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TITLE: COMMUNITY PSYCHIATRIC NURSES AND THE CARE CO-ORDINATOR ROLE: SQUEEZED TO PROVIDE 'LIMITED NURSING'

SHORT TITLE: THE CPA AND LIMITED NURSING

ABSTRACT:

Background: The Care Programme Approach (CPA) is the key policy underpinning community-focused mental health services but has been unevenly implemented and is associated with increased inpatient bed use. The care co-ordinator role is central to the CPA and is most often held by Community Psychiatric Nurses (CPNs), but there has been little research into how this role is conducted or how it impacts on the work of CPNs and their ability to meet the needs of service users.

Aim: The study aimed to identify and illuminate the factors that either facilitated or constrained the ability of CPNs, in their role as care co-ordinators, to meet service users' and carers' needs.

Methods: A multiple case study of seven sectorised community mental health teams was employed over two years using predominantly qualitative methods of participant observation, semi-structured interviews and document review.

Findings: Additional duties and responsibilities specifically associated with the care co-ordinator role and multidisciplinary working, combined with heavy workloads, combined to produce 'limited nursing', whereby CPNs are unable to provide evidence-based psychosocial interventions that are recognised to reduce relapse amongst people with severe mental illness.

Conclusions: The role of the CPA care co-ordinator was not designed to support the provision of psychosocial interventions. Consequently, CPNs in the co-ordinator role faced with competing demands are unable to provide the range of structured, evidence-based interventions required. This may partially account for the increased inpatient bed use associated with the CPA.

Keywords: care coordinator, care programme approach, community mental health teams, community psychiatric nurses, limited nursing

2

SUMMARY:

What is already known about this topic:

- ❑ The CPA is the key policy underpinning mental health services but has been unevenly implemented and is associated with increased inpatient bed use

- ❑ The care co-ordinator role is central to the Care Programme Approach (CPA) and is most held by Community Psychiatric Nurses (CPNs)

- ❑ There has been little research into how this role is conducted or how it impacts on the work of CPNs and their ability to meet the needs of service users

What this paper adds:

- ❑ The care co-ordinator role incorporates specific additional duties and responsibilities that include increased liaison, administration and attention to social care needs

- ❑ Combined with heavy workloads, these additional responsibilities reduce the opportunities for CPNs to provide evidence-based psychosocial interventions that are associated with decreased relapse and hospitalisation

- ❑ The failure of the CPA to include the provision of psychosocial interventions as an integral component of the care co-ordinator role may contribute to the increased inpatient bed use associated with this policy

BACKGROUND

The Care Programme Approach and the developing role of the CPN

The Care Programme Approach (CPA) was introduced in England in 1991 to improve the co-ordination of community-focused care for people with severe mental illness (SMI). It was based on the principles of case management, although not any particular model (Simpson, Miller & Bowers, 2003a). It introduced systematic arrangements for the assessment of health and social care needs, the provision and regular review of care, crisis and contingency plans, and close monitoring and co-ordination by a named keyworker, later termed care co-ordinator (Department of Health, 1999a). The CPA has been beset by difficulties (Simpson, Miller & Bowers, 2003b): it is often disliked by clinicians (Norman & Peck, 1999), has made little impact on service users (Rose, 2001; Webb, et al., 2000), appears limited in efficacy and is associated with increased inpatient bed use (Marshall et al., 2001). Yet it remains the key policy underpinning mental health service provision in England and is now being introduced in Wales (Welsh Assembly Government, 2003).

Alongside the introduction of the CPA ran concerns that community psychiatric nurses (CPNs) were not concentrating on people with SMI (White, 1993). A major review recommended that this client group should become the 'essential focus' for CPNs, who would also work in multidisciplinary teams (Department of Health, 1994). The Clinical Standards Advisory Group on Schizophrenia echoed this recommendation and suggested that CPNs were 'ideally placed' to act as CPA keyworkers (Gournay & Beadsmoore, 1995). Accordingly, CPNs became the profession most likely to act as keyworkers/care co-ordinators (Schneider, 1993;

4

Schneider et al., 1999). Sullivan (1997) suggested this role was designed to build on a trusting, therapeutic relationship and would enable CPNs to develop traditional nursing skills, employ various therapeutic interventions and take centre stage in the care process. But many were concerned about the ability of CPNs to fulfil the requirements of the CPA co-ordinator role whilst faced with numerous other demands (Gupta, 1995; May, 1996; Wells, 1997).

Initial studies stressed the lack of preparation and planning for the keyworker role (North et al., 1993; Durgahee, 1996). Additional paperwork and lack of resources created frustration, overwork and stress. Some predicted that staff might adopt rigid interpretations of roles and tasks but it was also anticipated that the monitoring role would enable early identification of potential relapses and reduce hospital admissions (Schneider, 1993). CPNs continued to identify the need for improved training in later studies and differences of opinion emerged as to the role and duties of the keyworker, particularly between social workers and CPNs (Simpson, 1999b; Miller et al., 1999; Miller & Freeman, 2003). The development of multidisciplinary teams (CMHTs) and the focus on people with SMI had led to changes for both professions. CPNs were expected to address social care needs traditionally seen as the province of social workers, who were now being forced to take on increased statutory responsibilities as their numbers within CMHTs were being reduced (Marshall, 1996; Miller et al., 2001). Consequently, social workers felt it reasonable that CPNs took on these social care tasks as part of the keyworker role. Against this, CPNs often felt insufficiently knowledgeable and resented spending time on these aspects of care at the expense of one-to-one therapeutic work with clients, reflecting tensions over 'blurred' roles, reported elsewhere (Brown et al., 2000).

5

The realignment towards people with SMI and teamwork raised the question of whether the workforce had the necessary skills (Sainsbury Centre for Mental Health, 1997; Devane et al., 1998; Simpson, 1999b). Fluid professional roles and core competencies were required (Department of Health, 1999b; Sainsbury Centre for Mental Health, 2001). Evidence also emerged that psychosocial interventions (PSI) benefited people with SMI and reduced episodes of relapse by improving the ability of users and carers to manage and cope with mental illness. Interventions included cognitive behavioural therapy and family work with users and carers (Baguley & Baguley, 1999). New approaches to educating and training staff were developed (Gamble, 1995; Gournay & Birley, 1998; McKeown et al., 1998) and formed an increasing part of education provision for CPNs (Hannigan, 1999). But, there was little evidence that PSI training resulted in implementation (Thornicroft & Susser, 2001). Structural factors such as high caseloads, lack of supervision and allocated time were identified as obstacles (Brennan & Gamble, 1997; Fadden, 1997; Price, 1999; Grant & Mills, 2000; Johnson et al., 2001). CMHT staff had 'unacceptably high' workloads that did not allow adequate contact time for effective working (Moore, 1997; Sainsbury Centre for Mental Health, 1998). Whether it was possible for CPNs to meet users' and carers' health and social care needs, provide evidence-based psychosocial interventions *and* act as care coordinators was unclear (Johnson et al., 2001).

THE STUDY

Aim

The study aimed to identify and illuminate the factors that either facilitated or constrained the ability of CPNs, in their role as care co-ordinators, to meet service users' and carers' needs.

Design

A case study design was employed, which allows the study of complex, dynamic contexts where there are multiple, influencing variables difficult to isolate (Fitzgerald, 1999). Case study is especially useful in explaining real-life causal links that are too complex for survey or experimental approaches (Yin, 1994) and actively advocates consideration of historical and social contexts (Platt, 1992). Case definitions emerged: the most important influences on the ability of CPN care co-ordinators to meet the needs of service users were those that existed in their interactions and relationships within the teams and with the health and social services organisations, not with the service users. Consequently, each CMHT was defined as a case within this multiple case study (Stake, 1998). Each case was explored in an attempt to identify issues relevant to the phenomenon under study, namely care co-ordination. Within each case, each CPN, service user, team member or manager was a 'sub-unit of analysis' with organisational, theoretical and policy matters identified and considered as contextual factors (Bergen & While, 2000). Predominantly qualitative research methods (interviews, participant observation and document reviews) were employed

7

because of their sensitivity, flexibility and adaptability in natural settings (Robson, 1993).

Sample and data collection

Seven CMHTs in one NHS trust were studied using participant observation between January 1999 and February 2001. Field notes were taken at over 70 CMHT meetings with additional observation undertaken in team offices, CPA review meetings and during CPN-service user consultations. Tape-recorded, semi-structured interviews were conducted with 23 of 24 CPNs (one refused to participate). Tape recorded interviews every three months for 15 months then took place with 15 of those CPNs, purposively sampled as working with service users with severe mental illness and complex needs as identified by local CPA criteria (tier three/enhanced). CPNs also completed the Camberwell Assessment of Need research questionnaire (Slade et al., 1996) once every three months. Additional interviews were conducted with all CMHT managers and a number of psychiatrists, social workers, occupational therapists and carers. Nursing files and care plans were reviewed, alongside local and national policies and audit reports relevant to the CPA. Questionnaires were used to collate demographic and caseload data. Service user involvement is not reported in this paper.

Rigour

Multiple data sources within cases were employed as they create a rich, detailed description of the phenomenon under study (Yin, 1994) and allowed triangulation

between methods that provided elucidation, rigour, breadth, depth, and the stimulation of further analysis (Denzin & Lincoln, 1998; McFee, 1992; Murphy et al., 1998; Sandelowski, 1995). Regular memo writing and progress reports for supervisors and funding bodies included tentative exploration of categories and concepts as part of a strategy aimed at enhancing the credibility, robustness and trustworthiness of the emerging categories and themes and of the research process itself (Cutcliffe & McKenna, 1999; Long & Johnson, 2000). As analysis of all data sources led to the development of categories, themes and concepts, 'theoretical sampling' was employed in questions to pursue analytically relevant distinctions and explore or test theoretical developments (Murphy et al., 1998). As an 'insider' to mental health nursing and CMHTs (Dandelion, 1997), constant critical reflection was conducted with supervisors and other researchers on the choice of methods and the gathering and interpretation of data in order to challenge intuitive assumptions and values (Mackenzie, 1996). Rigour was also provided through prolonged contact and engagement, care in collecting, interpreting and presenting data, and discussion of emerging ideas and findings with participants and within local settings (Davies & Dodd, 2002).

Ethics

Ethical approval was obtained from the Local Research Ethics Committee. All staff, service users and carers gave written consent for recorded interviews. Written and verbal information was provided to all CMHTs and consent obtained for participant observation at meetings. Participants were reminded of the researcher role and focus

to minimise inadvertent confusion of roles created through ongoing contact (Seed, 1995). All names have been changed.

Analysis

Qualitative data was stored and analysed with the aid of QSR NVivo (Richards, 1999). Constructivist grounded theory methods were employed to provide structure whilst respecting the social constructivist framework underpinning the study (Charmaz, 2000; Schwandt, 1998). Central to this theory is the technique of 'constant comparative analysis', which involves the comparison of data (an interview, an observation, a theme) with other data in order to develop conceptualisations of possible relationships (Thorne, 2000). By comparing the experiences of CPNs and other staff within the teams, patterns, themes and contrasts emerged. Core concepts and their properties were identified and an emerging theory formulated. This paper reports on the emergence of one of those concepts, 'limited nursing'.

FINDINGS

Of the 23 CPNs initially interviewed, 12 were women and 11 men. There was a similar gender balance in the 15 CPNs recruited to the full study, with eight women and seven men. The average age of all CPNs was 41.7 (SD 7.9) compared with 39.4 (SD 6.2) for those fully recruited. Of the 23 CPNs, 18 described themselves as white British or white European. There were four Asian CPNs. The CPNs had an average 18 years service as a mental health nurse (SD 7.1) and just over nine years (SD 4.7) as a CPN. At least 13 of the CPNs had completed a CPN certificate course and six held at

10

least one degree. The majority had completed further education and training in a range of therapies, several to masters level. One CPN had completed the 'Thorn' training in psychosocial interventions (PSI). Four others had completed advanced modules in PSI approaches. Average CPN caseloads were 33 (SD 6.1) but this included staff working reduced hours. Experienced CPNs working full-time had caseloads of between 35 and 43, in line with national figures (Brooker & White, 1997). The average number of clients on tier three/enhanced CPA was 5.5, but ranged from none to 14 per CPN.

Accepting the focus on severe mental illness

Overwhelmingly, the CPNs in this study accepted the emphasis on those with SMI, in contrast to just a few years earlier (Simpson, 1998). Three still wished to maximise the use of counselling and psychotherapeutic skills that they had developed and this was reflected in their case mix. The service was now seen as "more focused"; CPNs were no longer expected to be "all over the place trying to do a little bit of everything". For some, the re-orientation of the service had finally caught up with their own interests in focusing on SMI, whilst others had sought out specialist education and training to ensure they now had the appropriate skills. This predominant shift in viewpoint followed the national and local agenda (Allen & Rodrigues, 1997). It was also recognised that the process of change was ongoing with significant implications for the CPN role, not seen in wholly positive terms. Key developments were identified and the impact of the combination of these will be explored. The concentration on SMI, the move to working within multi-disciplinary teams and the development of the care co-ordinator role had resulted in CPNs being

11

unclear about their role. They were often suspicious of developments and fearful about their future position within mental health services:

> I think we're going through another period of change. We're going into community mental health teams. There's all sorts of stuff going on for each of us at the moment, not necessarily about our own roles … but about management structures and keeping a sense of who we are and what we do within community mental health teams. (CPN Deirdre).

This transition was recognised as one familiar to the broader profession, with nurses being asked to take on a variety of roles, "from washing floors to minor surgery". Tensions around these developments will now be explored in relationship to the CPN and care co-ordinator roles.

Restricting the therapeutic role of the CPN

In a trust document, *'The Role of the Community Psychiatric Nurse'*, the centrality of the care co-ordinator role was recognised alongside the range of skills and therapeutic interventions that CPNs could offer. Most CPNs identified a focus on the therapeutic relationship and psychotherapeutic skills within a psychiatric framework as key factors in the CPN role:

> You need personal skills to bring about therapeutic change…I see that as the core of my role. It's a nursing role, isn't it? A role which involves improving the quality of people's life through psycho-social skills, educative things, working with families, using what I know about illness … (CPN Deirdre).

But all CPNs spoke of how their ability to fulfil their role and provide therapeutic interventions was being restricted by workload pressures. Most agreed they were not being asked to see more people or hold larger caseloads but there were additional demands that required more of their time. They described the therapeutic role as the 'ideal' alongside the 'reality' of the job, which was more about "constantly managing crisis after crisis".

> If I was able to offer more intensive input into a client who's breaking down, in an acute psychotic state, perhaps I'd be able to keep them out of hospital. But it's very rare that I can visit somebody daily, which is what that needs. That will come back to reduced caseloads and having the ability to spend more time… (CPN Bob).

They concluded that the CPN role was 'narrowed down' to its basics as a result, which served to negate or ignore skills they had often spent years developing. This was sometimes linked to the continuing dominance of the 'medical model' within the teams, as reported elsewhere (Warner et al., 2001). Alongside having to establish contact with inpatients prior to discharge, their role was becoming more like 'psychiatric police officers' that monitored medication compliance:

> The skills of CPNs are ignored and negated these days. I've got a psychodynamic training as well as cognitive therapy training and that's ignored and devalued. I think CPNs feel devalued as part of the problem of the trust whereby medics have the control, the medical model predominates. So, I can offer all these clients all these things but they're not allowed to have them. (CPN Frazier).

CPNs were less able to provide 'hands-on' or 'face-to-face' work with clients, which might mean working on specific therapeutic interventions, devising relapse prevention strategies or educating the user and their family about their condition and treatment. It could also mean something less technical but just as valuable, in the form of establishing a therapeutic relationship using 'low visibility skills' (Michael, 1994; Allen & Simpson, 2000). Effective therapeutic relationships have been identified as reliable predictors of patient outcome in psychiatric care, may affect users' quality of life and are probably important mediators of interventions including case management (Reeper, Ford & Cooke, 1994; McGuire et al., 2001; McCabe & Priebe, 2003).

Keyworker/care co-ordinator role

None of the CPNs provided a structured or comprehensive description of the keyworker role or included all of the components found in CPA policy. It was still subject to wide interpretation and some thought that a tighter definition was required in order to achieve a more consistent approach. This lack of clarity and consistency perhaps reflected the failure to link the CPA with a particular model of case management (Simpson et al., 2003a), and a failure on the part of managerial leadership and educators to ensure the role was understood. Introduction of the new title of 'care co-ordinator' added to the uncertainty as it was initially unclear what this apparently new role would involve.

Communication aspects of the role appeared paramount and most recognised the keyworker as being the central point of contact and co-ordinator of care but suggested the need for improvements:

14

> Certainly there's lots of scope for improving how we function as keyworkers. And I don't mean by separating out away from the therapeutic role, but consistency in what we do and how we provide care to people as the keyworker across the team…procedures of what we should be doing. (CPN Pat).

Most CPNs saw a strong overlap between the CPN and keyworker roles, with the allocation of keyworker responsibilities formalising many duties undertaken by CPNs but adding another more structured layer of co-ordination and communication. Accordingly, CPNs associated the role with those additional duties and there was also a belief and some anxiety that being the named keyworker carried with it an extra level of responsibility: should something go wrong it would be their neck on the line. Although this might not have been stated explicitly by service managers, it was a widely shared and expressed perception that the identification of a particular individual under the CPA was in order to hold that person responsible if there were an 'untoward incident':

> I'll tell my colleagues something [and they say], 'Have you documented it?' 'You've got to cover yourself. Write to the GP, document it, then you're in the clear. They can't come back on you.' So many people have said that to me. (CPN Beth)

Increased administration

An increased demand to keep detailed nursing notes and care plans, input information on computers, communicate with others and co-ordinate care was a constant source of complaint. Some of this increase was directly related to the CPA, some to an

increased tendency in healthcare organisations to record information and activity with the aim of improving patient care. But there was also the belief that some of it was due to protective or defensive thinking within organisations; as 'proof' of actions taken should something go wrong. Even CPNs who produced concise and comprehensive care plans and client files found the increased administration a burden:

It's just letters and phone calls that seem to take up an awful lot of time. The communication with different people involved with different clients, their carers, especially people on [enhanced] CPA just takes forever. (CPN Gwen).

Several CPNs had been forced to cut down the number of client contacts in order to remain on top of it all. Things became even more demanding with the introduction of new documentation following reforms of the CPA ostensibly aimed at reducing paperwork (Department of Health, 1999a). Incompatible management and IT systems made matters worse. Team managers were very aware of the additional administration required but suggested that CPNs were often quite poor at delegating such work and stressed that the increase in administration was aimed at improving standards of care:

In terms of the admin, it has meant that they spend more time at their desk completing papers. But […] people should be better informed about the service they receive and they have a right to receive the care plan, they have a right to know what we as so-called professionals are writing down about them. Yes, […] it's a resource issue and it means that CPNs can't spend as much time with patients, they therefore can't see as many people, and that has to be acknowledged and that has to be quantified somewhere, I think. But in terms of providing good standards and good practice, it's a healthy way to be thinking. (CMHT Manager).

16

Whatever the reasons, the significant increase in administration associated with the care co-ordinator role further reduced the time CPNs could spend in face-to-face therapeutic contact users and their families.

New roles and role blurring

With the emergence of teamworking and the care co-ordinator role, CPNs were increasingly expected to take on new demands. These included being put on duty rotas, previously the domain of social workers, and addressing users' social care needs. Being 'on-call' widened the focus of their work away from people with SMI and whilst some CPNs had always seen social care as part of the CPN role, others saw it clearly as social work territory, as reported earlier (Miller & Freeman, 2003). Even those who embraced the wider role held concerns that they were being expected to take on responsibilities for issues about which they lacked confidence and for some, learning when and how to delegate was also a challenge. These tensions were directly linked to the additional expectations and responsibilities associated with the care co-ordinator role and further detracted from their psychotherapeutic CPN role.

'Scrunching the bit in the middle'

All these factors converged to effectively reduce the ability of the CPN to operate as a 'nurse', or as a 'therapeutic agent'. There was a conflict between the extended care co-ordinator role and the therapeutic nursing role, with the latter being "scrunched in the middle". CPNs used phrases like "limiting what we can do for clients", "taking us

away from what we are already doing" and "diluting" the role and not wanting it "diluted any further". One CPN who welcomed the care co-ordinator role but saw it limiting her "care-giving role", laughed as she said, "It's fine but I want someone else to do the co-ordinating":

> I have never had a problem with keyworker or care co-ordinating until very recently when I thought, 'Hang-on. I'm doing more co-ordinating' which I don't think is nursing. Well, I didn't think it wasn't nursing until I felt the other bit, the other pressure. I didn't have time to see people. (CPN Shelly).

She felt she had to justify spending time with service users, as though it was no longer seen as a key part of the CPN role:

> I find it quite a struggle to justify doing things with patients, with clients. Because you're questioned […] I'm not paranoid, but there's a feeling that somebody else can be doing that […] And I think any time away from clients isn't nursing. Now that may not be right, and that clearly isn't right. I mean, nurses have always done… you've always got to do care plans and documentation and stuff. But I think there's more and more being asked of you, or it feels like there is […], that you are having time taken away from nursing. (CPN Shelly).

All the attendant duties and demands associated with the co-ordinator role severely restricted the range and depth of therapeutic nursing interventions CPNs could employ: CPN care co-ordinators provided 'limited nursing'.

Verifying and developing the concept of 'limited nursing'

In later interviews with participants, the usefulness of the concept of 'limited nursing' was verified. It was immediately understood and accepted by CPNs and other CMHT staff. A consultant psychiatrist seized upon the concept of 'limited nursing' and applied it to the medical role:

> I like the idea of the 'limited nursing'. I think I'd endorse that and the idea of 'limited medicine'. It feels like we do the same. You can just about keep on top of seeing people to keep on top of them, review the medication and make the decisions that we'll discharge them. But you don't get to do much that is meaningful. You don't actually ever spend much time doing anything psychotherapeutic anymore. (Consultant Psychiatrist)

The team managers understood how and why CPNs felt increasingly constrained in their role and recognised the idea of 'limited nursing':

> That's an interesting one because obviously I think, for instance CPA forms now are different and … they encompass a sort of social care assessment and they will ask you to look at different areas. And that's all going to be more time consuming. […] So I can see that in a sense the implications of that are that people, if they want to do those things *and* have the time to do nursing then they need to have smaller caseloads. (CMHT Manager)

They also suggested that the contract between the trust and the health authority, which demanded a minimum number of CPN-client contacts, might also be a factor:

19

> Where people are expected to achieve a number of contacts, that probably comes into play a bit as well. Because if you've got a situation whereby people feel that they've got to see a certain number of people a day and they've also got to do all these other bits, the time that they get with people is going to be squeezed a bit. (CMHT Manager)

All the team managers confirmed that reduced face-to-face contact with clients was directly related to the development of the care co-ordinator role and was likely to continue or even worsen. But the managers did not think that freeing up CPNs to provide psychosocial interventions was the answer. It would be important to ascertain the level of need for specific interventions and then decide how best to provide those skills. Specific skills and interventions needed to be made available but provided by selected individuals within a team or even across several teams. It was doubted that CPNs who were care co-ordinators would ever be able to provide such interventions alongside their other duties.

LIMITATIONS

The findings are derived from a relatively small number of cases in one NHS Trust in one part of England. The CMHTs were in an early developmental stage, with staff adjusting to their new teams and staffing levels were recognised as poor. However, through presentation and discussion at a number of national conferences during the development and refinement of the concept of 'limited nursing', it is suggested that the findings are generalisable to CPNs working in other CMHTs, certainly in England. The concept also appears meaningful to other professional groups. The

research identified other factors that interrelated with the concept of 'limited nursing' and further hampered the ability of CPN care co-ordinators to meet the needs of service users. These have not been explored here because of space limitations.

DISCUSSION

Overwhelmingly, CPNs accepted the care co-ordinator role and identified significant overlaps with their CPN role. This is as it should be. The CPA was introduced to provide a framework to guide good practice and was based on what effective workers were already doing. But this paper has identified some of the tensions that exist for CPNs between the care co-ordinator role and their wider therapeutic remit. The role adds significant extra burdens and is perceived to add a weight of responsibility to the named care co-ordinator with attendant fears and suspicion, reflecting early alarm (Gupta, 1995). CPNs have also been required to increase their involvement in social care interventions as the result of two factors: a broader understanding of the needs of people with SMI and the move to establishing core competencies across professions within multi-disciplinary teams (Sainsbury Centre for Mental Health , 2001). This has led to a fear of 'role blurring' where the overlap between the different professions increases and philosophical differences that underscore their approaches appear to be ignored (Brown et al., 2000; Norman & Peck, 1999). Additionally, the involvement of other workers in the care of the user is diminishing as the co-ordinator is expected to take on more responsibilities. As a result, whilst acknowledging the importance of their client's social care needs, CPNs often resent the drive towards establishing a more 'generic' mental health worker at the expense of their specific therapeutic nursing skills. These problems are further magnified by the inhibiting size of CPNs'

21

caseloads and other time pressures, which now include duty rota work and regular inpatient liaison. Consequently, for CPNs the care co-ordinator role is strongly associated with an expansion and blurring of their role at the expense of the very aspects of mental health care that attracted them to the job; establishing and developing therapeutic relationships and providing therapeutic interventions to people with mental illness.

The suggestion that specialist individuals or teams provide PSIs has certain advantages but service users prefer advice, support and interventions from the person they have developed a trusting relationship with and do not like repeating the same information to different people (Beeforth et al., 1994; Repper et al., 1994; Gauntlett, Ford & Muijen, 1996; Simpson, 1999a). This was one of the motivations for introducing the CPA, alongside reducing the risk of users falling between different services (Department of Health, 1999a). Secondly, this view assumes that such interventions would be administered over a limited number of sessions, allowing the therapist to move on to other users. More commonly with people with SMI, therapeutic input is required over a long period of time and is ideally delivered in accord with the changing needs of the user. Subtle changes in mental state and need are constantly assessed and re-assessed by the clinician through an ongoing, close relationship with both the user and his or her family (Kanter, 1989; Watkins, 2001).

CONCLUSIONS

The failure to incorporate PSIs as a key component in the CPA keyworker/care co-ordinator role may partially explain why the CPA is associated with only limited

improvements in mental or social functioning amongst users, has little impact on quality of life and is linked with increased bed use (Becker et al., 1998; Wykes et al., 1998); Taylor et al., 1998; Burns et al., 1999; Marshall et al., 2001). Such interventions tend to be perceived as 'add-ons', to be provided once the core duties of assessment, monitoring, co-ordination and administration are completed, if time allows. Yet recent research suggests that sensitive proactive casework centred on engagement and preventing crises is central to the prevention of relapse and hospitalisation (Weaver et al., 2003). Future developments of case management in England, Wales and elsewhere need to consider how these complex and often contradictory tensions can be addressed.

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28

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