophrenia ____
   Schizo-affective psychosis ____
   Paranoid state ____
2. Mania ____
   Hypomania ____
   Severe depression ____
   (a) Predom. retarded ____
   (b) Predom. agitated ____
   (c) Depressive delusions and/or hallucinations ____
   Has patient had both manic and depressive episodes? ____
3. Mild or moderate depression ____
   (a) Predom. anergic ____
   (b) Predom. tense and restless ____
4. Anxiety state
   (a) Generalised ____
   (b) Situational exacerbations (e.g. on leaving house, in public transport) ____
   Monosymptomatic fears (e.g. of cats or feathers only) ____
   Specify _____
5. Obsessional neurosis (Specify) ____
   _____
6. Hysteria (Specify) ____
   _____
7. Sexual problem (Specify) ____
   _____
8. Personality disorder (Specify) ____
   _____
9. Psychosomatic disorder (Specify) ____
   _____
10. Alcohol addiction ____
    Type of problem _____
    _____
11. Drugs dependence ____
    Name of drug _____
12. Organic conditions ____
    (Specify cause and clinical state if known, e.g. dementia, confusion, etc.)
    _____
    _____
    _____
13. Mental subnormality
    (Specify cause and degree) ____
    _____
    _____
    I.Q. _____ Test _____
    Date _____
14. Other diagnosis (Specify)
    _____
15. Situational Stress (Specify) _____
16. No psychiatric abnormalities ____

Elaboration of diagnosis, if needed plus Underlying Cause _____
_____
Physical illness or abnormality (including deafness) _____
_____ None ☐

Consultant _____ Institution _____
Signed _____ Date _____

3L DIAGNOSTIC GROUPS - EXPANSION OF 3C, DERIVED FROM 3A

1	Schizophrenia	Group 1 in 3A
2	Mania and hypomania	From Group 2 in 3A - PI = 201: 202; 200
3	Other severe affective disorders	From Group 2 in 3A - all those not included above - and all of Group 3 in 3A and 210
4	Senile and presenile psychoses	Group 11 in 3A
5	Mild-moderate depression	Group 5 in 3A
6	Anxiety states	From Group 6 in 3A - PI = 040 to 045 inclusive
7	Other neuroses	The rest of group 6 in 3A - PI = 050, 060; 131 and group 7 in 3A
8	Personality disorders	Group 8 in 3A
9	Alcoholism and addiction	Group 10 in 3A
10	All others	Groups 4, 9, 12, 13, 14, 15, and 16 in 3A
11	Depression N.O.S.	250

DIAGNOSIS - 16 Groups

3A

Use Psychiatric Illness - P.I.I code
and Organic code

and Mental Subnormality for 13, 14 and 15 on date specified for relevant table.

			P.I.I. code	Organic code
1	Schizophrenia	a)	010	00
			011	85 83 87 - 99
2	(of demonstrable aetiology)	b)	ditto	01 - 23
				25 - 56
				63
				71 - 78
	(Puerperal)	c)	ditto	84 86
	(Senile)	d)	ditto	57 - 61
	(Alcohol & Drugs)	e)	ditto	64 - 70
2	Manic and Psychotic Depression	a)	200 201 202 220 221 222 223 224 225 226 227 228 229	

			P.I.I. code	Organic code
2	Manic and Psychotic Depression (continued)	a)	230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249	As for 1.A
	(of demonstrable aetiology)	b)	ditto	As for 1.b
	(Puerperal)	c)	ditto	As for 1.c
	(Senile)	d)	ditto	As for 1.d
	(Alcohol & Drugs)	e)	ditto	As for 1.e
3	Severe Depression	a)	210 213 214 215 216	As for 1.a
	(of demonstrable aetiology)	b)	ditto	As for 1.b
	(Puerperal)	b)	ditto	As for 1.c
	(Senile)	d)	ditto	As for 1.d
	(Alcohol & Drugs)	e)	ditto	As for 1.e

			P.I.I. code	Organic code
4	Other and N.O.S. psychosis	a)	130 012 013	As for 1.a
	(of demonstrable aetiology)	b)	ditto	As for 1.b
	(Puerperal)	c)	ditto	As for 1.c
	(Senile)	d)	ditto	As for 1.d
	(Alcohol & Drugs)	e)	ditto	As for 1.e
5	Depression - Moderate		030 037 038 039	Any number
6	Neurosis (not depression)		040 041 042 043 044 045 050 060 046 031	Any number
7	Psychosomatic		090 091 092 093	Any number
8	Personality Disorders		142 800 801 802 803 804 805 806 807 808 809 810	Any number except 24 and 62

		P.I.I code	Organic code
8 Personality Disorders (continued)		811	
		812	
		813	
		814	
		815	
		816	Any number except 24 and 62
		817	
		818	
		819	
		820	
9 Sexual problems		070	
		071	
		072	
		073	Any number except 24 and 62
		074	
		075	
		076	
		077	
10 Addictions		100	
		101	
		110	
		111	
		112	
		113	
		114	
		115	Any number
		116	
		117	
		118	
		103	
11 Senile and presenile dementias and psychoses		122	57
		123	58
		124	59
		125	60
		126	61
			63
12 Other organic conditions	a)	120	01-23
		121	25-56
		122	63
		123	71-78
		124	81 and 82
		125	98
		126	99
		127	

		P.I.1 code	Organic code
12 (Encephalitis, Syphilis	b)	ditto	24 62 86
(Alcohol and Drugs)	c)	ditto	64-70
(Syphilis and Encephalitis other sequelae)	d)	As in diagnostic 1 2 3 4 8 9	24 62

	P.I.1 code	Organic code	Mental Subnormality
13 Neurological syndromes with no behavioural abnormality	000 129	 01-56 71-78 98 99	00
14 Mental Subnormality	000	Any number	Any number except 00
15 No psychiatric abnormality	000	NOT in 13 or 14 above	
16 Other and Not Known	128 140 141 999		

CLIENT CONTACT SCHEDULE M.P. Y/N Centre & No.

Date

Worker Number CPN 1 SW 2

Start Time Contact Duration

Patient

Sex Age Group Diag./Prob. Group

Place of Contact

Patient's Home	1
Primary Care Office	2
Hospital Ward	3
Day Hospital/Centre	4
Social Work Office	5
Other, Specify	6

Length of Time Patient Known to Worker

None - 1st Visit	1
< 3 months	2
3 < 6 months	3
6 < 12 months	4
12 months & over	5

Contact

Planned	1
Unplanned	2

Specify reason

Referral Source

GP	1
Psychiatrist	2
Social Services	3
CPN	4
Other Health Prof.	5
Self	6
Relative/Friend	7
Other, specify	8

Type of Contact

Client/Patient Only	1
Relative(s) Only	2
Client/Relative(s)	3
Client/Patient Group	4
Other, specify	5

Worker's Contact Network Relating to the Case

GP	1	Persons living with patient	6	Other Prof. Workers	9
Psychiatrist	2	Other relatives		specify	
Patch S.W.	3	specify	7	Others	10
Specialist S.W.	4	Friends	8		
CPN	5				

Purpose of Contact

OBSERVATIONS	Clarifies/Elicits Information	Advice	Support	Other
Supervision of Medication. Side Effects etc.				
Current State of Physical Health				
Current State of Behavioural Problems				
Nature of Symptoms and Prognosis				
Arrangements for Treatment				
Social Life				
Bereavement				
Employment				
Finance				
Housing/Accommodation				
Legal				
Family Relationships				
Other Interpersonal Relationships				
Anti-Social Behaviour Problems				
Sexual Problems				
Prev. Medical/Psycho/Social History				
Other, Specify				
General Conversation				

Counselling	Yes/No	Clinical Investigations	Yes/No	Change of Medication	Yes/No
Direct Drug. Admin	Yes/No	Transport Provision	Yes/No	Supv'n of Beh. Therapy	Yes/No
Other Intervention	Yes/No				
Specify					

Time in Mins. Time in Mins

Personal Services Practical Assistance in Daily Living

Time Contact Ends.

Methods/Techniques Used Joint Worker/Researcher	Not at all	Briefly	Fairly	Mainly
Did you?				
Try to establish an empathic relationship				
Allow or encourage ventilation of emotions				
Offer support/reassurance/encouragement				
Encourage examination of nature and effects of patient's behaviour in relationships				
Use a dynamic explanation of present behaviour to explain the circumstances surrounding the current illness				
Show disapproval				
Adopt a directive approach				
Undertake treatment				
Other, specify				

Was anything achieved or learned from this contact? If so would you describe it?

What do you think will be your next step with this patient?

APPENDIX 4

PURPOSE OF CONTACT & OUTCOME OF CONTACT - 3 DIGIT CODE

PURPOSE (FIRST DIGIT)

0 None

1 To learn/observe

2 To encourage

3 To give information/advice

4 To administer physical or behavioural treatment

5 To give verbal therapy

6 To give some personal service e.g. transport, collect pension etc.

8 None specific/support

9 N.K./Not relevant

TOPIC (SECOND 2 DIGITS)

01 Psychiatric treatment

02 Psychiatric symptoms

03 Behaviour

04 Physical symptoms

05 Inter-personal relationships

06 Treatment administrative information

07 Day-to-day coping

08 Social life

09 Welfare

10 Relationships with professional workers

11 Psycho/social history

12 Other

13 Non-specific

'NEXT STEPS' CODES - 2 DIGITS

FIRST DIGIT

1 Refer totally to other agency

2 Consult/involve

3 Inform

4 Other

SECOND DIGIT (PREFIXED WITH CODES 1-3)

1 Psychiatric health agencies

2 Primary care/other health agency

3 Social services mental health agency

4 Social services non-mental health agency

5 Other local authority agency e.g. housing

6 Social security/financial agency

7 Voluntary agency

8 Non-professional carers

9 Other

SECOND DIGIT (PREFIXED WITH CODE 4)

0 Non-specific

1 Support - to keep stable

2 Further assessment/observation

3 Construct care plan

4 Physical or behavioural treatment

5 Check on compliance

6 Do a 'task'

7 Verbal therapy to obtain change

8 Close case

9 Other

99 N.K.

OVERALL OBJECTIVES, RAW CODES

00 Not relevant
01 To promote independence from services
02 To prevent symptoms
03 To teach 'coping' strategies to client
04 To teach 'coping' strategies to family
05 To change illness/behaviour pattern
06 To establish appropriate life-style
07 To improve 'welfare' position
08 To improve inter-personal relationships
09 To maintain present level of functioning
10 To try to understand client's difficulties/problems
11 To 'support' relatives/carers
12 To mobilise/co-ordinate services
13 To keep out of in-patient care
14 To promote personal autonomy
15 To monitor child care
16 To move from in-patient to more 'appropriate' care
17 To maintain treatment
18 To reduce medication
19 To monitor medication
20 To observe symptoms/behaviours
21 To monitor physical illness
22 To try to get client to accept treatment
23 To maintain at optimum level of functioning
24 Other
25 Not recorded

99 N.K.

GROUPS	RAW CODES
Cure	2
Change	3 - 8
Maintain	9;11;23
Monitor/Observe	10;15;19 - 21
Services	1;12 - 14;16 - 18;22

Appendix 5
Interventions
Numbers and Percentages

	Question				Advice				Support				Total			
	CPN		SN		CPN		SN		CPN		SN		CPN		SN	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Medicine	493	11	64	4	804	15	97	5	438	15	20	7	1435	13	181	5
Physical	407	9	64	4	584	11	33	2	126	10	19	7	1117	10	120	3
Behaviour/symptoms	1028	23	296	17	939	17	254	12	276	29	51	18	2243	20	581	14
E'ment Empl	91	2	76	4	320	6	207	11	17	2	17	6	432	4	300	8
T'ment Arr	515	11	89	5	1360	25	245	11	111	11	6	2	1986	18	340	8
Social Life	352	8	84	5	268	5	95	5	55	5	12	4	675	6	191	5
Bereavement	38	1	6	0	28	0	17	1	5	0	5	2	71	2	28	1
Work	104	2	32	2	62	1	42	2	19	2	6	2	185	2	80	2
Finance	117	2	128	7	122	2	314	16	10	1	36	10	249	2	474	12
Accom'n	71	1	104	6	73	1	107	10	19	2	30	10	163	1	321	8
Gold Care	234	5	130	7	152	3	106	5	54	5	11	4	440	4	247	6
Legal	19	1	12	1	19	0	26	1	3	0	9	3	41	1	47	1
Family Rel	409	11	341	19	599	12	186	10	92	10	33	11	1100	11	560	14
Other Rel	149	3	92	5	88	1	58	3	10	2	23	8	247	2	173	4
Anti-Soc Beh	22	1	23	1	31	0	20	1	1	0	5	2	54	1	48	1
Sex	3	0	49	3	-	-	27	1	-	-	4	1	3	-	80	2
History	318	7	150	8	28	0	16	1	8	1	3	1	354	3	169	4
Others	71	2	41	2	69	1	48	6	19	2	6	2	159	1	115	3
Questions	4522	100	1795	100	5542	100	1940	100	971	100	280	100	11035	100	4023	100
%	30		41		47		56		8		7					