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**Perceptions on the development and implementation of a
care pathway for people with schizophrenia**

(Volume Two)

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A thesis submitted in partial fulfilment of
the requirements of the City University for the degree of
Doctor of Philosophy

St. Bartholomew's School of Nursing & Midwifery

City University

April 2002

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Chapter Six

Development of the care pathway & organisational change

Introduction

In this chapter, some of the problems in developing and implementing the care pathway will be described such as the ability to describe and represent psychiatric work. The research study took place within a volatile change environment. Particular problems were maintaining interest and engagement with the project and morale within the team. Throughout the entire process, the researcher endeavoured to follow an action research cycle (Carr & Kemis 1986) through a series of working group meetings and individual discussions. Some of the difficulties in conducting the study will be reviewed.

Problems with development & implementation

Visibility of psychiatric work

Much research has been undertaken to establish the role and function of major occupational groups in psychiatry (Miles 1977) although this has been found difficult for hospital settings (Walton 2000). The first major theme identified in the data was the difficulty in describing the process of psychiatric care and how respondents identified the most and least visible parts of work tasks. A second factor was the perceived complexity or simplicity of the care pathway for practice.

Some respondents identified a whole list of roles and functions for psychiatric professionals whilst others focused on tasks such as administering medication. For example Linda who was a staff nurse working on the ward suggested that the work of mental health nurses was difficult to quantify into tasks:

You're seen to give out medication but talking with a patient on a one to one is invisible, managers can't see what you're doing.

Simon experienced difficulties in describing the process of psychological care largely because of the traditional way, in which he worked. In both the working groups and interview data Simon claimed that he never conceived his work to fit into a standard pattern. For example, following a patient assessment a case formulation would be developed which would then lead to an unpredictable number of contact sessions. Each session would then be guided by the response of the patient. Illustrating the difficulty in specifying the process of psychological care, Simon described the process of care pathway development as a '*discovery*' and a '*challenge*'. Similarly for other respondents, their descriptions of usual care were very nebulous, particularly when describing symptom management and predicting response to treatment. George described the experience as '*at one stage it's in focus and next it becomes blurred and suddenly it becomes a hugely difficult question to answer*'.

Although some respondents identified that the care process and the human condition was beyond clearly described processes, the view from Giles was that care could be described as a series of tasks:

We have treatments and outcomes and given the unshakable reality of those things, it is not a myth to try and pursue a better way of doing that. There is a beast in that jungle you are trying to catch; it's not an empty jungle.

George also observed the difficulty for clinicians to identify core tasks in the working group meetings but took solace from the research nature of the study.

During a later interview, George suggested that the care pathway would be more accurate with '*future generations*' of development and shaped by the patients treated within it. However, this ability to develop the care pathway would be limited by the professional team to explain their action.

Derrin found it difficult to identify the work tasks of an OT and argued for the individualised nature of patient care. In line with other respondents, there were some aspects of practice that were easy to identify (assessments), whilst the less visible parts were more difficult to define such as motivating patients and setting aims and objectives for any resultant problems. This observation can be compared to the process of '*caring*', which is again difficult to define, and in many respects, invisible in the care process (Barker 2000). The nursing profession has found it difficult to identify practice parameters (Witz 1992)

largely due to parts of practice being less visible and this has been partly supported by this study. Likewise the OT profession have found it difficult to explain practice to others because of the various settings in which they work and the many interventions they proclaim to use (Finlay 1997).

Pat identified that he had problems in specifying the work that he carried out with psychiatric patients and attributed this to the complexity of psychiatric work. Coupled to this was difficulty in deciding the exact intervention leading to the improvement. Pat suggested that most patients who present to the service would follow a set progression of tasks, although noted the difficulty in describing this list of tasks. Similar experiences were found in a case study into developing a care pathway for mentally disordered offenders (McQueen & Milloy 2001). These authors found that as the monthly development groups took place, the care pathway changed to include aspects of best practice and particular legal issues pertaining to this type of client group. Pat suggested that it would take a number of generations of care pathways for it to become a true representation of care:

Finding that key pathway of a schizophrenic patient is extremely difficult to pin down. The first few pathways are nothing more than theoretical quoting, because you'll say I do such and such, but that won't be defined or accurate.

Mike observed that nurses were content to identify those tasks attributable to the medical model and mental health legislation. However they were unable to move

beyond tasks that he describes as '*the old sort of mental health issues*' such as '*give medication*', '*monitor for side effects*' and '*signs and symptoms of illness*'.

These visible tasks were very easy to describe and place onto a care pathway.

The danger with this point is that the care process may be broken down into only the most visible and '*mechanical*' parts and not on the central vehicle of nursing practice (nurse-patient relationships), which has been identified in previous sections and also in the theoretical literature (Buckingham & Adams 2000).

Although some clinicians stated their difficulties in identifying the tasks that clinicians perform, others such as Steve were strongly in favor of clarifying professional roles, if only to do it in the most basic of processes:

It's possible to itemise what clinician's do from day to day for the sake of accountability and clarity, so that we're all working towards the same goals and aren't using interventions that are going to work against each other.

Simon offered a competing perspective of the task-orientated nature of the care pathway by drawing on his experience as an educational psychologist working with the national curriculum. Simon questioned whether the approach of a care pathway was ultimately accurate or cost effective to the organisation:

Task analysis doesn't fit reality because people tend to jump steps, so you've got a problem if you base your practice on a theory, and then find it's false. A pathway is just an ideal and it may be more pain to implement than the services as they are.

A further problem with presenting psychiatric work as a task is that it shapes the way practitioners view the patient and perhaps denies other sources of information. Giles argued that it might lead clinicians to treat all patients the same (the intention of standardisation) regardless of whether it is appropriate:

When the care pathway says have your first assessment within two days, and on day two and a half a really crucial piece of information comes along, that piece of information isn't seen in the same light because you're no longer thinking about assessment.

It could be considered that those visible tasks, (e.g. as carrying out the care program approach, or patients responding to medication by set times) are more amenable to standardisation. However, those tasks that are less visible, (e.g. relationship building or patients coping with their illness or development of insight), may be less amenable to standardisation. The least visible parts of the care process were more likely to be included as examples of individualised practice and the resultant effect of these occurrences could arguably be a less representative sequence of care on the pathway compared to the realities of psychiatric care. The nature of a care pathway would be to include aspects of care that could be standardised. However, when respondents were unable to achieve this it led respondents to view the care pathway as lacking detail or too simple. The following examples will unpack these contrasting views and examine how they compare to the complexities of psychiatric practice.

The logic of a care pathway is to attempt to have all care that is delivered adequately described (Pettryshen & Pettryshen 1992) although respondents spoke about how their conceptions of the care pathway would not always capture the totality of care. For example doctors who designed the medication care pathway prompted the response it was too simplistic to account for the complexity of psychiatric care. Kerry felt there was a danger in that it may lead people to provide an idealised picture of health care:

Only prescribe Lorazepam if this person is aggressive, but the reality is that you would prescribe in case they became aggressive, you would use it a lot more frequently than the care pathway states.

The process of developing the care pathway may have constrained respondents to identify the most visible parts of care and in doing so respondents may have perceived the care pathway to focus on single interventions that lead to clear outcomes. For example, giving medication and symptom reduction. Other respondents may have been aware that the '*goals of intervention are multi-dimensional*' (Perkins 2001) and that a care pathway may distort the view of psychiatric care.

For Giles, the care pathway needed to be developed in a way that offered a network of options with more complex interactions. Giles suggested that the care

pathway would need to reflect a patient's condition where progress and treatments changed constantly:

For any one instant there is no correct drug treatment, but 20 or 30 forms of drug treatment...It's not as simple as saying that this person goes into box A then do B...care pathways reflects a crude digital signal of a much more subtle analogue curve.

George suggested that it would be more appropriate to start off with a basic version of a care pathway adding more elements to build up to a greater account of psychiatric practice and so '*reflect more honesty about what people do*'.

George built on this theme in a later interview by suggesting that the care pathway was not reflective of the reality of psychiatric care (in support of a view that the care pathway was too simple). The care pathway was constructed by the participants, but ultimately not delivered:

It represented a large economical chunk of it where it comes down to this purchaser / provider requirement but it wasn't what's delivered to the patient because very little was being delivered.

Simon identified that a standard package of psychological interventions could be developed but argued for this to be at a basic inclusive level so that its relevance for all patients could be maintained. An example was a simple statement where '*everyone must be offered therapy, the chance to talk to somebody and to standardise a repertoire of actions and responses at a simple level*'. Simon felt that the danger in determining care in more precise terms was that '*no one can*

fit the reality of it' and so invalidating the care pathway. However, Simon may be indicating a problem experienced by other respondents where only the most visible parts of psychiatric care could be illustrated. Alternatively Simon may be deliberately evading the process of specifying his role. Johnson (1972: 43) noted that professions entered into a '*process of mystification*' when examining what they do. The researcher also observed that uncertainty of role was not completely attributable to an inability to describe psychiatric work. In both the working groups and individual discussions respondents were unwilling to specify their role and function and focused on the most visible parts of their role. Clinicians may highlight the uncertain parts of their role to hinder the ability of managers to control the work process.

The care pathway attempted to represent work tasks into a single working document by negotiating the content of a clinician's role that was acceptable to them. This led to the criticism that the care process lacked the required detail and focus and misrepresented the nature and workload attached to patient groups. George offered further deficits on the care pathway structure:

It will identify what services are offered and identify housing needs, but then can't specify what those workers are going to do about those problems or the actual clinician work load, it will say the person has social care deficits but doesn't say how the OT will tackle them.

Kerry noted other problems such as the care pathway not recording medical contact sessions with the patients. For example, Kerry could see some patients every day and this may not be recorded whilst for others it was unnecessary to see them as prescribed on the care pathway. Essentially, the care pathway failed to take account of the intense contact at the start of the admission and the tapering off later. However, the function of the care pathway was to ensure that psychiatric patients were seen at regular set intervals throughout the admission period. Moreover, as Kerry commented earlier, she felt constrained by a care pathway.

The nature of writing down problems, interventions and outcomes for in-patients with schizophrenia led to some respondents feeling that it failed to represent the realities of psychiatric care on hospital wards. However, others suggested that the care pathway illustrated a crude minimum of what a patient should receive in hospital. It has also been noted that describing the visible parts of psychiatric work attempts to make practice more transparent. The question asked of respondents assumes that psychiatric care can be described and to a certain extent respondents attempted to describe it. However, they were limited to only the most visible parts of psychiatric work. Observations carried out by the researcher found that clinicians performed more tasks for the patient than was detailed on the care pathway. For example, the doctor assessed the patient more frequently than that detailed on the care pathway. Moreover, evaluations of

nursing care occurred daily in the 'hand-overs' but neither were they documented in the clinical notes or included on the care pathway. This could be due to the difficulties in describing psychiatric work such as clinicians not knowing about their role or poor preparation for undertaking the task. Alternatively, respondents may be deliberately evading the process of describing psychiatric work due to a perception of vulnerability in the working group process. In all, the ability to describe psychiatric work was problematic and constrained by a number of complex factors.

Inserting care delays

A second major problem for the development of a care pathway was the insertion of delays in the care pathway. Some respondents have suggested delays were inserted into the care pathway in order to give clinicians '*time*' to carry out tasks. The most commonly noted delay was the patient's mental state preventing services from being carried out. In this section some of these care delays will be reviewed as one of the problems in developing a care pathway.

Many respondents who were both positive and negative about the ideology behind a care pathway noted the patient's pathology as a reason for why some services could be accessed and not others. The difficulty in predicting a patient's clinical progress was rigorously defended in all working group meetings. From a community worker perspective Mike spoke about some of the delays that he

attributed to the mental state of the client following implementation of the pathway:

I didn't see Peter on the ward for the first two weeks because he was very paranoid. It would have been fruitless for me to come around and sort out community needs or do a CPA on him, it would have harmed our relationship and wasting my time trying to get things done.

Observing this factor from an in-patient perspective, George also highlighted the need for symptom control as a barrier to accessing services in the care process:

With Tanya there is nothing we can do until symptom control, she's not even willing to entertain the idea of looking at the reasons for her requiring admission and she won't do because her delusions are extremely fixed.

Pat felt that clinical symptoms could be controlled within a 'reasonable time' but was unable to say what this would be. Alternatively, for Zeb the problem lay with the interface between external departments such as housing and welfare agencies:

The locality will say we know what were doing, we don't need anything new to tell us how to do it, the bad things are to do with not enough housing and not enough beds and getting benefits quickly.

Some studies have found that diagnosis accounts for only 6% of the variation in hospital stay (Horn *et al.* 1989) whilst Creed *et al.* (1997b) identified other factors such as levels of suitable housing. Many reports have identified that

psychiatric patients remain in hospital beyond clinical need due to the lack of supported accommodation (Fullop *et al.* 1996). For Steve, this produced feelings of '*frustration*' at being unable to make the system more efficient:

Nurses feel fairly helpless in that they phone up the key-worker or the hostel and try and get things pushed along the patient is just hanging around waiting to go, the problem is organisational and it needs to be standardised.

The Government has identified that NHS Trusts need to produce efficient mechanisms of ordering clinical information (NHS Executive 1998). Moreover, other studies have found that community workers do not always integrate with the ward team to plan for effective discharge as quickly as necessary (Barker & Walker 2000). For Tina, problems were observed in the way the hospital implemented its clinical information policy and so impacting on the hospital-community divide. This problem manifested itself as a care delay in the care pathway:

It's an ad hoc process where clinical information passes from one sector to another and this delays the whole process of admission and discharge, it can take the CMHT a week to process a patient and allocate a social worker or a nurse and that's down to poor communication.

A view from Zac who worked for the Health Authority was that the emphasis on acute mental health care needed to change, where the ward became more of a resource for the community team. Zac suggested that the majority of care should

be relocated to a community setting with the emphasis being to get '*the patient out as fast as possible*'. Zac advocated for the community team to monitor the frequency of admission but also manage the speed by which people were allocated a key-worker and discharged from hospital. However during a second interview, Zac built in the delay of finding accommodation (resource issue) and the possibility that this may be a realistic factor preventing people from going through a care pathway:

However much you refine the care pathway so that somebody makes fairly rapid progress, if at the end of that time, there is no where for them to live, then the phenomena of bed blocking will prevail.

Similarly to Tina, George identified the allocation of the key worker as a possible delay in the care system, which supports some of Zac's points above. Reluctance was expressed in the working groups to change the process of patient allocation. Respondents identified that unless a patient was allocated to a community worker then a care pathway would not start. George suggested a greater role for the community mental health team where the community worker becomes the central person from the start of the admission. Reconfiguring the role of the community worker to act as the initial start to the care pathway suggested that not all participants acted to insert delays.

Likewise, it was the perceived bureaucratic blocks in the system that acted as a stimulus for Mike to engage with the project. For Mike, care delays were both a

bureaucratic and clinically related problem but the important issue was to distinguish when each barrier occurred. Using a care pathway includes variance analysis, which aims to provide some record of care delays (Schriefer 1995). However, before this system becomes useful it is necessary to be clear that some care delays are legitimate and not inserted for the needs of the staff groups. The process of psychiatric care requires adequate description for a care pathway to be designed.

Care delays may come from a source external to the care process such as accessing supported living projects. For example, Jude used this factor to suggest the care process should '*build in time*' to account for this problem, and for this respondent, it was difficult to predict if or when accommodation would become available:

The accommodation people will place time delays until tenancy can begin and so that needs to go on the care pathway because it takes about 4 months from the date of referral, and if the patient is accepted, the patient cannot come until a vacancy becomes available, put the patient on a waiting list.

Bill perceived that the pressure in the service affected his ability to say when he would carry out an assessment of need:

It's reasonable to have an assessment completed within a month, but the difficulty is getting the appropriate accommodation, securing their

assessment date, having enough staff in the locality team to do the assessment.

With repeated interviews and discussion with community workers, respondents were eventually able to develop a sequence to assess and obtain a range of accommodation types for the care pathway. For example, the care pathway would determine high, medium and low supported accommodation and determine the stage for considering the accommodation type. For those patients that required intensive rehabilitation, a referral route was developed to quickly determine this need. This sequence would be the starting point to determine a future estimate for supported accommodation in community settings and displays again the ability to describe psychiatric work and reverse potential delays in the system. However, in only a few cases did the patients follow these routes and so the success in predicting the sequence remains questionable.

Additional to the problems in describing psychiatric work, respondents identified that parts of the care pathway were inaccurate due to the insertion of care delays or blocks in the system. The nature of the patient's illness or the problems in interfacing different agencies was a major factor. However, there could be other reasons such as participants expressing the view that they '*know best*' through their clinical experience. Closs & Cheater (1999) also considered this with the interpretation and application of evidence based practice. Zeb suggested that this attitude would undermine the process of developing a care pathway:

People have this genuine belief that they've cracked it and got a way of working that's effective, its meaningful, it gives them satisfaction and if only everybody else did what they did, it will be even more wonderful but this gives them control which is not always in the best interests of the system.

There have been various examples of respondents both building in and removing time delays in the care system. Delays may be due to the unpredictability of a patient's progress or bureaucratic issues such as the interface between the mental health system and other agencies. However, the inability for respondents to adequately describe their role affected the development of the care pathway. The ability to build in or remove time delays suggests that clinicians have a degree of control over the care sequence to either increase or decrease costly resources. By implication, respondents would influence this by the particular view they have over patient care. For example, if clinicians hold the view that care can be controlled it may lead to improved co-ordination of patient care. In this section, the scope to insert delays in psychiatric care was possible and one that a care pathway development process has been able to identify.

Exaggerated view of work skills

The difficulties in developing a care pathway may also be due to the difference between the practice and theory of psychiatric care. Much has been documented about the theory-practice relationship within clinical practice for nurses (Conant 1967, Fealy 1997, 1999) and social workers (Reay 1986, Marshall 1990). This

may have led to respondents giving an exaggerated view of their work skills. There may have been an appreciation of this supposed 'gap' in practice and respondents may have attempted to bridge it by exaggerating their role and function. Carr (1986) identified different ways of viewing the theory-practice relationship and identified four typologies, which can be extracted from the views of the respondents. Various examples of this theory-practice gap will be explored alongside how the care pathway was perceived to uncover these instances.

Clinicians experienced difficulty describing usual care for the care pathway and George for example firmly planted this problem with a tendency towards identifying theory as opposed to practice:

Looking at theories of what should happen and then working out how that fits in with what does happen, you're going to get a care pathway which is half practical, half theoretical.

This example illustrates a search for theory to guide practice (applied science approach), but also the dual existence of theory and practice as two entities (Carr 1986). The surprising observation from the working groups is that people who played a large part in the development of the care pathway expressed the view that much of the role and function of the clinician went beyond that of the care pathway. This became apparent when the care pathway was implemented into clinical practice.

Nurse training has been criticized for not providing nurses with the correct complement of skills (Gournay 1995). Respondents identified with this position and felt that a care pathway illustrated the gap between what nurses would like to do compared to what they have been trained to do. Peter identified that the care pathway was a version of ideal practice as opposed to usual care:

Assessing mental states or educating on prodrome relapse states is a specialised skill beyond that of basic level training and in making the care pathway doesn't change what we do.

Other respondents from a nursing discipline disagreed with this perception and posited that basic nurse training provided one with many skills included within the care pathway. However for George, the nursing environment within the hospital worked against a care pathway structure:

Nurses don't have an over-inflated view of their skills...I remember being trained to do all the things listed in the care pathway. Managerial duties have been pushed down the grades and this has displaced the therapeutic role.

Yet other respondents noted that although they had agreed to use the care pathway during its development, following implementation it enabled them to think about their work in different ways. For example Kerry observed that many of the interventions listed on the care pathway were '*ideals of what we should be doing*' but were not a routine part of practice. For Kerry, being confronted with this conflict enabled her to question her own practice. This would be a positive

feature of care pathway development but only if it gave rise to improved patient care and this was not evident during this study.

The difference between the 'ideals' and 'reality' of psychiatric practice may be explained by the research approach and the way respondents were asked to describe psychiatric care. Walton (2000) also observed that psychiatric care was described as a 'fragmented' approach when data was collected through 'impressionistic' and a less structured fashion. However, respondents in this research study were asked to describe psychiatric care according to the structure of a care pathway. It appears that respondents deliberately exaggerated their work regardless of the defined structure of a care pathway.

Some respondents identified that the working group and development meetings led to nurses and other professional groups giving inaccurate accounts of their role and function and argued for a '*reality check to be inserted*' to ensure that the discussion arose from a practical rather than theoretical position. In a sense, George was applying a critical approach to understanding the theory-practice relationship. This view accepts the contributions of both positions in understanding this complex relationship (Carr 1986). George suggested that some professional groups exaggerated their role and function due to the political nature and transparent structure of the care pathway procedure and that the

every day practice of psychiatric work '*sounds very benign*' compared to the rhetoric of evidence based practice:

People make it up to maintain their own position in the Trust. There is no doctor who sits down every week and re-does the mental state examination and the nursing staff do not have regular key-worker sessions to educate their patients, it was all put in to make them look as though they're doing something useful.

Supporting the above example, and describing the approach as '*referring to a text-book*' during the development of the care pathway, George reiterated the exaggerated picture of psychiatric care. Steve illustrated this point further by using the teaching package of interventions that was included within the care pathway:

The education process goes along but it becomes the whole hotch potch of nursing interventions, which are so varied that nurses are not even aware that they're doing it. The care pathway leads nurses into a false sense of role security in thinking they can do things.

In a sense, respondents have used the action research cycle as a form of self-reflection to understand the difficulties in constructing psychiatric practice within a care pathway. George recounts some of his thoughts on how the role of the clinician was misconstrued and exaggerated to fill the care pathway, but noted how this became apparent following implementation. This observation can be supported by the researcher's entry in his field notes because inspection of the care pathway found large parts were not being completed:

Everyone was in an idealistic mode, 'I can do that', but people didn't know how it was going to reflect on them when they tried to put it into practice because people just carried on doing exactly what they were doing before and the care pathway didn't reflect the care delivered at the time.

Jude described the content of the care pathway, as '*too ambitious*' and suggested that the process of development should start with a simple representation of care. Following implementation, further parts of the care process could be included within the care pathway. This may reverse some of the exaggerated functions included within the care pathway but also enable a measured response to changing psychiatric practice. At no time during the working group process was a staged approach to development advocated by the respondents.

Ingrid claimed that the contents of the care pathway was a fair representation of OT work but identified that the type of patients who were admitted onto the care pathway would not usually receive the same level of input in her usual care.

Again, this observation demonstrated the inaccurate content of the care pathway:

We do what is written down, but the people you had on the care pathway, from my own experience, they are difficult to engage, so I wouldn't have tried to engage them as much as I did.

In this section three major problems in developing the care pathway have been explored. In the first, respondents felt that a care pathway presented a too simple or over idealised approach to care. This was largely due to the visibility of psychiatric work and how this dominated the less noticeable aspects of work on psychiatric wards. Moreover, identifying the process of care was difficult for the respondents. The role of the researcher was to facilitate this process. This was achieved by uncovering aspects of practice that respondents did not discuss such as when the psychologist became involved in a patient's care or why patients did not receive community assessments at an earlier stage in the care process. This did lead to accusations from respondents of partiality in the collection of data. The researcher was accused of manipulating the development of the care pathway by forcing clinicians to say what they did for this particular client group. A second problem was that respondents inserted delays into the care process. Many respondents recognised this occurrence and used the action research cycle to illustrate and learn from their working group experiences. Psychiatric professionals may have inserted delays into the care process to protect their role from increased workload or because of an inability to predict patient care. A third problem was a respondent's willingness to exaggerate their role and function and this was presented as a theory-practice gap deficit. Respondents may have done this to protect their role in response to organisational change. A central element of the working group process was the negotiated content of the care pathway although this led to an inaccurate picture of psychiatric care.

Nature of change environment

Turnover of staff

The nature of change management programmes will produce a variety of responses from 'enthusiasm' and 'support' to 'reluctance' and 'antagonism' (Parsley & Corrigan 1994). In this section, the effect of managerial changes to the ward and community team and how this affected the development and implementation of a care pathway is explored. Particular problems covered by this topic, reflective of the wider problems in psychiatric hospitals, include the lack of adequate number of staff to provide the minimum therapeutic standards of care (Royal College of Nursing 1998).

Maintaining contact and commitment with a ward team experiencing a low retention of staff proved to be difficult. Both Simon and Steve spoke directly about the retention of staff and how this influenced the development of the care pathway. Such factors ranged from unstable management structures across the ward and community team, low morale, disrupted education process and poor participation in a change process. For example, a considerable number of the nurses involved with the project were moved onto other wards. This affected the relationship between the ward, community team and the working group process.

Giles spoke openly about his frustration at the disruption caused to 'his' ward and linked the changes exerted by management as the cause:

At the start it was a more receptive environment and you'd find it much easier, you wouldn't have nurses moving on, you wouldn't have people saying sorry I'm too busy to fill in your forms. As a result of clumsy management changes, five of the best nurses left over night leaving the place in what was effectively a vacuum, there was sex on the floors, dope was being smoked openly, it was total chaos.

Steve also spoke about the importance of having an established ward manager prior to the start of the project. Steve felt that the acting ward manager was not always acting in the best interests of the project and described him as '*stamping his mark on the ward*'. Steve advocated a stable management structure in order to establish a care pathway:

You've got a person who is anxious to make a name for themselves and any research is going to be subjected to that...care pathways was being used as a tool for the manager on the ward too improve their own systems which are already in place.

For George the ward experienced an unsettled period by not having a permanent ward manager and this affected the levels of motivation within the staff team for developing the care pathway. It was considered that opportunities to display leadership and innovation were not taken up by the acting ward manager such as staff meetings and supervision arrangements. George even questioned whether the ward manager was supportive of the project. Throughout the

duration of the study, three different ward managers were in post, each displaying a different style and approach to the project. In the researchers' field notes, it was recorded that towards the end of the project, the third successive ward manager paid only superficial attention to the project with little awareness of the various stages of development or to the political consequences for individual professional groups.

Ingrid on the other hand felt that the dynamics on the study ward had always been difficult leading to the impression that it was a difficult ward to carry out research:

They've been going through a lot of different changes, but it's always been a difficult ward, it wasn't a stable place or well received by the staff.

Peter was the second ward manager in post during the project and he was candid about the major organisational changes that were past and present within the organisation and how this distracted attention from the project:

There's not been enough stability on the ward, people moving, big changes, more important considerations for people and energies had to be in other directions. It was a shame you couldn't keep up the momentum at the beginning, because it felt very exciting and positive.

The problem with staff turnover was the perceived competencies of staff that later were to be employed on the ward. George described the process as

'plundering' the more able members of staff and replacing them with *'rejects from around the hospital'*. Other staff on the ward also registered their intention to leave the ward. George spoke about this being a particularly difficult phase because the process was reliant on examining role function and required interest from the new members of staff. When this enthusiasm was not evident, it contributed towards low morale within the team. This created a process where people were continually being trained to use the care pathway.

A particular difficulty for some respondents was the lack of preparation time for people to feel comfortable in implementing the care pathway. This led to increased pressure on the remaining few nurses. Jude stressed the importance of training all staff who were to be involved with the care pathways project, but also to have the right type of staff for it to be viable. Jude felt that care pathways should not be used if a hospital relied on agency staff due to the poor levels of training and use in practice:

If all had been trained to use it, it would have been more effective because when I wasn't around things weren't getting done, it was the poor permanent staffing level you couldn't inform agency staff to be prepared in the same way because there was no guarantee they would be there the next day and then you ended up explaining it every single day. People had tried to use it as a normal nursing document and it hadn't worked.

Steve felt that the changes implemented by management were a thoughtless action, which inevitably damaged the process of engagement:

Management didn't have enough foresight to see the implications of pulling staff off Singleton ward, but they've taken people involved in the care pathway who were generally interested and enthusiastic and they're now on wards where they're not involved with the care pathway process...how they expected Singleton ward to engage with this project is beyond me.

Steve described situations where many agency nurses were being used who were both unfamiliar with care pathway systems and with the type of patient eligible for the research, thus affecting the viability of the project. However, there was also unwillingness from the agency staff to become involved with the research. Towards the latter end of the research study, there was a difference between the people who planned the pathway and those who carried it out. Steve identified the extra time and resources to educate and prepare people for the care pathway process and observed that the constant decline of staff destabilised the care pathway process.

Kerry noted there was a great difficulty in implementing the care pathway, in part due to poor communication channels but also due to not having a regular team of nurses. The problem became apparent when on-call doctors were called to assess the patient and so either ignored the care pathway components or made incomplete records within it. For Kerry, following the care pathway was '*impossible and potentially litigious*' without the full team knowing how and where to document clinical information. This finding is in contrast to that of the

literature. Hall (2001) for example suggested that communication patterns were improved with a care pathway and this prevented the chances of litigation cases from occurring.

Respondents have identified factors present in other studies documenting the problems in implementing clinical guidelines (Hadorn *et al.* 1996). For example, Cotton & Sullivan (1999) found that hospital doctors were too busy to carry out the guideline and were influenced by negative opinions from their peer group. Hospital nurses expressed concern over the lack of training. These factors were present in stable change environments. Some of the problems identified by the respondents may be due to the amount of extra paperwork involved in carrying out the care pathway. De Luc's (2000) study of implementing a maternity care pathway found many problems with the documentation, particularly the amount of time required to complete it. De Luc (2000) used the critical incident technique to discover that respondents perceived the care pathway to offer a no more useful source of information than the currently used paper systems.

In this section some of the problems in developing the care pathway in this research environment have been explored. For many respondents, the rate of staff retention from a full complement of nursing staff to one that relied on agency staff created many problems. The major issue was one of enthusiasm for the project alongside the difficulties of preparing staff to implement the care

pathway. There were many respondents who felt the problems of staff retention were due to managerial staff intervention. Other respondents felt that the problems of staff enthusiasm were evident before any managerial intervention. It seems unlikely that these findings would be a feature of all staffing complements in London hospitals but if this was the case, it would be difficult to develop care pathways within this changing staff environment.

'We just couldn't be bothered'

The preceding parts of this chapter have reviewed the occurrence of a low retention of staff and attention is now focused on some of the perceived effects of this staff movement. Morale and enthusiasm for change are important for new change initiatives to be successful. How these factors influenced the process of developing and implementing the care pathway will be explored.

The difference in morale from the start of the project to the end can be illustrated by the willingness to undergo an internal critique of practice. Peter described the nursing staff as *'fairly keen to explore practice'* and willing to improve care processes. However, these positive aspirations for the research study quickly turned into negative views when sudden changes were made to the staff complement. Steve felt that the environment required a stable complement of nursing staff for effective engagement with the study. Moreover, as suggested

by George, the morale factor led to disciplines not 'selling themselves' during the development process:

It's difficult for people to say what they do at the best of times but for something that is cost efficiency based, each discipline would want to sell themselves to the highest to have 20 pages dedicated to just what they do on the care pathway to show how much the hospital needs them, but people couldn't be bothered to take ownership.

Mike expected Peter who was the acting ward manager to promote the project 'constantly' and this lack of effort turned into a potential barrier to generating interest. However, it may have been difficult for Peter to maintain motivation given the staff turnover on the ward. For Peter, attentions were directed towards practical ward management issues such as ensuring the ward nursing duty was 'covered' although he did acknowledge the difficulty for people to participate in the research study. Primarily this was due to people experiencing a wavering sense of morale, which led them to feel insecure in their role, and so it was 'difficult for them to achieve the basics, let alone extra research activity'.

Simon who was a clinical psychologist described how the project started with considerable enthusiasm and then stopped and attributed this effect to the lack of interest from clinicians and the absence of support from the Trust as a whole:

Things have been sliding, and since I've only ever received one note about one person, I've just began to think well, is it just fading out. The ward hasn't backed care pathways for a second. The whole organisation

has to be persuaded. There was a lot said, say 6 months ago, when these meetings were happening, and then they stopped.

The problems in implementing the care pathway also stemmed from the lack of co-ordination between the ward and the community team. This process was coupled with the small number of individuals whom had invested themselves into the research study. This created a dynamic where some individuals were engaged in the implementation and some that stood as passive observers on the project. Buchanan & Huczynski (1990) note that this may be due to a lack of trust in the change initiative and certainly questions the approach taken by the researcher to engage the ward and community staff. Mike described the team as *'fragmented and lacking in real interest'* and this led to the care pathway not being adequately completed. Moreover, Mike felt the study participants were conscious of other political factors occurring in the hospital referring to the *'clumsy management changes'* that had taken on such importance for the staff in the hospital.

Mike commented on the level of insecurity that clinicians felt on the ward and how this adversely affected their involvement. For example, Mike perceived Wyn who was the general manager to be unappreciative of staff efforts and how a *'blame culture'* permeated the organisation from *'top to bottom'*. This led to staff feeling insecure and reluctant to adopt new change initiatives and an attitude of *'lets just do the basics'* leading to a maintenance of past work patterns.

Another respondent suggested that people failed to engage with the project because of the absolute levels of low morale on the ward, which created a sense of apathy for usual care practices. George identified that members of the team rejected the extra demands of the care pathway:

If people aren't enthusiastic about their job, the least possible route to existence and eventual laziness. People's enthusiasm just died very quickly and felt they don't do it (care pathways) on other wards, why should I do it here.

In a further exchange, George spoke about how the care pathway documentation was incomplete leaving large parts of the care patients received unaccounted for. Information was not being documented about why an intervention or outcome was given or achieved:

Variances weren't being recorded and it didn't reflect why the care wasn't carried out. If the patient was too disturbed to do the education on the medication, do it at a later date, but that wasn't done, no record was kept of that and it was a case of blank pages and laziness.

Looking back over the implementation phase, Zeb attributed many of the problems of development to the unstable influences on the ward and suggested that the project should be re-established at a more appropriate time. However, having sufficient numbers of staff was no guarantee for ward motivation:

At the beginning, Singleton ward looked very stable but the big killer factor was the level of unrest. It was extremely difficult to predict how bad that would of got. You need new nurses coming on to the ward with a fresh approach, they're not institutionalised, it's very easy to settle into an air of apathy and new nurses do that very quickly.

Mirren observed that staff felt too de-moralised to engage with new ways of working. Additionally, there was a perception that clinicians were subject to high levels of past change and that any further change was going to bring about resistance. This affected the lack of commitment of the nursing staff to the working groups and the numbers of nurses who attended evidenced this. Nurses also felt demoralised because of colleagues moved by 'management' and others who were leaving to take up other positions in the Trust.

George offered a broader view by drawing on how the Trust managed new innovations and staff morale. For George, this resulted in resentment in engaging with a research project that was going to enhance the reputation of the Trust. The major factor for George was the feeling of a sense of depreciation and lack of support from the wider organisation. George described psychiatric work as a 'thankless task' and indicated that nurses felt sensitive towards this when the organisation undervalued their work:

People are less keen to be involved in something, which is extra to the minimum that they can get away with. If we can't feel as valued members of staff, then we're hardly going to develop the future of nursing for Hackney...people involved will get nothing from doing it and we're doing the Trust a favour.

However, not all participants who engaged with the research project experienced a sense of low morale, although they recognized it within the wider workforce. Mike and Bill perceived the researcher as making a certain effort to engage them particularly with the research project. For example, Mike felt that he was informed more about the objectives of the research study compared to others. It could be that respondents who experienced a low sense of morale might be less inclined to engage with a research project. More effort would be required from the researcher to involve this potential group of staff with the development of a care pathway.

Other respondents commented about the one-way nature of research studies where the actual participants gained little benefit from engagement (Fryer & Feather 1994). Mike spoke about his perceptions of why respondents failed to engage with the project and recognised that people perceived it as a '*research project*' which was '*short term*'.

What do we get out of this because this isn't going to be on-going like CPA. If care pathways was coming in people would see it on a long term basis and lead to greater investment but it was just research.

The nature of change affects people in different ways. The intention at the start of this research study was to identify a ward and locality that was both '*highly staffed*' and motivated to examine practice. The researcher purposefully spent

time securing the commitment from all staff. Other factors identified by participants were the confusion of using care pathways alongside usual care processes and people being too busy for developmental work.

In this particular research study, there was a sudden change in ward personnel. This created a period of disengagement and disinterest from the project and this was also exhibited by feelings of low morale. There was also some reference to feeling under valued by senior management within the Trust and some studies have found that when people feel unappreciated there is a reluctance to collaborate and take on new roles and responsibilities (Davies 2000). In this section some of the problems in securing the role of the participants in developing a care pathway have been reviewed. The following section will focus on the role of the facilitator and the use of change management strategies.

Managerial impact upon empowering process

Paradox of power

The process of using action-orientated procedures to secure respondent engagement with the study will now be reviewed. As will be shown, respondents overtly and covertly used coercive management strategies to ensure compliance and domination over professional groups and clinicians. The intention was to use action orientated research methodology within a collaborative fashion, and as far as possible, this strategy was pursued. As detailed in previous sections, the

environment changed considerably, impacting on the morale and interest within the research study. Respondents wanted to take control of the project by influencing the researcher to make people comply with the care pathway structure.

George performed a key role in developing and implementing the care pathway from its conception. Even during the first consultation, George wanted to covertly ensure respondents complied with the actions of the research study and the researcher. Primarily, George wanted to introduce the care pathway in a way, which would prevent role erosion for psychiatric nurses. Tina spoke about 'selling' the proposed research strategy to the ward and community staff. This was in contrast to the views of the researcher who pursued engagement and empowerment:

Not being seen as having limited clinical credibility or some academic whose using the ward to get a PhD and being convinced that you're committed to improving care, being careful on how we sell it as improving care.

Meyer (1993) attempted to use a bottom-up approach at the start of her study into developing patient centred care on a surgical ward but found circumstances in the field to dictate a top-down style. For example, an ultimatum was given to the ward manager, from the senior managers, to either support the project or leave. Similarly, both Wyn the senior manager and intermediary managers such

as Tina wanted to coerce people into being part of the research study. The researcher felt uncomfortable with this position, but similarly to Meyer (1993) had little choice in pursuing a compromised collaborative research process.

Both George and Tina were providing the researcher with important information to successfully engage the respondents. However, their intentions were to secure compliance. The surprising finding was that Tina wanted the facilitator to be autocratic in the management of the project and that she would '*support this way in all of the meetings*'. George readily accepted that participants had been coerced into taking part in the project:

It has been coercion because people were initially afraid to commit themselves to something that goes against traditional individualised care and potentially proving themselves surplus to requirements for the hospital and that's a scary thought.

The intentions at the start of the research study were to let the participants decide the contents of the care pathway. However, major stakeholders in the process were reluctant to concede this ground to fellow colleagues. George felt that the role of the facilitator should be to externally examine practice and for this then to be endorsed by a group of professionals. George argued that this would be a more successful method of creating the care pathway. Pat advocated for a facilitator who would '*force*' people into complying with the demands of the

care pathway structure and say, *'you're doing this and you must change your ways of working'*.

The OT department had been very cautious about engaging with the researcher throughout the study. Derrin spoke about how the care pathway had been developed in a highly political context and how she perceived general management as somehow splitting the voice from the OT department:

There has been pressure on OT from management to cut back our resources and this project has worked that agenda, but Helen and myself have known each other for years, if we didn't have a good relationship it would have been divisive with two messages coming out and this research was exploiting potential differences in working relationships.

Although Wyn who was the general manager for the hospital was overt about requesting OT to be involved with the project there was also a covert strategy to somehow undermine the effect that OT played in the whole package of care. The researcher had also gained this impression by informal conversations with Wyn. At the time of the research study, Wyn was in the process of taking management responsibility for the OT department. OT's were unhappy with this development because they suspected that the autonomy of the OT interventions would be compromised. Wyn had stated to the researcher in a further informal contact that he thought OT's *'were a waste of time on the wards and they should be part of the numbers'*. Wyn was referring to a desire for OT's to be part of the

complement of ward nursing staff. Derrin would be correct in her perception of managerial control by senior nursing personnel over the OT discipline.

Even at the end of the project, for Jude there was an acknowledgement that you need to have a recognised facilitator of the project who would command respect from all disciplines. A person employed within this role would add legitimacy to this task:

You need a facilitator who will chase people up to ensure that they comply and you have to ensure that there is a system in place to monitor that. If it's their job people won't think, who is that nurse telling me how to do my job and they would just accept him.

Following the process of implementing a care pathway in a special hospital for mentally disordered offenders, McQueen & Milloy (2001) also found that they needed to develop a 'co-ordinator' to ensure clinicians implemented the care pathway. A person with 'great access' to professional groups was advocated and the nurse ward manager adopted this role. The difficulty would be ensuring that other professional groups accepted the remit of this role and as demonstrated within this study, clinicians were resistant to examining roles and functions.

Both George and Peter attributed the willingness of nurses to engage with the project to the occupational class of the researcher, and the trusting relationship that had been established over the years by the researcher working for the

hospital. Paradoxically, this relationship with the Trust led to some respondents to disengage with the researcher and the project:

It was a nursing led thing and we thought we could trust you but for others you were being paid by the Trust and they will have access to the findings when it's published. People have been careful about disclosing too much information, so to limit awareness over what they do but this is not a criticism but you need to be aware of your agenda, your agenda is not too positive about OT's or psychologists and you are pro-care pathways.

Other informants agreed with this perception, but wished to capitalise on this position. For example, Tina adopted a defensive stance towards the management of the project where *'care pathways would be seen as a nursing initiative, not a medical thing'*. This position reflects one of control and domination over other discipline groups. However, the researcher did not support this position and actively engaged with a wide group of people to be part of the project.

In an action research study investigating the development of an advanced nurse practitioner in dementia care and treatment, Rolfe & Phillips (1995) noted that the researcher also wished to change practice. However, the direction of change was supported by the researcher and so in effect, shaped the final outcome of the project. Respondents in this research study may have perceived the researcher to be exerting a dominant role in the care pathway project, although this was not a consciously engineered role.

Some respondents did not perceive the researcher as having a dominant influence. This finding mirrors that of the literature where qualitative approaches have the potential for informants to feel as though they are being listened to and influential in the representation of the ethnographic account (Patton 1980).

Simon for example felt that the researcher was likeable and this led him to engage with the project:

It's by chance we get on, and I've done more for you than I might have done, but it's to your credit that you've been persistent and pleasant that you've actually got somewhere against the odds because the organisation has not supported you.

Some scholars have noted the importance of the interpersonal skills of the interviewer to gain compliance with the study objectives (May 1989) and similar to Simon above, Giles engaged with the researcher because of the amicable relationship built up over time. Giles also spoke about the constraints of his job impacting on the role he played in the research study. Giles was honest in his appraisal of his role in developing and implementing the care pathway:

You've been so charming and persuasive, but I've got enough on my plate without you coming around wanting me to write it all down, fortunately the paper work has been kept to a precious minimum for me and all I do is sign and agree with things, and they're written down on paper, and so I've got away with it.

In this section, the perceived role of the facilitator in managing this research study has been explored. Action orientated methodology aims to empower

participants to change practice (Webb 1989), attempting to draw people from all perspectives. However, evidence from this particular context conflicts with this perspective. Respondents wanted to coerce participants into working with care pathways and for some discipline groups such as nursing, to take ownership of the project. A perception of professional coercion may have led clinicians to feel uncomfortable with the development of a care pathway.

Managerial styles

Approach used by the researcher

It is widely reported that clinicians are more receptive to developments if they are involved in their development and this typically means using a bottom-up approach (Kennedy 1996). In this section, it will be explored how the researcher was able to adhere to this ideal but also adapted the style to match the local needs of the research context.

The need for the facilitator to be perceived as both a '*specialist*' and available for consultation is important for the development of care pathways (Hainsworth *et al.* 1997). Zeb was able to confirm this view when the researcher attempted to engage with the community staff. The researcher made several visits to the community team and attempted to secure their involvement throughout the research study although there was only partial success:

Get the community staff to see you as knowledgeable at the initial stages because then they'll feel they've invested something in it and trust you because if your not involved then you tend to think well its not going to work and then it becomes a self fulfilling prophecy of why should we listen to him.

Some respondents were very clear about the way individuals should be *'instructed'* to engage with the research project and actively supported autocratic change management styles. For example, Zeb wanted *'instruction in writing from the Trust board'* telling clinicians to participate with the research study. This departs from other studies, which encourage participative decision-making processes (Broome 1980). Other respondents have taken a mixed perspective where both change strategies should be used. Mike reflected on his own contributions and felt that opportunities were made to *'describe the real world in the community and the restrictions'*. However, Mike still valued the importance of gaining higher managerial support, which may force other clinicians to be part of the project.

Degeling *et al.* (1998) found that if the hospital management culture was perceived to have an organic orientation in involving staff in the development of initiatives (i.e. bottom-up and participative), more of the respondents were geared towards accepting work control methods. However, this was not perceived to be the case for the staff working in the hospital within this study. For example, Mike felt that management should have addressed some of the *'deeper'* problems occurring within the organisation that were making clinicians

feel uncomfortable such as the levels of poor motivation and disengagement experienced by the team. Reversing these negative staff attributes would be vital so as to enable staff to positively embrace the work control methods contained within a care pathway.

Other respondents rejected the calls for clinicians to decide on the content and implementation of the care pathway. Zac felt that the method of change management advocated in this research study would have been more successful if it was co-ordinated by senior management:

You've got to have a lot of people who are in power in the organisation behind it and actively engaged with you. There is a great danger if the innovation is on the shoulders of one person, especially if they are just sort of added to the ward as you have been.

Steve on the other hand commented that '*management*' created an unreceptive environment and worked against clinicians wanting to engage with the project. Steve described the process of '*management coming down in a heavy manner*' and felt this worked against empowerment and inclusion:

For people to get involved all opportunities were made, it's fairly natural that people are going to feel wary about placing themselves on the line due to the nature of the Trust and how Wyn manages people.

Both Zac and Steve acknowledge the need for support from senior management of the Trust. However, it is the nature of the support that appears important.

Bond *et al.* (2001) observed that if care pathways were introduced at a ward level, without a firm strategic overview from senior management, they tended to fail. Support for care pathways from all levels of the organisation was required for the tool to be successfully implemented.

Mirren commented that the nursing staff on the ward felt '*alienated*' by the perceived '*managerial presence*' in the working groups and suggested that some meetings should have been reserved just for the nursing staff on the unit. Mirren was critical of the way the working group attracted its membership who she perceived as '*having nothing to do with the ward*'. Although this impression gives some insight into the fractious culture of psychiatric care, it did leave respondents with the impression that some members of the group were more important. Mike on the other hand was unconcerned with non-nursing disciplines such as members from the Health Authority attending the working group although attributed this to the role insecurity experienced by some disciplines. Mike felt that Zac from the Health Authority would provide a more informed view of the care team and how it should deliver care for people with schizophrenia. This was also the intention of the researcher. By including as many clinicians and interested parties as possible in the project it did leave people with the perception that their voice was less important compared to other participants.

For some respondents, an approach was required that would serve to empower professional groups. Peter asserted that the role of the group was to make people feel as '*equal partners*' and to '*make the ride as pleasant as possible*' in deciding the content of the care pathway:

I like the idea of action research and developing it in practice, the laboratory as the workforce, you wouldn't have as much success coming in with a ready made package that had been researched somewhere else. You'd get a lot more resistance.

Mirren commented that if management became too dominant, clinicians would only pay lip service to implementing the care pathway. This may have been the case, because very little of the care pathway was implemented. The significance of this example is that the circumstances of the ward would not have responded well to any management style given the nature of care pathways:

Being very authoritarian doesn't mean you're going to increase motivation or compliance especially over the past few months...implementing the care pathway was on a losing path from the start because people just got so despondent and angry, 'management telling us what to do', they couldn't be bothered with a research project.

Jude felt that both approaches were necessary to complement all sections of the workforce although acknowledged that some clinicians were adverse to change:

If it comes from top to bottom, not giving people the choice, people will respond negatively because overall they don't like change.

Ingrid felt that the development of the care pathway was hindered by not having a patient representative on the working group. Ingrid wanted to discuss the client's perspective of what they wanted to include in a care pathway. Much has been noted on the need for users to be represented at the strategic level in planning services (Health Advisory Service 1997) although this failed to occur in this study:

It doesn't involve the client and they would have to be involved in the development and implementation of it. You could do it with people who had come in a number of times by looking at the records and talk to them when they're more stable.

The action-orientated approach to develop and implement the care pathway did not lead to full participation, although some respondents personally liked the researcher. In other words, there was a limit to people's involvement without the presence of a managerial directive. Simon likened the position to '*looking at video instructions*':

Putting the care pathway together has had almost no impact yet, except for a few meetings. It will if they refer someone and then I'll start analysing it properly. It's like video instructions for changing channels, I glance at them and then when I really need to do it, I'll get out the book and start sweating and say what the hells this all about.

Respondents identified that the working group process may have placed pressure on people to structure care into a more standardised fashion. However, Steve offered a different impression of the working group process in that it afforded

the chance for people to determine the direction of the care pathway development project:

Opportunity was made to get people into the working party and once you're in, you're part of the arena as much as everybody else...if people don't want to take part, it leaves them with fewer options.

Steve also felt that when professional groups refused to attend the working groups, the researcher was limited to individual discussions with members outside of the working group. However, this compromised the input from discipline groups and Steve felt it was allowing disciplines to make it '*too easy for the process to be compromised*'. Steve questioned whether there was a lack of information at the start of the research study although another respondent confirmed the view that sufficient opportunity was made for individuals to be involved with the research. Linking this point to the general apathy towards the introduction of a research programme, Jude noted:

All of the people involved had several meetings before it started, they all accepted to use it, some of them tried to use it, and others didn't bother. They didn't take it seriously because it's research and they don't see it as something they've got to follow.

The difficulty in securing the involvement of the participants for the research study was evident by the number of sessions that the participants refused to attend. The researcher experienced difficulty in contacting the various individuals and for the viability of the project, the researcher needed to secure the role of

the general manager to ensure compliance with the overall objective of the research study. Some respondents have been critical of this move, whilst others such as Steve felt that it was the only way forward. Disciplines were '*holding out*' until their stance was '*shunted*' along by managers in the directorate.

For Derrin the role of the OT was negotiated to fit the structure of the care pathway. The fieldwork diary charted how much of the content of the care pathway was negotiated with individual disciplines. Derrin recognised that her reactions had changed from negativity to acceptance of the care pathway, in response to the empowering approach taken by the researcher:

We haven't compromised on making decisions before the individual is seen, we didn't get pushed into that, it's been negotiated, we've perhaps put more structure to it than we'd wanted, but that will do no harm and we're happy with the end result.

Action research has the potential to fuel a sense of empowerment in making decisions about care, but also a positive feeling generated from being involved in these decisions. For example, Hart & Bond's (1996) action research study into improving standards of care found ward managers to feel '*positive*' about their role and a perception '*that they might be able to influence the course of events where before they had been negative*'. In some respects, this was similar for Derrin and the role of the OT. Perceptions of the OT were held to be negative prior to and during the research study. Following implementation, some

participants were able to experience an enlightened perspective of the role of the OT.

The aims and objectives of the project were complicated by the fact that the researcher was following a research agenda alongside the Trust's aims of attempting to implement a care pathway. Management intervened to ensure that disciplines engaged with the project to form a care pathway document. All respondents did not accept the role of the researcher in attempting to create the conditions for receptive change. Key informants wanted to coerce participants into developing the care pathway. Additionally, the researcher needed to coerce respondents to achieve the objectives of the Trust. Taking a broader perspective, the respondents discussed the nature of change using autocratic and inclusive management styles. A range of views was elicited suggestive of support for both approaches either separately or together. This twin style approach appears to have been most appropriate within this particular context

Conclusion

In this chapter, three areas appear important for the development of a care pathway. In the first, respondents identified those aspects of practice, which appeared most visible to describe and illustrate on a care pathway. This had the effect of displacing those aspects that were least visible such as therapeutic contact or *'being with'* psychiatric patients. By identifying the visible parts of

psychiatric practice, it gave respondents the impression that it represented the totality of psychiatric care. It was only through the process of implementation that respondents identified that large parts of care were not included within the care pathway. The second major difficulty identified was for respondents to identify and insert care delays in the care system that prevented psychiatric work from being carried out at certain times. The most common reason was due to the patient's illness and being unable to predict symptom control. Bureaucratic problems such as the interface with housing, supported living and benefits agencies were also identified. The inability to access such services forced respondents to insert a delay mechanism into the care pathway. The final difficulty in developing the care pathway was the extent to which respondents exaggerated their role and function. This had the effect of displaying a gap between those areas of practice taught in college and those skills practised on a psychiatric ward.

The three problem areas identified above have all been characterised by a process of negotiation and coercion whereby clinicians debated their role and function to fit the confines of a care pathway. For many respondents, the developments of the care pathway laid bare their 'visible' role in psychiatric care. This may have contributed to them either constructing delays or exaggerating their role and function. Both courses of action would lead to problems of matching the care pathway to clinical practice. Attempting to introduce a

potentially challenging structure like care pathways was able to draw out this distinction.

Analysing the context of this research study was crucial to understanding some of the perceptions held by respondents towards a care pathway for practice. In this research study, respondents viewed a sudden change in ward personnel as a negative factor for the development of a care pathway. This factor is important given that recruitment and retention of psychiatric staff is a constant problem across the UK (Audit Commission 1997) and so the issues identified in this study would have relevance for the uptake of care pathways in other hospitals. Changes in staff personnel also led to feelings of low motivation and poor engagement with the research study. These two elements may well have contributed to the unwillingness of participants to be more honest or aware of their role and function and its representation on a care pathway.

The final section has looked at how the change process for the development and implementation of a care pathway was facilitated. Organisational change theorists have posited that change should be targeted at many levels (organisational / individual) (Moss Kanter *et al.* 1992) although in this study, it was directed at staff working on the ward and in the community. Participants in this study expressed positive views about authoritarian and bottom-up change management strategies. Alongside this, key informants identified the role of the

facilitator as forcefully coercing participants to engage with the research study. In some sense the researcher was torn between the objectives of the research study and organisational objectives. Ultimately the approach used within this study was reflective of the particular context and relations with the participants.

Chapter Seven

Macro issues impacting on development & implementation

Introduction

In this chapter, the way managerial policy in the NHS has shaped a movement towards the acceptance of care pathways will be discussed. In the first section, the way in which professional groups identified the various managerial techniques used in practice are discussed. A care pathway has been identified as a tool to extend this managerial agenda. It will be described how respondents displayed negative views about managerial techniques, but then paradoxically advocated managerial techniques within practice.

Much has been written about evidence-based practice (Sackett *et al.* 1996) and how this should form an integral part of practice (Department of Health 1996). Care pathways make great use of evidence-based practice but the deficits in knowledge for the building of a care pathway have not been rigorously explored, especially for unpredictable states such as schizophrenia. In the final section, the perceptions held by respondents towards evidence-based practice and experiential practice for people with schizophrenia will be described.

Business ethic within the NHS

Presence of a managerial agenda

The way respondents discussed business like practices within the care process will be discussed as one of the main themes in this chapter. Some have argued that NHS resource allocation has always been dominated by a cost benefit relationship (Maxwell 1995). For example, the introduction of the Resource Management Initiative in 1986 involved professional groups in the management of health care and its effective and efficient distribution (Perrin 1988). Other examples include the internal market placing responsibility on health authorities to both assess health needs and purchase services (Madhok 1999) and the care programme approach (CPA) attempting to place a defined structure on care (Department of Health 1995b). In this study, many respondents were concerned with the costs, effectiveness and outcomes of care.

Some respondents who provided direct clinical roles rejected the structure of care pathways in the initial discussion groups by suggesting that it was too '*managerial*' and that their role was to care for patients. Nurse's that occupied managerial positions were more in favour of work control methods to reduce clinical variation. To some respondents this created a sense of tension. Linda spoke about the nurse's role in managing patient care and referred to the wider political imperatives to reduce the costs of care:

Practices are cost based now, we're being told to look at different ways of cutting back the number of nursing staff that we have on the ward, it's purely looking at the financial implications, it's not considering the patient's needs.

Clinicians have become more aware of the need to justify the level of expenditure in health care (Richards & Lockett 1996). This has led respondents to suggest that they are '*budget conscious*' and that it is part of their role to identify skills and needs as part of a '*resource justification*' process. Possibly, this may have influenced some respondents to become involved in the research study. For example Pat could foresee a nursing environment with '*one RMN to hand out medication and then a handful of unqualified nurses looking after the basic needs, it's a cheap way of doing the same job*'. Although not an accurate appraisal of psychiatric care, Pat was conscious of the tension between cost pressures, effectiveness and job security.

The tensions of delivering an effective outcome, and of more importance, the person who judges this outcome are apparent for all areas of health care. For example, Firth-Cozens (2001) has identified the different stakeholders for a patient who has suffered a stroke and demonstrated that all have different but ideal outcomes. Problems in agreeing outcomes for people with chronic schizophrenia have also been found (Meltzer 1997). The preoccupation of '*cost*' dominating health care has also led respondents to question the beneficiary from

this situation. Giles contrasted the perspective of the purchaser, provider and consumer of care:

Best possible to a mother of a schizophrenic means he sits pleasantly at the dinner table and converses spontaneously with his family, for the patient he sits upstairs in his bedroom and doesn't talk to anyone, that he's happy eating without the voices laughing at him, for the hospital manager he's on the cheapest drug available, just to shut him up.

This view appears unfairly critical of the hospital manager. It seems more probable that Giles was simply questioning the human motive for measuring efficiency in the service. Like von Otter (1991), Giles felt that the application of market principles distorted the value of health care, leading to a cynical situation between the clinician, patient and relative:

You've got a recipe for a perverse set of incentives that will lead to corruption, disinterest, lying and knowing that homeo-sapiens are the grubby dirty little ape that it really is, it lies just to pay the mortgage.

In this example, the tension between a business style care system and the clinicians desire to deliver a patient focused system has been illustrated. The NHS is dominated by a 'value for money' orientation and this pervades the planning and provision of health care. Although it is unlikely that Giles's view of clinicians is correct, it is more probable that Giles is reflecting this particular monetary dominated ethos but in a cynical fashion.

Policy makers have attempted to develop a more effective service by emphasising evidence-based practice (Department of Health 1996) and this has impacted upon some parts of clinical practice. Simon for example questioned the effectiveness of some psychological interventions:

You can't justify having therapies which all empirical research suggests don't work. Why should we give someone three years therapy when they've found out that 10 sessions is just as effective.

Hospital based organisational systems have emerged to better manage nursing staff resources and over the years have included task allocation (Berry & Metcalf 1986), team nursing (Waters 1985) and primary nursing (Manthey *et al.* 1970). Some have argued that the organisational-based changes have led to a greater scrutiny over the quality of care (Black 1992). All systems share the aim of delivering a more structured care process. Respondents have identified that a care pathway would extend the managerial control over health care. For example George suggested that the role of the in-patient case manager, who was to ensure quality and check on the delivery of care was comparable to the role of the charge nurse using primary nursing. George spoke about '*checking up, pushing down, you've got to do this*' and so managing staff in order to deliver health care.

In an earlier interview, George described how he reviewed case notes on a weekly basis to ensure care was being delivered and outcomes achieved. The

method was depicted as an informal surveillance mechanism to monitor performance and quality of care. However, George mentioned many difficulties with this technique such as the informal nature of the role and emphasis on single discipline review:

We need to get proper team meeting and structure, with far more effective sharing of team views because it's still a nurse only plan of care, my role is never to look at what other disciplines do, there is no overall coordination of care.

Some research has shown that clinicians express negative attitudes towards the business culture of the NHS and prefer to highlight the caring aspect of their role (Flynn 1992). However Tina was very positive about the business like nature of the NHS and felt that joining the nursing profession was to work towards improving the health service. This view from a nurse manager reflects that of other managers in health care who have internalised the principles of general management in their work (Austin & Dopson 1997):

The incestuous old culture that anything financially driven is dirty was rife before the new breed of managers arrived to remove the complacency and wastage within the health service, we need to support that and make sure it impacts on practice.

George has supported this perception because in his third interview he identified that the health service was geared towards managing length of stay by claiming that purchasers were requesting clinicians to '*justify resources*' for patients to

receive hospital care. This has become known as bed management and George identified this task as a typical nursing function of acute hospital care. Similar to the findings of a Government report, *Better off in the Community* (House of Commons Health Committee 1994), George also recognised that the interface between the ward and the community services was not operating as efficiently as possible leading to a wastage in hospital resources. The essential point being a greater accountability on the part of the clinician on the delivery of costly resources:

Purchaser's don't care that schizophrenics are individuals who respond differently to treatment, all they want to know is how many days stay do they need to buy for that patient and we should endeavour to meet that because it backs up on the rest of the system if some parts are not working.

The development of a care pathway aims to standardise care (Pettryshen & Pettryshen 1992). Derrin identified a source of conflict in working towards pre-set patient outcomes because the values of OT lay with individualised care. This example supports some of the literature that has identified a clinician's reluctance to work towards a business culture of health care, which values the principles of short hospital stay (Bray 1999) and reaffirmed medical dominance in organising psychiatric care (Lego 1992):

The care pathway is for the purchasers and costing and auditing, but we are here for the patients because with a care pathway the patient has to

come and fit in with the service rather than the other way around because this would harm patient care, not improve it.

This OT respondent may be preserving her role against a managerial intention to standardise the role for a care pathway. Derrin has argued that the needs of the patient should be foremost to the needs of the organisation. This defensive strategy has been seen in Ardvern's (1999) study where an attempt was made to change the function of a day hospital for dementia care. The staff group stated that patient care would suffer if the day hospital changed its function. Placing the needs of the patient above that of the organisation is a powerful strategy that has been used by respondents in this study.

A further way in which clinicians have felt pressured to manage health care has been the increasing emphasis on coordinating discipline groups through the CPA process. Peter noted the current structure of the ward team and how it could benefit from greater cohesion. The central element was the need to monitor the role and function of all team members:

The problem is ensuring that disciplines are providing what they're supposed to provide and working towards jointly agreed goals...if the OT is involved, she'll come to the CPA and ward round but we are limited because we don't feed into the OT's, its ad hoc, there's no stratified structure or control over what they do.

Mike for example perceived that the role of the nurse had become dominated by managerial tasks:

There is a lot of work in the office, getting staff for the shifts, filling out forms, doing supervision, coordinating the shift, writing out reports, sorting out bed state, which are more managerial and visible to their managers. A lot of nurses feel safe with that; you'll find a lot of nurses in the office, because when they're out there on the ward, they're not entirely sure what they should be doing.

Other studies have found psychiatric nurses to congregate in the ward office and this spatial dislocation from the psychiatric patient may be a feature of greater control over the management of care (Hall 1996). In Hummelvoll & Severinsson's (2001) study into psychiatric hospital care the emphasis was on effective crisis management, quick diagnosis and treatment and reducing hospital stay.

Respondents identified some parts of the care process, which were inefficient, and in need of management changes. Steve used the example of the ward round, which was the main forum for discussion and decision making in psychiatric hospitals. Steve described the ward round as a '*waiting game for something to happen and for the person to get well*' as opposed to a planned management of care. This point was particularly relevant for patients with chronic schizophrenia given the observed apathy of the staff groups on the study ward.

George described the present managerial structures as retrospective and repetitive as opposed to outcomes focused. George again used the example of

the ward round and described it as '*backward looking*' and '*damage limitation sessions*' with little attention to coordinating community resources:

Ward rounds are like a running commentary, very unstructured, it's rare that you'll find a designated person attached to that care plan. We've got patients for over 6 months and psychiatric symptoms were dealt with long ago but their social situation is still being dealt with.

Both Steve and George have identified that further management changes were required to improve the co-ordination of resources. It seems to be the case that both these respondents have internalised the drive to find the most effective ways of managing resources.

Throughout the course of this research study, the researcher collected numerous and varied accounts of the managerial structures that were used within patient care systems and used to best effect to ensure a transfer of care to community services. The aim has not been to be exhaustive, but to demonstrate that these systems were operational within the NHS. Respondents have identified that 'costs', 'effectiveness' and 'efficiency' dominated working practices. Some respondents felt that it was their duty in coming to the profession to identify and extinguish aspects of inefficient practice. Other respondents were less positive about the changes and promoted the needs of the patient above the interests of the organisation. However, respondents also identified examples of managerial systems to extend the organisation and control of resources such as effective

ward rounds and using prospective goal planning. An issue that has not been addressed in this section but identified by some respondents was how clinical information would be best managed to make greater use of resources. In all, it has been observed that business style principles have been widely applied in mental health practice.

Extending managerial structures through a care pathway

Mental health policy has arguably been extended to provide greater control over both the patient (Burns & Priebe 1999) and care processes (Department of Health 1990). Respondents readily identified care pathways as complementing this managerial agenda and as a mechanism to improve the overall quality and management of care.

One of the frequently reported benefits of care pathways is their perceived focus on costs of care (Velasco *et al.* 1996) and how a care pathway would illuminate deficiencies in the service. During one of the first interviews, George suggested that for clinicians to disregard the costs of care were '*living in a self-deluded world*' and expressed an exclusionary attitude towards professions and interventions perceived to be of little value:

The model of the NHS is a business style and the main thing is to spend your money wisely. Care pathways are going to identify where the money's needed and where its being thrown away and if people aren't

doing their jobs properly the Trust has a right to say your services are no longer required.

This view may have been inspired by the attempts of the care pathway to standardise the process of care and assign the most appropriate resources to the clinical objective. It could be argued that clinicians have taken on board a greater sense of accountability for the outcomes of care. In doing this, clinicians have attempted to build in productivity measures (Shaw 1997) such as effective bed management. However, Seedhouse (1994) has posited that clinicians are ethically responsible to ensure that resources are applied in a cost-effective way and so this sense of accountability could exist regardless of a managerial intention.

Nursing documentation has been used increasingly in cases of litigation (Young 1994) and untoward incidents. George noted the potential of the care pathway as a '*blaming tool*' in these cases. However it may make clinicians more accountable for care delivery and possibly reduce the number of untoward incidents. The problem would be gaining acceptance for care pathways if certain occupational groups such as nurses and doctors feel vulnerable in caring for certain types of patients.

At the start of the research study, the researcher attempted to gain support for the project by giving published care pathway literature to the respondents. Some

respondents referred to this literature and identified the managerial focus of the care pathway. Tina focused on the ability of the care pathway to improve on the current system of measuring outcomes and emphasised the importance of determining appropriate skill mix:

It's a way of measuring outcomes and how effective interventions are changing the service to meet the demand, the service at present is not co-ordinated to get a control on outputs.

Pat described the current system of managing patient referral in community teams and suggested that a care pathway would act as a trigger to monitor the referral process and so remove some of the delays in the locality teams:

If locality assessments fail to take place for whatever reason, then we have a time frame in which a second assessment needs to be attended too, and it's not just left in the duty basket for the next duty worker.

Simon spoke about how a care pathway should offer a greater range of psychological therapy for patients, irrespective of the costs involved:

There should be sets of standards in practice, which include, as the Government has said long ago and if care pathways encourages that, it would be a good thing but it contradicts fundamental issues like patients' rights and innovation in practice.

One of the benefits of a care pathway is to compare differences between the quality of care in various provider units (Arkell 1997). Reflective of a view from

the Health Authority, Zac recognised the pitfalls in doing this such as differences in the social economic composition of the boroughs and lack of evidence in procedure although he did recognise certain benefits:

Care pathways can be developed in a quality perspective rather than a contract mechanism perspective. It will identify current difficulties such as beds being blocked due to lack of availability of accommodation.

Other respondents suggested that a care pathway would extend the structure of CPA to improve the co-ordination and evaluation of care. However, this position fails to take account of the stated intentions of CPA (discharge preparation) within Government policy. Steve differentiated between the two structures:

Care pathways would take more interest in what's going on whilst the person is in hospital such as building relationships, attending groups, compliance with medication.

Rob supported the use of a care pathway to set out the sequence of events such as when a patient should be allocated to a community worker, setting out when assessments should be completed and how quickly the key-worker should visit the patient during this assessment exercise. However, similar to other respondents, the completion of these tasks was always balanced to the individual needs of the patient.

It is clear in the previous examples that respondents perceived a care pathway to extend and improve the managerial control over health care and this has been found in other studies (McQueen & Milloy 2001). Respondents were positive about the desire to co-ordinate, achieve targets and attain best practice. The terms and principles included within these statements quoted above resonate with the processes of general management (see chapter one).

A fundamental issue within mental health is the cohesion between different disciplines, departments, sectors and agencies. One of the most problematic to overcome has been the demarcation between the hospital structure and community team. This has been highlighted in many untoward death inquiries (Ritchie *et al.* 1994). Zeb spoke about areas that were presently uncoordinated such as multi-disciplinary note keeping and '*response times*' for meeting clients in line with the social services requirements and the patient's charter. It was argued that a care pathway might add greater transparency and improved working towards predetermined deadlines. Further, for some kind of action form to include the categories of accommodation, benefits, and compliance with medication:

If we're serious about this idea of a seamless service, then we need to have a central administrative system that's uniform within the ward and the locality and that could be achieved with a care pathway. Care is already standardised through the CPA tiered system and the requirements for certain people to be involved and time scales and care pathways would add more substance to this.

For George the process of making decisions was unplanned with little predictable sequence but he argued that a care pathway would add greater accountability to care:

Care pathways will provide the nurse and patient with a better expectation of what should happen, where and when, presently, its very much a case of relying on what's going through that primary nurses head at the time when they write out the care plan and make decisions, a care pathway will make clinicians tied to performance measures.

The difficulty in being both a clinician and manager within the care pathway framework was illustrated by Pat. The benefits of greater managerial control could be to the disadvantage of other areas:

Somebody else standing outside of the care provision with very little hands-on, may well be in a better position to monitor and press the right buttons and make sure the right things happen but it's where that human resource comes from because its adding a second layer of bureaucracy.

Respondents identified that a care pathway may be able to reduce length of stay although this was not always seen as a positive feature. The pressing point was to be able to manage resources in an efficient way, even if this meant patients would be discharged before it was therapeutically desirable. However, Zac suggested that a care pathway might be able to '*ensure people received appropriate treatment at the right time, in the right place and at the right cost*'.

The question is whether a care pathway could fulfil any of these functions for

psychiatric patients given the inability to determine the exact content of the care pathway.

Bond *et al.* (2001) explored the perceptions of implementing care pathways for orthopaedic patients across six hospital sites in the UK. Evidence was found to suggest care pathways were used as a tool to reduce length of stay or waiting times for surgery, to improve care processes and outcomes, and to ensure greater managerial control over work processes. Respondents in this study also identified care pathways as a mechanism to maximise resources, through a more co-ordinated length of hospital stay. However, there is no conclusive evidence to suggest that a care pathway can reduce length of stay (Hale 1997). Other respondents suggested that a care pathway may improve the quality of care. De Luc (2000) notes that the ability of a care pathway to improve the quality of care has been a major feature of their success in the UK. This would be important given the greater consumer voice in health care and the demand for a more transparent and responsive service.

The policy of the NHS has been to improve on the ability to manage staff resources (Department of Health 1998c) and respondents identified this aspect in many informal and taped interviews. Moreover, it was observed that a care pathway would serve to advance this managerial agenda by removing costly delays in the care system, offering a greater range of therapies, identifying

expensive bed blocking patients and linking clinicians to performing certain duties. Other respondents highlighted the organisational structure of CPA and how a care pathway would improve the functioning but extend managerial control over certain areas. Some respondents noted the disadvantages of care pathways for managing psychiatric care such as respecting patient choice, funding of innovation and preoccupation with cost and perceived control over clinical practice. Others questioned the additional layers of bureaucracy within the system of care. Ultimately, a care pathway has been recognised as a tool to extend the managerial agenda over health care, albeit with both negative and positive views for practice.

'Big brother watching'

Many scholars have noted that clinicians perceive a loss of control over clinical practice alongside a process of continual scrutiny with the advent of care pathways (Gibson & Heartfield 1996). This factor may be important for the development of care pathways in psychiatric practice. Work control methods were perceived to be less easily defined compared to physical disease conditions. In this section, how respondents indicated a strong reluctance to work within an explicit managerial framework will be explored.

Many respondents perceived the intent to develop the care pathway to arise from within the '*management side*' of the organisation as opposed to a set of

research objectives. For example, Peter suggested that *'management wouldn't have this going on if there wasn't a saving to be had'*. Although Peter voiced little opposition to this, he did not accept the primary reason for carrying out the study, which was principally to explore the factors important for development of the care pathway.

A perception of management influence over the study led some respondents to reflect on why clinicians did not want to get involved with the project. During one interview, Mike perceived the care pathway structure as being directly managed and conspired from the *'offices of management'* as a further attempt to monitor the work force:

With Wyn involved people felt, this is another management thing handed down and people are very reluctant to get involved, we've got enough structures in place now, CPA, contacts, and they're seeing care pathways as an extra duty to keep an eye on us.

Many studies that have described the development of a care pathway identify the importance of involving all professions in the process (Dunn *et al.* 1994) although this was problematic for this research study. Some participants were content to have their role and function determined by a care pathway, although this was not the case for the wider team. Bill gave many reasons why the team felt threatened by a care pathway such as the increasing level of managerial

surveillance over patient care, increasing paperwork, and the infancy of care pathways for practice.

Similar suspicions were also voiced by a Senior House Officer who felt that a care pathway would place too much of a managerial focus on health care. However, Kerry conceded that it would prescribe a basic minimum for practice:

If we could have those structures but not to the extent that you had to sign every time you did it, and you felt you were being watched in every thing you did.

As demonstrated in previous sections, respondents have identified a greater managerial scrutiny over what they do and one could argue that the process of action research has enabled a conscious awareness of this process. However, action research '*implies that the group being researched are powerless until empowered*' (Banister 1995: 119). Previous extracts have demonstrated that respondents showed some awareness of managerial control prior to the development of a care pathway. For example Zeb suggested that workers were reluctant to attend the working groups largely because of awareness of past and current management inspired changes. Moreover a working group process that uncovered under-performance from staff members:

It's about the less confident, less experienced workers who will think, it's a way of finding me out or show them to be a bad worker.

Ingrid attributed a clinician's reluctance to engage with the project by drawing on the general perception of managers in the hospital. For some people, the actions of some managers made them appear cynical about the workings of the Trust and a perception that '*management were looking after themselves*' as opposed to supporting clinicians:

There's an underlying paranoid element to everybody working around here, and wary of who wants to know...care pathways was such an unknown quantity that it was viewed with a huge amount of suspicion...if it's difficult to identify what you do, the easiest option is not to be involved at all.

All discipline groups did not hold this perspective. For example, from a nursing perspective, George attributed this view to the level of contact that patients had with them. However, this finding is unsurprising given the relative power of medically dominated hospital structures (Turner 1987):

Medicine and nursing are the two securest professions around because wards are 24-hour nurse staffing. Doctors are essential for the treatment of the client and so they've got nothing to fear.

In this section respondents have discussed how they perceived the care pathway to extend the managerial focus and control over mental health care and included the impact on general care systems, length of hospital stay and the overall efficiency and effectiveness of care. Primarily, respondents felt that current service arrangements provided for sufficient managerial surveillance over

clinician activity. A care pathway would extend this surveillance activity. Some respondents frequently asserted that it was '*big brother keeping an eye*' on the workforce in taped and informal interviews. Some respondents also felt the initiative was supported by management and accepted it as the usual milieu of the reformed NHS. Also included within this section has been the suggestion that the research was ill received because there was too much organisational change occurring within the organisation. Clinicians felt detached from playing a positive part in these changes.

Some respondents argued that the externally imposed '*managerial agenda*' has changed the working mentality of psychiatric professionals. Respondents support this observation by identifying structures to manage resources rather than be therapeutic agents. However, some respondents expressed positive opinions about the managerial focus on health care and felt that part of joining the health profession was to eliminate '*waste*' in health provision. Alternatively some respondents placed the centrality of patient care above the needs of the organisation.

Evidence guiding psychiatric practice

Professional versus the cleaner

In this second theme, the relationship between evidence-based practice and the expressions of the evidence for people with schizophrenia will be explored and

include three central components. The first details the various responses that clinicians gave to underpinning practice with evidence. The second discusses how clinician's experienced difficulties in identifying evidence. In the final part, the way respondents described the process of clinical experience guiding psychiatric practice will be explored.

The Government has actively promoted evidence based mental health practice (Department of Health 1998c, 1999) although some have asserted that the majority of health care is of uncertain benefit to patients (Baker 1998). This leaves a whole gulf of practice where clinicians are operating within a system that is subjective and ultimately responsive to individual ways of working. For example, Kerry felt that a care pathway '*painfully*' showed the failings of being able to predict the process of psychiatric care:

We don't know enough about schizophrenia and there's all these new drugs coming on the market and it seems a shame not to use them, because we have not got any ideal drugs.

In a further exchange, Kerry commented about the advent of new technology such as Positron Emission Technology (PET) scans to '*better diagnose the schizophrenia before it becomes chronic but we don't even have the scans to do this*'. Kerry acknowledged the infancy of this diagnostic tool for practice and its current limitations but also how and in what ways the knowledge would be used

to best effect. For example, PET scans are not a routine part of practice with their use restricted to research settings.

Giles questioned the research base, specifically examining the types of studies carried out for people with schizophrenia and suggested that clinicians believe this body of knowledge rather than accept the futility of what they do and proposed that we are all '*playing the game*'.

The types of research are nonsense, you can't control as effectively for the canons of science and you'd rather believe that than the false control...80 to 90% of what gets written is flawed. If you accept that then the whole edifice on what society is built, science, mates, paying your mortgage comes crumbling down, so clinicians hide behind these edifices.

The process of developing a care pathway led some respondents to think that care practices were based on experience with little reference to evidence based practice. The researcher also observed respondents to experience a sense of futility with the research base for schizophrenia. This factor appeared to partly support the use of the care pathway. For example, respondents suggested that the care pathway could label those interventions supported by evidence and so highlight other areas for future development. However, this factor also acted as a barrier for people to engage with the development process. Respondents would argue that the limited amount of evidence counter balanced the rationale for a care pathway. In many respects this is true because the care pathway was observed to show little reflection of psychiatric work.

There were some respondents such as George who offered such a negative opinion of the evidence base for schizophrenia that he described the '*guess-work*' like nature of current treatment approaches such as medication and nursing care:

There are numerous accounts of literature portraying medication as ineffective for large numbers of people with schizophrenia but we all assumed that what we did was beneficial, otherwise just close the whole place down, what is there left to offer.

The suggestion that psychiatric practice is based on a '*myth*' or a '*belief that what people do is effective*' would not be accurate given the knowledge on how and why systems of care are known to work. For example, medication does offer relief for large numbers of people with schizophrenia. Moreover although the precise effect of ward psychiatric nursing is unknown, the importance of psychiatric nursing to provide the care and management of patients is crucial and unchallenged in modern hospital care. What has been challenged is the lack of therapeutic intervention between nurses and patients and this problem has been identified for the last thirty years (Altschul 1972, Higgins *et al.* 1999).

Derrin discussed the quality and quantity of the research base for OT and described it as '*narrative*' as opposed to '*testing*' interventions. Derrin attributed this problem to the unpredictability of mental health problems:

There isn't a lot of evidence into OT in psychiatry and what we can work from because the nature of psychiatric OT is less defined compared to OT in physical conditions, it's much easier to measure what difference an OT makes on the outcome.

Steve felt that the structure of a care pathway enabled psychiatric care to become more evidence based by acting as a research structure for the future.

Steve located his argument within the larger structure of the NHS driving evidence based practice, but acknowledged the perceived paucity of research for nursing practice. Steve used the example of the educational interventions included within the care pathway to demonstrate this point:

How much evidence is there for educational interventions? We're working on an assumption that if you tell the patient more about their medication, they'll be more agreeable to taking it, but this is subject to all matter of personal biases such as value systems and clinical judgment and we just don't know enough yet.

Additionally, Steve perceived that the lack of knowledge about interventions for people with schizophrenia excluded them from a care pathway. An important point is that if 'mile-stones' were set, then it assumed that interventions have been proved to work and this was far from the case. Steve maintained the worthwhile benefits of developing a care pathway based on local practice as opposed to evidence-based practice such as helping to clarify what clinicians do. However, there were some disadvantages noted such as potentially reducing interventions that could be included within the care pathway. This had the effect

of minimizing the interpersonal relationship between nurses and patients as a central part of care:

Losing too much individuality in those micro-structures, for professions like nursing it's all we have, each profession hasn't got that evidence based practice to put forward and people don't know what to discard and what to keep in.

Lydeard & George (1996) suggest that professionals will resort to clinical judgment in the absence of evidence. One avenue would be to wait until more evidence is forthcoming were it could be developed in a more coordinated way. Some discipline members have been open to this lack of evidence, but only with repeated interviewing did the researcher uncover it. For example, Simon identified problems for psychological research into schizophrenia, such as the differences in diagnoses within and between different countries and poor use of robust designs and research instruments. Simon feels that the quality of the research would need to improve to establish causal relationships. In the working groups this was denied during discussions about the role and function of a psychologist. Although Simon recognised the lack of evidence-based practice to support the inclusion of psychological interventions within a care package, he was adamant that patients should be given therapy.

Simon identified other problems for research practice and psychology such as the illusion that evidence based practice existed. Simon perceived that the drive for

evidence was a cover for reducing the amount of psychological interventions that could be performed for people with schizophrenia. This argument has also been deployed for reducing the availability of medical interventions under the guise of 'scientific medicine' (Dent 1999):

Evidence based practice for psychiatry is a misnomer and its dangerous, it looks impressive, but all it's doing is saving money. We're treating evidence as though it's just given and not debatable and people have been fighting like hell over findings, we must be given time to find the evidence.

A huge diversity of opinion on how people with schizophrenia respond to psychological treatment exists and provides little direction for practice. For example Mike provided an example of working with a patient who suffered from a delusion to illustrate the level of inconsistency in using nursing interventions:

Previously, it said ignore the delusion, now they're saying try and work with the delusion. There's so much variance with schizophrenia, people's reactions and there's not going to be a treatment of choice for each individual, it's all hit and miss.

During his first interview, Giles was open about the limited knowledge base of psychiatry, which would ultimately affect the content of the care pathway. Giles identified the process of making predictions such as levels of dangerousness, suicide, response to drug treatment and suggested that psychiatrists were not particularly well 'armed to make predictions' and questioned why he should do it

given that the patient will stay on his case load. For Giles, *'just carry on looking after him and see where he ends up'*.

Given the perception that little can be predicted for mental health, Giles also suggested that clinical audit not only displayed these inadequacies but lead to a disinterest to monitor practice:

We are looking into an abyss of uncertainty and a reminder of our own impotency, the uselessness of our treatments, by and large, nature and Tempus Fugee work as effectively as we can. You don't want to work in a system that is going to remind you of how useless you are.

In a further exchange, Giles admitted that evidence for drug treatment was inconclusive but he still performed this role and advocated its use within the care pathway:

This patient is on 75 milligrams of Haloperidol Decanoate weekly for her delusions. If the delusions haven't gone after three months, let's increase it to a 100 and see what happens. Of course it won't make any difference but we've done something to put off the moment of reckoning for another few weeks and get on with the other 1500 patients.

When evidence for practice is lacking it possibly exposes the underpinning knowledge of a professional ideology. Simon illustrated this by looking at the conflict between those clinicians that advocated psychoanalysis and cognitive behavioural therapy:

When the different factions question the evidence base, it will expose the cracks because there is very little. We haven't got to a stage where we can say CBT is the best and put it into standardised packages.

During the development of the care pathway respondents were asked to build the treatment grid using interventions with reference to evidence based practice. However, clinicians were not always able to provide this and discussed their reasons why. Repeated interviewing and close contact between researcher and informant detailed that some parts of psychiatric care were not supported by evidence. This could be due to the availability of finding or translating the evidence into practice. Many respondents have noted that the care pathway identified areas for future research such as on-going medication treatment and the effect of nursing interventions.

Many respondents have noted that very little evidence has been found to support psychiatric practice. This assumption is incorrect given the evidence for psychological interventions and medication management (see chapter two). If these statements were to be taken at face value, the development of a care pathway would be severely affected. This finding displays the importance of having people involved with the project who are aware of the interventions supported by evidence. In this study, psychologists, psychiatrists and nurses were among the professions interviewed and contributed most to the evidence presented within this section. It clearly displays a lack of awareness for the

evidence supporting interventions and if this was representative of staff within psychiatric hospitals, it would question the care given to psychiatric patients.

We'd like to use evidence...but?'

There has been a greater professional awareness to develop a culture of research and development within the organisation (Department of Health 1991a) and this may have spurred clinicians to express the wish to practice to this ideal. In this section, it will be described how respondents acknowledged the importance of using evidence, and reasons for not doing so are explored. Clinicians experienced a pressure to work towards delivering outcomes based practice and this was mainly from within the organisation.

Giles suggested that from a theoretical perspective, it was ideal to measure mental health outcomes, but counters this with the need for joint outcomes from all stakeholders in care. This is particularly pertinent to the care pathway with its drive to make clinicians more accountable for the total care process. Giles also offered positive interest towards standardised outcomes, but questioned if a linear care pathway would be able to represent the complexity of mental health care:

We set the care pathway up as the oracle to which we all go, managers, clinicians and patients but we've all got to agree that the oracle is correct, and that means writing the correct number of boxes and arrows so that it's flexible to reflect an effective approach to treatment.

Simon likened the search for outcomes in working with patients with schizophrenia as '*pioneers working at the cutting edge*' and used the following powerful metaphor to emphasise the importance of experimental work within psychology:

The psychology discipline is in it's infancy for it to be subject to rigorous analysis, there are only a set of pioneers around out there looking for gold, well a bit of metal would do actually, a tin can, out there in the mountains, we can't set up a mine yet, we are more like scouts. Is this a mountain worth even looking at for business?

Derrin spoke about external Government pressures forcing OT to adopt outcomes based practice, but again drew parallels with the psychology discipline in not having a sufficiently prepared research base. Similar to other respondents, Derrin would like to incorporate outcome measures into her practice and made the point that '*OT's believe that what they do was effective*' and it was just a case of demonstrating this:

Political force within the NHS driving this mantra of standardised care and we are being asked to look at outcome measures. We're not as far along it as some other professions, because of the inadequate research base and research training but we'd like to do it, but it's useful to have standards because services that aren't monitored become sloppy and they're vital if you want to offer the best service.

For example, Simon reflected on the difference between psychological services in the UK and the US. Simon felt that services in the US were dominated by an

insurance-based system, which restricted psychological services for people with schizophrenia. Simon refused to allow his work to be subject to this '*exclusionary pressure*'. This indicates that psychological work can be delivered in an autonomous way, regardless of organisational objectives.

Some respondents spoke about the nature of outcome measurement and used this as a potential barrier to the development of a care pathway. However, there is a problem of determining the causal link between treatment processes and outcomes (French 1995). This problem is compounded further when a variety of professionals are involved in the process of care (Long 1994). In the working group, Zac echoed the problems in measuring multi-disciplinary outcomes and determining how and in what ways different interventions lead to different types of outcomes. Although discipline groups recognised the difficulties in measuring outcomes, clinicians stressed the importance of using them and aligned this to the evidence based practice movement. Rob elaborated on the role of the locality team in working towards outcomes and how this could be used as a vehicle to persuade clinicians to use a care pathway:

Measure outcomes in a way that means something to clinicians, there will be resistance from people who are anxious about outcomes, but if they're seen as defining good quality care, it won't be impossible to sell.

Ingrid identified some positive benefits of measuring outcomes for OT such as raised staff morale and effective practice but cautioned this with the fear that if outcomes were difficult to find, OT jobs would be taken out of service:

Staff will accept it if it's explained to them and not used to cut funding...when posts are becoming vacant, they're not being filled, there is a feeling that we need to justify ourselves to survive.

The views represented above appear to be reflective of the wider national agenda to improving in-patient services. Howell & West (2000) describe the work of the In-patient Network who found respondents broadly positive about introducing evidence-based interventions in to practice through care pathways. There was an acknowledgement that psychiatric services were inadequate but respondents were unsure how to bring about change or to access evidence for practice.

Although clinicians identified with the need to work towards outcomes, little emphasis was placed upon it within clinical practice or within the working group process. Similar to the section in chapter six exploring delays in the care process, Steve stated that clinicians failed to build enough creative processes into a care package to measure and check clinical progress. In some respects this protected clinicians from working towards outcomes with the patient. Moreover, it was impossible to judge if the outcomes identified in the care pathway were met because large parts of the document were incomplete.

Derrin also acknowledged the importance of using outcomes for the OT discipline, but recognised some of the constraints that the discipline currently experienced. For example the OT department carried out meetings to search for outcomes based practice although this was limited due to not having an academic base to supply answers to measuring outcomes in psychiatry. However, not all discipline groups experienced this managerial pressure to the same extent. Giles identified a source of financial pressure, but tempered this with the assertion that there was no monitoring and performance mechanism:

The only restraint is financial, 'no you can't prescribe this drug without permission from the pharmacy', there are no standardised attempts to ensure you provide the basic minimum, it's down to us as clinicians.

Peter identified a financial pressure to standardise outcomes, but geared this towards maximising outputs from various professional groups. This tendency however can lead to professional degradation:

It gives the opportunity to quantify what the different disciplines do in a totally financial way to get cost effective work from them.

Simon preferred to view his internal work motivation as geared towards finding the best and most innovative way of working:

I'm interested in finding out what's the best way of working with people, we negotiate it with the psychiatrists here and say let us have a try...a finding of practice that care has to be individually developed for each person but it's not dominated by imposed ways of working, or 'you must meet this outcome', it's just not done.

The need to work towards evidence based practice forms the bedrock of a care pathway although identifying evidence for inclusion has been difficult in this research setting. Problems range from having sufficient evidence to set outcomes, acknowledging the infancy of professions to '*searching*' for outcomes, determining what interventions to use and how they affect the outcome. Some clinicians identified that they felt pressured into working with outcomes through organisational structures such as ward rounds, management directives and determining financial balance over therapies. The use of a care pathway has also added to this pressure. Other respondents have not perceived these pressures and continue to follow their own treatment methods. This displays a lack of parity across the professions and supports the observation that some professions felt more valued than other groups.

Experiential learning & practice

The difficulties in working towards evidence based practice and using outcomes have been abundantly demonstrated in the sections above. The importance of this final section is the acknowledgement that some professionals just do not know why they do things and rely on clinical judgement, intuition and experience. The relevance of intuitive and experiential forms of knowledge and

practice has become widely credited in the nursing (Benner 1984) and professional literature (Schon 1983). The challenge would be to represent this form of decision-making and practice on a care pathway.

Giles felt that his role and function could not be '*written down on paper*' and openly admitted that he works on '*subjective hunches*' and '*suggestion*' developed through years of experience. Eason & Wilcockson (1996) have considered that decision making of this kind should not be seen as irrational, but rather as a series of actions that occur in response to past learning experiences. Barker (2000) argues that these experiential learning episodes are 'personal truths' which contrast with the evidence from controlled trial research. It may well be the case that Giles has a realistic view of psychiatric practice. Giles accepts that '*uncertainty*' is a fact of psychiatric practice and that much certainty has an illusory quality. Moreover this position supports the idea that understanding practice is a form of knowledge that may be unable or undesirable to transform into protocols (Crook 2001).

Similar thoughts were echoed by Kerry who summed up her experiences of medical psychiatry and the ability for it to be presented on paper. One of the main difficulties for Kerry was the complexity and heterogeneity of the disorder and the theoretical basis of psychiatry as opposed to factual guidelines:

Psychiatry is more complicated for a causal relationship and deciding the interventions to cure it because in each case you've got to consider social aspects and what exactly has made them relapse and decisions are totally subjective.

Many of the problems in developing the care pathway arose from the lack of research based evidence. Reflecting on his role as a psychologist, Simon was specific in one interview when he applied this to his work with 'voices' and the range of interventions:

They're so new and only really being evaluated, it's too early to standardise care because we haven't got an empirical basis, we operate on best practice, developed through experience, it's personal to me and my work with the clients.

Giles has argued that specific training for psychiatrists have been so varied that no one way of working can be determined. This leads to a mixture of approaches grounded in experience. In his view, clinicians responded to problems by referring and comparing new clinical problems to the knowledge gained through clinical experience. This has become known as hypothetico-deductive reasoning (Higgs & Jones 1995).

For Kerry the process of medical training also influenced the nature of decision-making in clinical practice but instead of the hypothetico-deductive reasoning identified above, referred to the existence of gut instinct. A 'gut feeling' approach to making decisions has been identified in the psychiatric nursing literature (Rew

1991) but unlike some who celebrate this form of practice (Cutcliffe 1997), Kerry felt this was her only alternative given the lack of knowledge in treating people suffering from schizophrenia:

If people got trained right from the beginning to use evidence, it would become second nature, but everyone has got a different experience and so you go on your instincts on what works and what doesn't.

The examples suggest that different professional groups develop clinical decision-making processes from experience. This finding is relevant for greater understanding of the clinical judgement process for treating people with schizophrenia but also illustrates more clearly how professionals make decisions. However, it may also lead to potential barriers to integration as professionals profess to have their own methods of arriving at decisions (Buckingham & Adams 2000). As previous sections have detailed, this is conceivable given that interventions and outcomes are not easily identified.

Mike suggested that the process of psychiatry has arisen from a base of experiential learning as opposed to scientific fact and more emphasis should be placed on the experiential skills of professional groups. Mike used a powerful metaphor to illustrate this point:

Clinical skills have been honed down over hundreds of years that the profession's been in existence and we need to be more honest about what we can do....a nurse is a creature that has swam out of the water and has

evolved into this ruthless efficient caring machine...our training misleads us that we are able to predict care for schizophrenics.

Simon suggested that some aspects of clinical psychology for patients suffering from schizophrenia were not supported by evidence but based on experiential practice:

It stifles experiential work because someone's got to do the innovation, because patients may not receive some interventions just because they haven't been tested and that is ludicrous because we would end up doing nothing with them.

In the absence of evidence for practice, Derrin emphasised the interpersonal nature of her OT work developed through the unique learning experience and personality of the clinician:

Using the hidden qualities, the therapeutic use of self and that comes from experience, it's something you learn when you're training, and through modeling people who work well with patients.

An argument has also been made that because psychiatric professionals were unable to say with certainty what they do it did not equal a position of not doing anything useful at all. Giles suggested that psychiatric skills was grounded in experience which did not always require a sound rationale for it to be seen as important:

If I was to develop schizophrenia, and you stuck me in a room with people who have no experience of what to do with this hallucinating person, I might have an OK time for the first few minutes but that person will pack up and go home. It's a bit like sending soldiers into battle and not knowing how to fire a gun. You might not know what the war is about, but you still need the soldiers to fight it.

In this section views have been explored on the nature of experiential practice.

Many reasons were put forward for not being able to standardise care such as the 'newness' of the interventions for practice and insufficient knowledge about the aetiology and disease progression of schizophrenia. An argument was presented that it was satisfactory to use intuitive forms of practice, although for care pathways, such forms of knowledge would need to be open to inspection and ultimate description. As previously explored, this has been difficult for respondents.

Some respondents have disclosed to the researcher that they base their practice on individual judgment because they want to just carry on with their job and maintain the 'status quo'. This may explain why clinicians were reluctant to engage with the research study and aware of the frailties of their knowledge for clinical practice. Some clinicians even suggested that they had no idea why some patients improved and that practice and judgment were based on 'guess-work'.

This may lead to the questioning of the need for qualified staff if much of psychiatry is based on 'guess-work' or a re-evaluation of what is taught to mental

health practitioners. Clinicians involved in the research study have disclosed that applied knowledge has been gained from clinical experience.

This analysis would not claim to be representative, however it does question the evidence based practice movement that is supposedly guiding mental health services. Evidence based practice assumes that evidence exists to be discovered and that it is indisputable. It makes assumptions that clinicians will know how to access it, apply it and for the recipient to agree to it. Some studies have shown that clinicians are open to the idea of evidence based practice but do not have the skills to use it correctly (Carey & Hall 1999). This analysis has uncovered positive assertions of wanting to use outcomes and evidence based interventions, but this is tempered by the need for time to carry out the research, parity across the professions and use of all scientific traditions to conduct research. Clinicians value the use of training to help them clarify outcomes, but the question is whether clinicians would be willing to replace individualised work with standardised outcomes. Evidence from this study suggests this not to be the case.

Conclusion

In this chapter some of the managerial issues impacting on the development and implementation of a care pathway have been explored. Many of the respondents identified that the origins and purpose of the care pathway was to exert

managerial control over the care process. However, most respondents talked of a managerial control over their care processes prior to the introduction of a care pathway. This supports studies that have identified that clinicians are becoming more concerned over managerial issues (Dopson & Waddington 1996). The central analysis has uncovered evidence of these ideas in people's perceptions and observations when asked to develop a care pathway. Recent Government initiatives such as managerial structures and evidence-based practice provide greater pressure forcing professional groups to exercise control over resources dispensed. Some respondents in this research study wanted to extend their managerial remit over health care and for this to include cross-professional working within a care pathway. Government policy has been strident in placing quality as the priority (Department of Health 1998a) and an argument can be made that a care pathway strengthens the managerial agenda in health care. It was frequently asserted that a care pathway made clinicians conscious of being continually monitored.

In the final section, respondents discussed the amount and quality of evidence that would support a care pathway. Respondents identified that they could list '*best practice*' to go into a care pathway and most respondents would agree that very little evidence could be identified to underpin psychiatric practice. However, positive views were expressed about the importance of outcomes based practice and some instances have been discussed where respondents have tried to

identify the difficulties in both accessing and implementing evidence based interventions. In the absence of research-based practice, respondents have identified experiential practice, which appears to be based on practice based learning and clinical expertise. These findings would challenge any suggestion that hospital care packages for people with schizophrenia are based on evidence-based practice or whether clinicians have a sound rationale for providing psychiatric care.

Chapter Eight

Implications for psychiatric services

Introduction

This discussion chapter will draw together the main findings of the study and how they relate to the wider Government agenda of more integrated care and the impact on professional ideologies and inter-professional care. The National Health Service (NHS) has been steadily moving towards collaborative inter-professional health care to improve the quality and cost effectiveness of health care outcomes (Department of Health 1999). The development and implementation of care pathways for people suffering from schizophrenia may complement this quality agenda. Following a review and summary of the previous chapters this final chapter will attempt to discuss five major issues:

- Can care pathways produce a more effective management and change process for psychiatric services?
- What do these findings mean for psychiatric nursing?
- How may care pathways affect multi-disciplinary team (MDT) working?
- In what ways may care pathways shape education and training?
- Could the treatment of schizophrenia be any different using care pathways?

A final part of the chapter will discuss the benefits and drawbacks of the approach and research methods used within this study. This critical synopsis reviews some of the difficulties in carrying out the research within the study

setting. The latter part of the section details further areas for research and development, which could be applied to widen the knowledge base for care pathway research. A number of recommendations are also made for managerial and clinical practice.

Main findings

The development of a care pathway for people diagnosed with schizophrenia has illustrated quite clearly that professions were locked in debate regarding the individualised nature of psychiatric care and treatment. Other respondents perceived that care and treatment could be standardised such as the procedure of admission or the application of the care programme approach.

Both the researcher and respondents constructed this dichotomy into an individualised-standardised care continuum. Elements of care could be standardised such as the discharge procedure but developing patient relationships and knowing the patient was a highly individualised process.

Respondents may have argued strongly for care to follow an individualised care conception so to protect the unique identity of their role and function.

The intention being only that professional group could carry out the intervention. This possible explanation would not be inconceivable given the inter-professional difficulties observed in teamwork studies (Beattie 1995).

Alternatively some respondents argued that care should follow a standardised framework and this could be explained by the firm political drive to manage care more closely. For example the Department of Health (2002a) has

recently announced that certain operations will cost a standard tariff with the assumption that health providers are able to standardise and control the method of delivering care.

The development of the care pathway also demonstrated that respondents were not always clear of the rationale behind their interventions or those of other professional groups. This was aptly demonstrated when respondents attempted to implement the care pathway into practice. Inspection of the care pathway demonstrated that large parts were not implemented. Respondents also acknowledged that their representation of what they did was sometimes optimistic and openly acknowledged their lack of knowledge of why certain interventions were known to work. Uncovering this perception required a certain degree of trust and openness from respondents within the research process.

It could be that respondents were unclear of their role, function and interventions because the nature of hospital care was and still remains ill defined. This is further complicated because of the aetiology, disease progression and outcomes of schizophrenia being equally as contentious. Although recent guidance on the prescription of medication for schizophrenia has been produced (National Institute for Clinical Excellence 2002), there is still a wide range of activity that is variable and poorly understood. For example further work is required on understanding the purpose of admission to hospital and identifying what the outcomes of admission should be for a

person diagnosed with schizophrenia. Respondents may have been unclear on explaining their role because they may never have conceived their role to fit within the confines of a care pathway. This possibly led to respondents being critical of the role of the varied professional groups although the study did demonstrate that some understanding of role occurred through developing the care pathway.

Respondents may have been unclear on what they did because of the training and preparation to work with people diagnosed with schizophrenia. Evidence collected from reviews of the training of the psychiatric professions does point to a requirement to specifically address this issue but also to look at training a different type of practitioner. For example, the Implementation Guide for hospital care identifies the role of Support, Training and Rehabilitation workers to offer a different type of role for hospital care (Department of Health 2002b). Respondents, particularly nurses were critical of professions such as occupational therapy and psychology and this demonstrates a sense of vulnerability in their perceptions of the nursing role. Equally it may demonstrate a misunderstood role of mental health professions in the care of people with schizophrenia.

Findings of this study also demonstrated that the process of change is complex and fraught with difficulties that may be outside the control of the researcher. Particular problems encountered in this study related to staff changes and poor morale. This affected both the developments of the care

pathway in terms of engagement with the project, but also of more importance, the implementation of the care pathway. This was an unexpected occurrence within the project and led to participants having insufficient knowledge to implement the care pathway into practice. This finding would have relevance for similar hospitals experiencing a fluctuating complement of staff.

The role of the researcher in facilitating the change process led to respondents offering both positive and negative views. Some respondents perceived the change process to be a management inspired objective whilst others recognised that they were able to contribute and shape the agenda for change. The dual role of the researcher in being both a project manager and a researcher may have contributed towards the perception of ever increasing management control.

In sum, the findings indicate that the development and implementation of a care pathway led to a rigorous defence and articulation of the view of individualised care. Care pathway development did produce various responses on the perceived role of professional groups within the context of the multi-disciplinary team. However, these findings must be seen within the change context locally but also within the wider politics permeating the NHS. The following section will now apply these findings to the management of psychiatric services.

Management of psychiatric services - political imperative

In this section it will be considered how a care pathway would extend the managerial remit over psychiatric services. This will be considered in relation to the Government agenda of reforming mental health services to ensure greater quality and control over psychiatric work. The process of changing psychiatric practice will also be considered and include the development of evidence based practice, integrated care, managing corporate risk and enhancing the role of the user in psychiatric care.

A repeated argument throughout this study has been that there is increasing control over the management of health personnel and what they do (Edwards 1998), and secondly, how and where the client is managed (Chan & Rudman 1998). Respondents readily agreed that a care pathway was more aligned to the needs of the health service manager as opposed to a clinician.

Commissioning authorities may be positive towards this development because care pathways may facilitate improved service agreements. A care pathway is designed to ensure the patient receives the most effective interventions and satisfies the outcomes within a time-limited trajectory (Rietz *et al.* 1997) although in this study, it was not possible to manage the workforce in achieving these service aims. Respondents were able to identify the relationship of a care pathway to both the local needs of the service in managing resources, but importantly, convergence with the wider Government agenda of more integrated care.

Convergence of appeal

Following completion of the study, further advancement of policy has detailed a greater degree of control over the provision of health care (Department of Health 1997). The Government has identified that variations exist between the way mental health services are provided and integrated across the UK and has put forward a series of measures to place the quality of care into the centre of health care planning and provision. Under a system of clinical governance, Chief Executives of health care organisations will need to demonstrate that they and individual clinicians have systems to audit the quality of patient care (Department of Health 1998a). The Government has produced a mental health National Service Framework (NSF) (Department of Health 1999) setting standards in five areas: health promotion; primary care; access to services; focus on serious mental illness (SMI) and the reduction of suicide. A Commission for Health Improvement (CHI) (Department of Health 1998a) will monitor adherence to the standards. Respondents readily identified with the influence of past managerial structures on health care and perceived a care pathway to be a natural extension of this agenda. A care pathway could be used to introduce other managerial structures but as demonstrated within this study, respondents were not always positive if it was perceived to conflict with individualised patient care.

A National Institute for Clinical Excellence (NICE) has been established as a special health authority to provide authoritative and prompt guidance on therapies, treatments and clinical guidelines to the NHS. Following a period of

review, new treatments and health technologies will be proclaimed as a national standard and be included within NSF's (Department of Health 1998a). Systems need to be devised to incorporate and demonstrate NICE guidance (Littlejohns 1999) and a care pathway may serve this need. In this research study, respondents were unable to identify those tiers of interventions that were evidence based and most appropriate to introduce to the clinical encounter. Respondents could not agree on best practice which would be the forerunner to evidence based interventions and so the usefulness of a care pathway appears limited in this respect.

The Government's stated appeal to improve clinical accountability for the way professionals practice their work demands a major attitude change for mental health practitioners. Targeting groups of disorders such as schizophrenia also adds convergence of appeal for the use of care pathways as a tool to co-ordinate clinical governance. A care pathway may enable NHS Trusts to co-ordinate the use of clinical information to exert maximum influence on the patient's problem and provide best use of clinical resources (NHS Executive 1998). However, there were many problems in developing the care pathway, the most important being the inability of clinicians to say what they do for this client group. Moreover, each professional group has felt threatened by having their role and function displayed within a transparent framework. Although the research process did lead to a reappraisal of role function, the process of carrying out psychiatric work was not greatly changed.

Assessing the quality of care has been explicitly discussed in the NSF and was widely recognised as important by the respondents in the research study. Respondents questioned whether a care pathway added a too greater emphasis of '*big brother*' and a questioning of the workforce. However, this perception of surveillance is likely to be extended under clinical governance. The aim is for the process of care to be clearly mapped out for ease of audit. Respondents identified that a care pathway may make the professional more accountable for their performance and so rectify deficiencies within the service. However, inspection of the care pathway found large parts incomplete suggestive of greater deficits in care than was expected.

The recent changes to the NHS highlight increasing internal and external managerial control over how clinicians practice. The advent of the NSF heralds a movement towards reducing clinical variation and towards standardised care, monitoring the quality of care and opening up a new era of clinical transparency and managerial scrutiny (Department of Health 1998b). A care pathway works within these parameters, but as discovered within this research study, care pathways are perceived to be politically motivated to '*control*' the workforce. A perception of control manifested in many ways such as the care pathway preventing individualised work, challenging professional boundaries and adding a greater scrutiny over the rationale of care. In this study, respondents offered negative views of a care pathway when they thought management staff of the organisation was directing a care pathway.

Linking primary and specialist services

The management of illness episodes spreads far wider than the ward or community setting and a care pathway could be used to integrate all the different agencies and professionals involved (Hunter & Fairfield 1997, Edwards 1999). For example, the interface between primary and secondary care could be bridged with a referral route and specified action plans from the General Practitioner (GP) to a community mental health team. This would enable a greater degree of control over access to specialist psychiatric services and may prevent unnecessary use of expensive hospital beds. Lang *et al.* (1997) discovered that GP's were particularly concerned with poor communication between primary and specialist services with unclear roles and responsibilities. Respondents appreciated the advantages of linking primary and specialist mental health services such as improved communication, allocation of community workers and quicker discharge from hospital, although the tool was unable to demonstrate these features of integration in clinical practice. Arguably the process of managing services across different agencies is too ambitious for a care pathway given the lack of ability to manage services in one care area.

Control over corporate risk

Care and treatment negligence claims are increasing in the UK and a care pathway may be a vehicle to guard against corporate litigation risk to the organisation (Ellis 1997). The care pathway mechanism prompts the clinician to act when the patient is not conforming to the confines of the care pathway

(Pearson *et al.* 1995). Hyams *et al.* (1995) found that clinical guidelines could be used to both prevent and pursue cases of litigation. For example, organisations that develop care pathways for ambiguous treatment conditions like schizophrenia may be more able to demonstrate a considered view in the courts. The opposite case of providing care with less time to consider the possibilities may be less easy to defend. Alternatively, the courts may demonstrate that two different psychiatrists provided alternate types of care for the same diagnosis. However, in this research study there was little evidence to suggest a care pathway could reduce clinical variation and may actually increase the risk of litigation because clinicians were largely unaware of how to apply best practice.

Many nurse respondents were critical of the blame-culture within health care and felt nurses were too often identified as the culprits in medical and nursing negligence cases. However, this must be balanced with the fact that psychiatric nurses are the largest group of staff having the most face-to-face contact with the psychiatric patient (Thomas 1997). A care pathway may introduce a shared perspective to managing health care risk for all of the team but be unsuccessful in reducing negligence cases.

Refocusing practice: the evidence based culture

Broad directions have been laid down within the NSF for the future development of mental health services (Department of Health 1999). The development of a care pathway would aim to include those aspects of care

deemed best practice (Ellis & Johnson 1999). Respondents identified that the development of a care pathway was a dynamic process which would aim to include an ever increasing number of evidence based interventions. However, respondents could neither identify evidence-based practice nor describe psychiatric care accurately for inclusion within the care pathway. Following the process of implementation, respondents identified that parts of the care pathway were '*optimistic*' and '*unachievable*'. It could not be assumed that a care pathway would facilitate the development of mental health services as determined within the NSF.

Assuming that suitable evidence based interventions could be found for changing psychiatric practice, it would involve a large element of training the staff to use and evaluate these new interventions. For example respondents identified that using a rating scale to measure symptoms and outcomes of care was an improvement on the unstructured method of assessment previously practised. As part of the preparation to implement the care pathway within this study, clinicians were trained to use the Brief Psychiatric Rating Scale and the Health of the Nation Outcomes Scales. Many of the nurses were positive about their new skills but their application in practice was not widespread. Wider implementation of the care pathway would require further and on-going training commitments from the organisation. The use of care pathways may be a possible tool to demonstrate this on-going effort for evidence based mental health care (Dykes & Wheeler 1999). However simply

including more modern types of interventions within a care pathway would be no guarantee for their use within psychiatric practice.

A case of not using interventions simply for not being supported by evidence may deny patients a potentially therapeutic intervention. Steve, Mike and Simon put similar arguments forward for not standardising care. They felt that only standardised care could be supported by evidence. This has possibly led to the suggestion that the care pathway was unrepresentative of hospital care. For example, some care pathways from the United States do not include the role of a psychologist for in-patients with schizophrenia (St. Elizabeth Medical Centre 1995). Within this study, there was little provision of OT or psychological care for those patients who followed the care pathway. The bulk of the care pathway reflected the role of medical and nursing staff in managing the patient episode. It may well be the case that psychological and OT care could be provided as an exception rather than the norm. However, some studies have identified that psychiatric patients value the 'talking therapies' following their illness (National Institute of Health 1994). Moreover, the dangers of such a conclusion may lead to a disintegration and lack of involvement of the MDT in caring for the psychiatric patient. A rationalised or 'reduced' service may be the end result of practice not considered to be 'evidence based' by NICE or by care pathway analysis.

Managing morale

The NHS records a variable turnover of nursing staff (7% to 36%) and high rates of 'leavers' results in skill and knowledge attrition, low morale and retention of poorly trained and motivated staff (Audit Commission 1997). The impact of job dissatisfaction has been identified as a major source of stress for nurses (Farrington 1997) although the link between stress and absenteeism is not clear (Matrunola 1996). It has been argued that a care pathway increases work satisfaction (Newel 1994) and leads to a level of perceived control over the nature of psychiatric work. However, findings from this study identified considerable conflict both within and across the professions during both the development and implementation phase of the care pathway. Although recruitment and retention of staff remains a particular problem for psychiatric services a care pathway may compound the problem and be unable to conserve on this vital human resource.

A positive correlation has been found between increased levels of control, autonomy and work routines i.e. protocols in patient focused care (see chapter 1) with reducing stress in the nursing role (Jenner 1998). However, this study found repeated examples of role conflict as respondents grappled with contentious issues in deciding the content of their work. Some respondents expressed concerns over their ability to exercise control in the provision of care. Levels of morale on the study ward compounded the problem. Because care pathways are so new to the current systems of care, they demand a working environment and staff group that will accommodate

the features of a new system. It remains uncertain whether organisational systems could be better managed to enable care pathways to give higher levels of autonomy and control to clinician groups.

Realignment of care for the consumer

Greater emphasis has been placed on the role of the consumer as an interactive agent in the planning of care (Neuberger 1999). However, problems still remain in their actual involvement and patients understand little of the treatment direction (Spicker *et al.* 1995). A care pathway is an attempt to make the process of care transparent. Users of services can determine if the contents of the care pathway fit their expectations. This may challenge the dominant 'paternalistic' provision of care and embrace a new era of a self-critical public. There was some appreciation of these factors from Ingrid, but on the whole, the care pathway was interpreted as a mechanism imposed on the workforce and the patient. As a further step towards involving the user of care, some care pathways have included pictures or images of the care delivery episode (Bumgarner & Evans 1999). This may be useful for inner city areas that cater for a patient where English is a second or poorly understood language.

Some research from the care pathway literature analysing general adult conditions has found that patients score higher on care satisfaction. Patients valued the prescribed pattern of care so that they knew in advance what treatment to expect (De Luc 2000). This may enhance patient participation

and knowledge about the service. Users may prefer to have care given on an individual basis as advocated by the respondents in this research study.

In this section it has been considered whether a care pathway would extend managerial intentions over health care. Based on the evidence of this study, psychiatric practice is a poorly understood and applied body of knowledge. It appears unlikely that a care pathway would greatly extend the agenda for improved quality of care or to reconfigure psychiatric work to encompass evidence based practice.

A care pathway may lead to a greater appreciation of the factors contributing towards risk and the value of the consumer in planning care, although be ineffective in managing services across agencies. Although respondents perceived a care pathway to extend the managerial gaze over psychiatric work, the suggestion that a care pathway would lead to a more managed service has not been upheld in this study.

Psychiatric nursing

There is a perception that psychiatric nursing must follow an individualised perspective in caring for people with schizophrenia on hospital wards (Brooking & Ritter 1992) and this was highlighted by many of the respondents in the research study. It was claimed that people present with individual 'needs' which require an individual response from a clinician. It could be argued that care pathways represent the antithesis of an individualised

approach, so long espoused by psychiatric nurses for the development of therapeutic relationships (Hill & Michael 1996). It was a commonly expressed view that care pathways would somehow demean the interpersonal work that takes place between a nurse and a patient. Others have suggested that care pathways are intended for use in specific illness or treatment groups and have mechanisms for tracking variances (Schriefer 1995) and ensuring individual corrective action (Robinson *et al.* 1992). However, respondents only partially completed the variance section of the care pathway. If the patient did not conform to the care pathway, the stated intervention was not delivered. On very few occasions was nursing care changed to address individual needs. So in this regard, respondents using the care pathway failed to track variances from the stated care plan and certainly overlooked any corrective action.

Other respondents perceived that care could be standardised for some parts of the patient's care and treatment. One could argue that by following a standardised process, the nurse could be better able to respond to the needs of the client in a planned way. Individualised care may lead clinicians to be reactive to situations. Some respondents argued that the process of standardising care led to a more considered view on psychiatric care.

Although this may have been the case, it did not change the way nurses worked. Psychiatric nurses continued to do the same activities even when they advocated the benefits of individualised care.

Some scholars have argued that standardisation of nursing tasks reduce the potential for flexibility in working practices (Mangen 1982). It could be that the setting of standards removes the potential for nurses to insert delays into the care system, practice according to particular styles or to hold firm views on the nature of nurse-patient relationships. In this research study nurses used the problems of care delays to prevent the setting of standards. The impact of clinical governance and the NSF may ensure that psychiatric nurses work towards national standards of care for patients with a SMI (Department of Health 1998a). Professionals who favoured individualised care generally opposed care pathways and this could be the case for other Government initiatives such as clinical governance and the NSF.

Discourse on professional groups has identified psychiatric nurses to experience a sense of disempowerment (Stein 1967) and reverence towards their medical colleagues (Clarke 1991). Issues of social class, information and power have been central to this inter-disciplinary conflict (Pilgrim 1983). A care pathway may work towards re-dressing this balance by identifying parts of the role, which have clear links with evidence-based practice. Although nurse respondents in this study could find very little evidence to support their role and function, this may be due to poor research training. Retsas & Nolan (1999) used the Barriers to Research Utilization Scale (Funk *et al.* 1991) and found the most frequently identified problems were insufficient time to access, interpret and implement research evidence. Similar to the findings of

this research study, this led to problems in implementing 'evidence' within clinical effectiveness initiatives like care pathways.

Increasing amounts of research are finding evidence to support non-pharmacological interventions (Drury *et al.* 1996a,b, Tarrier *et al.* 1999). If these interventions were included, a care pathway may lead to a gradual realignment of nursing status and role with other professional groups such as psychiatrists and psychologists. There are two main problems with this claim, specifically for care pathways designed for schizophrenia. In this study, nurses encountered a great problem in describing a comprehensive list of interventions used for patients with schizophrenia. Moreover, nurses did not have the knowledge on how to apply or appreciate evidence-based interventions. Primarily, there would be the need to train psychiatric nurses to use these interventions and, possibly of more difficulty, persuading nurses to adopt these interventions within the confines of a care pathway. As identified within this research study, nurses may be unable to answer questions relating to evidence based practice due to the infancy of the research base (White 1997).

A more pressing problem has been the adoption of a humanistic ethic installed into nursing practice (Thomas 1997) and nurse education programmes throughout the 1980's (Nolan 1993). A humanistic perspective values the individual approach to care and prefers to look at the totality of the patient's needs. Mental distress would be seen as a product of the

environment and inner psychological conflict (Barker 1989, Barker *et al.* 1997). Some have argued that this perspective has led to a rejection of the evidence for a neurobiological understanding of mental disorder (Betemps & Ragiel 1994), which embraces both the use of medical and psychosocial interventions. Within this study, the care pathway was designed for people with chronic schizophrenia and based on the medical classification of disorders. This ultimately influenced and confronted commonly held nursing perspectives. Preparing psychiatric nurses on the possible conflict and confusion between a humanistic and medical care perspective would be fundamental to securing the adoption of a care pathway.

The nursing profession has generated a body of knowledge and skills that are claimed to be unique to the discipline. Within the research study, nurses claimed to have developed unique areas of expertise specific to the patients' illness. This may have fuelled some of the antagonism towards '*letting go*' of certain nursing duties. It has been demonstrated that nurses perceived themselves to be '*over-worked*' in both the delivery and management of psychiatric care. A care pathway may begin to illustrate the amount of time and activity that psychiatric nurses could potentially spend with patients. This would confirm the conclusion that past and contemporary studies continually find that hospital psychiatric nurses disengage with psychiatric patients and spend little therapeutic time with them (Johns 1961, Higgins *et al.* 1999). A care pathway may enable psychiatric nurses to improve on this important

deficit in care and also produce a more robust mechanism of determining therapeutic contact.

A care pathway may be able to identify periods of time when psychiatric nurses have been engaged in activities that are considered important or not important for ward work. The problem is that nurses were unable to describe their role and this raises questions over whether nursing care is sufficiently formalised for ward nurses. This could be due to respondents not having a sufficient awareness of their role and many nurse respondents demonstrated this. However, this position questions whether it is appropriate for psychiatric nurses to work on wards or if people with schizophrenia benefit from being admitted into hospital. The development of the care pathway helped to identify nursing work but also displayed large gaps where nurses were unable to say how they justified their role on psychiatric wards. This could explain why nurses were so defensive of an individualised approach to psychiatric care.

Like other accounts of inter-professional rivalry (Lyons 1998), this study found evidence of a rigid adherence to professional domains and this may possibly prevent clinicians from accepting the generic roles held by health care practitioners. The development of a care pathway aims to identify common ground, generic working and clinically effective interventions. This may have antagonised some of the respondents because the approach gives little support to professional ideological differences in its pursuit of efficient health

care. If psychiatric services were to adopt care pathways, the nursing discipline would need to suspend some of the concerns of inter-professional rivalry that have been so strongly asserted.

Psychiatric nurses are the largest occupational group in mental health services (Thomas 1997) and therefore provide the bulk of the responsibility to deliver and co-ordinate the process of care delivery. One could assume that nurses would have a greater overview of the input from all professions involved in the patient's care. Respondents identified that it is the nursing staff that largely co-ordinate this care through daily 'hand-overs', ward rounds and the CPA process. One could have expected therefore a greater appreciation of the roles and responsibilities of both the nursing staff and other clinician groups. As discovered in this research study, the development of the care pathway provided a forum to re-examine the role and function of all psychiatric professionals. Although nurses were unable to capitalise on this forum, future exercises could prepare psychiatric nurses to become adept at extending their practice into roles undertaken by psychiatrists and psychologists. This could lead to an increase in role legitimacy, but may also strengthen negotiating positions for parity of status, pay and conditions.

Some have argued that nurses need to develop a standardised language to reflect their input into the care planning process (Dean-Barr 1994) and this has been put into practice by the work of the North American Nursing Diagnosis Association (McFarland & McFarlane 1993). Jones (1997) argued

that a standardised nursing language would enable the nursing input to be formally recognised by purchasing bodies and more visible to policy makers. It could be argued that a standardised conception of care illustrates a considered and formal view on the delivery of nursing interventions. This would be in contrast to an informal and ad-hoc way of describing nursing care, which is subject to the interpretations of individual practitioners. A standardised nursing language within a care pathway may also work towards demonstrating the contribution in improving health outcomes albeit compromising the individualised ethic in nursing practice. In this sense, a form of discourse projects power (May & Fleming 1997) where the language of standardised care supersedes the implementation of individualised care. Although clinicians may have been taught to deliver care in an individualised way, or as identified in this study, deliver individualised care according to the practitioner's value system, a standardised nursing language would counter and bring into line these alternative ways of working. Greater concordance in working to set outcomes of practice may then be achieved.

The prospect of greater managerial control over the workforce may well have influenced the Trust to support care pathways research. This research study gained support from the Director of Mental Health Services, but there was little support for the project throughout the organisation. This was recognised and affected the commitment from professional groups such as medical and psychological staff. Due to the power and autonomous status of medical staff (Flynn 1992), the use of care pathways may be more effective in managing

psychiatric nurses that hold less power compared to their medical counterparts. For example, nurses could be employed specifically to provide care as determined on the care pathway. The care pathway could specify more clearly the skill mix requirements for ward staff and so control more efficiently the costs and deployment of psychiatric nurses. The problem would be for psychiatric nurses to implement the interventions specified by the care pathway. Nurse respondents were open and critical about the lack of training or support for implementing specialised interventions on psychiatric wards.

Many studies have found that psychiatric nurses experience stress in their work (Sullivan 1993) but one of the main factors associated with 'burnout' is that to do with unrealistic expectations of the nursing effect on patient outcomes (Melchior *et al.* 1997). Burnout is thought to consist of three parts: emotional exhaustion, depersonalisation and reduced personal accomplishment (Maslach & Jackson 1982). A care pathway may begin to redress the third issue where nurses can develop a more focused and realistic awareness of their effect on patient outcomes. This is particularly so for those patients that may be slow to recover from their illness. However, in this study, respondents offered unrealistic expectations of their role in both delivering interventions and being able to predict response to treatment. Moreover, respondents attempted to build in delays and exaggerate their role on the care pathway. This may contribute to a perception of decreasing control over clinical progress and so exacerbate the effects of burnout in psychiatric nurses.

The practice of psychiatric nursing would be challenged by the impact of a care pathway specifically the gulf between individualised and standardised approaches to care. In this study, the care pathway challenged the ideals of psychiatric practice namely that of the therapeutic relationship, the language of psychiatric care and the assumption that a nurse knows what they do. If psychiatric nurses are unable to explain their role it begins to undermine the rationale for hospital care. The proposed benefits of a care pathway in focusing psychiatric nursing have not been found in this study. It is questionable if a care pathway would reduce levels of burnout in staff or improve the co-ordination of psychiatric nursing for people with schizophrenia.

MDT working

The literature contains a vast amount of research into how professions dispute territorial roles between one another (Hugman 1995) and how they extend their role into vacant occupational territory (Jordan *et al.* 1999). A care pathway has been proposed to improve inter / intra professional communication and team integrity (Musfeldt & Hart 1993). Mental health care is no exception and possibly more complex in the potential for conflict not just between professionals, but also between professionals and users. For these reasons, most studies stress the importance of developing care pathways through meetings and consultation between key members of the MDT (Velasco *et al.* 1996, Barnette & Clendenen 1996).

A frequently cited benefit of psychiatric care pathways is their ability to provide definitive role functions and work activity patterns (Dykes 1997a). In this study, the development of care pathways questioned the appropriateness of certain clinicians to deliver interventions. This led to professional groups asserting their control over certain interventions. Professional groups felt disinclined to discuss their role beyond superficial dialogue. Some respondents identified the lack of '*evidence*' supporting the role of the team, whilst other respondents identified that it was difficult to describe their role and function.

There are advantages to developing a care pathway. Firstly, it exposes some of the underbelly of MDT working such as suspicion and the tendency to '*scapegoat*' other professional colleagues. It also exposes power imbalances in the team, which may fuel disintegration of the team structure. With repeated discussion about one's role it may reduce role ambiguity although it remains doubtful whether it leads to improved MDT working. Respondents were able to identify common problems for people with schizophrenia although had great difficulty in listing interventions and outcomes for individual disciplines. The group were unable to identify interventions and outcomes common to the MDT. This suggests that generic MDT working is in name only although a small number of respondents were able to recognise and respect both similarity and diversity across the professional team. Many respondents identified that a care pathway did not deliver a more focused response to care

and others suggested it lead to further demarcation into rigid professional boundaries. A more pressing concern is that if the MDT had difficulties in explaining their role, it undermined the rationale for the spectrum of psychiatric care for people with schizophrenia.

Much of the working group debate centred on the need for definitive professional domains of practice because it was felt that any move towards the use of care pathways would dilute the role and function of certain professional groups. In this study the care pathway was synthesised from the research and theory of a number of health care professions. Government policy has suggested that services should be designed to minimise professional and geographical demarcations (Department of Health 1999). It would appear that a care pathway could integrate the wider continuum of mental health care to include, as the NSF has suggested, housing, benefits and employment agencies (Department of Health 1999). However participants were unable to describe in clear terms the admission route into hospital and the subsequent involvement of the community team. It would appear too difficult to integrate and represent a far broader approach to care as detailed within the NSF. Respondents in this research study were positive about the moves to recognise the diversity of mental health care although the team was unable to detail the complexity of multi-agency service configuration.

The roles of different psychiatric professionals share many similarities (Sainsbury Centre 1997) and respondents observed that teams provide

unnecessary duplication of psychiatric work most notably that of assessment and care planning duties. For example, the researcher observed that nursing staff assessed the same reasons for admission as the admitting doctor. A care pathway could be used to economise on limited resources and also protect the patient from being over-assessed. However, respondents would comment that they thought their individual assessment was important for the planning process and refused to limit this role in place of other professional groups. A care pathway would begin to challenge particular views but gaining consensus of opinion and streamlining what does occur for psychiatric patients was incredibly difficult in this research setting.

In this study, some data on how MDT's re-conceptualise their work within care pathway structures have been examined. The process continually questions the nature of interventions used, the effectiveness and the appropriateness of the professional groups who aspire to use them. The process by which health care become partitioned into observable chunks and how MDT's negotiate their work within a care pathway will undoubtedly produce many professional 'turf' wars. However, the prime factor that should fuel future research and policy formulation is that the MDT were unable to say how they work or what they do in great detail for people with schizophrenia. If this finding was to be representative of all wards and community teams it would question the provision of psychiatric care in the UK.

Education & training

There has been some suggestion that current methods of training mental health workers have been largely ineffective (Sainsbury Centre 1997) and this is inclusive of psychiatric nurses (Tunmore 1997). This is largely because educational establishments have failed to deliver on the practical needs of the service. It has been asserted that a care pathway type structure could act as a framework to train a workforce to deliver care. The components within the care pathway could determine specific issues for inclusion within multidisciplinary training routes. The problem is deciding the content of the framework and how near it comes to evidence based practice. Some scholars have rejected the preparation of nurses focusing on evidence-based practice. For example, Gordon (1998) has argued for students to be exposed to practices that celebrate individualised care. Respondents noted on many occasions, and for different parts of their role, that evidence for practice was difficult to establish for people suffering from schizophrenia. This has relevance for training psychiatric professionals to deliver evidence-based practice. The NICE will issue guidance on the types of interventions for certain patient groups and it is not inconceivable that guidance would be issued within a care pathway structure.

Changing to care pathways would demand a compatible working culture where the team will work cohesively and collaboratively in the pursuit of jointly agreed interventions and outcomes of care. It is only recently that a skills deficit has been identified and addressed by courses such as the Thorn

initiative (Lancashire *et al.* 1997). It is to this end that services using care pathways will require MDT's that are able to conceptualise care within outcomes-based-language, articulate psychosocial interventions and have a greater understanding of the overall process of care. However, given the evidence secured in this study it appears unlikely that the MDT would be able to achieve any of these objectives.

A care pathway that focuses less on outcomes based practice and more on the process of care may be a more realistic starting point for training psychiatric professionals. For example, a care pathway could track the various stages of securing accommodation for those patients who habitually disengage from their housing and benefits entitlements. This process could then be taught specifically to new employees. It may well be the case that less time would be spent teaching professionals on issues that are not included on the care pathway. Although this could produce a highly skilled mental health worker, it would be at the expense of a broader application to mental health care. This could be evidenced when mental health workers choose to go and work in different areas of practice. Mental health workers could be trained to deliver a larger proportion of tasks common to professional groups. However, highly skilled and specialised staff such as psychiatrists and psychologists would challenge the expansion towards a larger generic role for mental health workers. Although a care pathway would identify areas of generic practice that could be identified for training material,

it was observed in this research study that professional groups resisted any dilution in role.

If the contents of a care pathway were taught to all the involved professionals, it might enhance and focus teaching programmes on the most appropriate care components. For example, some reports note that no single mental health profession has been trained to adequately deliver and manage psychiatric care (Sainsbury Centre 1997). Teaching professional groups to follow a care pathway may enable clinicians to follow common goals of treatment for particular types of patients and clinical environments. The problem is making sure that education and training does not become too constrained or dominated by any one single care perspective. This teaching programme would also conflict with an interactive, consciousness-raising approach to learning such as those advocated by Freire (1972). This viewpoint makes the assumption that students will simply learn facts from the educational programme with no individual interpretation or application to practice. It would be a retrograde step for nurse education to simply teach nurses the contents of the care pathway. Nurses require critical thinking skills to be able to challenge practice and dominant care ideologies. The history of nursing shows subservience to the medical model (Nolan 1993) and given the fears of a medically dominated care pathway from within this study, the use of a care pathway as an educational tool must be viewed with caution.

By its very nature, a care pathway itemises what the service requires professionals to achieve. Respondents noted that it was very difficult to describe what they do and when asked this question, spoke only of the more measurable tasks. Teaching professionals how to care and treat people through the contents of the care pathway may minimise the hidden skills of psychiatric practice. Respondents noted many occasions when *'just being with the patient'* was a meaningful activity. A care pathway also presents the image that care is a mechanistic activity and that professionals have control over the condition. As the contemporary research data indicates, the predictability of health states such as schizophrenia is poor (McGlashan 1988) compared to surgical conditions such as total hip replacement (Gregor *et al.* 1996). Moreover, when respondents observed patients to proceed through the care pathway it confirmed the view that clinical progress remains largely unpredictable.

Before a care pathway is used for training purposes, further research should be performed to establish whether health professionals are content to follow this method. It may be found that it produces a too limited viewpoint of patient care. This was certainly the case for the OT and psychiatrist respondents. They argued that the complexity of a patient's care could not be splintered into a set order. It was advocated that treatment required a multitude of options unconstrained by rigid practice parameters.

In this section, it has been considered whether a care pathway could inform the future training of mental health professions. The nursing profession has stated a commitment to promoting inter-professional working (UKCC 1992) although whether a care pathway could deliver on this aim remains debatable. Nurses, amongst other clinician groups were resistive to identifying generic practice. Quite possibly boundaries will merge to create a common professional training although it remains questionable whether a care pathway would be the most appropriate vehicle to bring this about. In this study, respondents did not perceive care pathways to result in clinicians becoming less territorial or implement inter-professional collaboration at a level where it improved the quality of care patients received. Greater purchasing authority to commission health care education which supplies suitably qualified mental health professionals to manage specific diagnostic groups fits comfortably with care pathways. However the recipients of this education may be less positive when they attempt to challenge care or go on to work in different areas of mental health. In sum, moves towards a multi-skilled workforce give little support to individual professional ideologies and with this being such a strongly asserted principle for the respondents in this study, little use for a care pathway can be seen within this area.

Treatment and care of schizophrenia

The development of a care pathway assumes that health professionals have a degree of certainty over how patients will respond to interventions. This has been indicated by published accounts of care pathways and the attempt to

implement the care pathway in practice (Andolina 1995). However, for the disease type of schizophrenia, this may not be so easy. The problems in treatment are in part due to the changing and complex picture of its presentation, course and outcome (Johnstone & Lang 1994). By attempting to develop the care pathway, respondents have identified that the care of a patient with schizophrenia is determined by individual circumstance. Process related activities were easier to identify compared with outcomes based practice. This may explain the dominance of process related care pathways in the literature (Lowe 1998). However, some elements of care could be standardised such as the admission of a client into hospital and planning for their discharge.

The diagnostic classification of schizophrenia has come under intense critique with many scholars perceiving the label as a heterogeneous category with poor validity and reliability (Boyle 1990). Others have considered the term schizophrenia essential for clinical practice. In one study Wing *et al.* (1998) expressed concern that nurses were particularly negative in appreciating the importance of the label in assessing and delivering care. Respondents within this study could identify with people suffering from schizophrenia, but preferred to identify common problems that affected people with this diagnosis. In effect, the working group ignored the diagnostic label to focus on common problems such as '*improving social functioning*' and '*securing accommodation*'. Respondents argued that by focusing on common problems, mental health care became more tangible to plan and deliver. The use of 'lay'

terms may also reflect the social language of mental health that would be acceptable to all professional groups. Some respondents perceived the label of schizophrenia to be representative of a medical discourse and felt uncomfortable in being part of a project that focused heavily on '*symptoms*' and '*diagnosis*'. Therefore it may be more appropriate to design care pathways for groups of patients that exhibit common problems as opposed to focusing on a diagnosis.

The pharmacological treatment of schizophrenia plays a major role in managing the disorder (American Psychiatric Association 1997) and an important part in the care pathway. Greater promise has also been found with the newer types of 'atypical' neuroleptic compounds compared to classical drugs (Franz *et al.* 1997, Tollefson *et al.* 1997), although further research is required (Wolfgang Fleischhacker 1999). However, the process of developing the care pathway involved a single responsible medical officer (RMO) and the medication algorithm was designed from his experience. It is questionable whether other RMO's would agree to implement this medication regime and this study demonstrated differences of opinion regarding the predictability of schizophrenia. There appears to be little consensus across the medical profession for following set medication algorithms and this itself indicates the inability to predict the treatment direction. A possible way forward is for all the psychiatrists in the local hospital to agree on medication protocols. These protocols could then be included within the care pathway. However, medical dominance and independence allows the profession to alter and change

treatment to follow particular ideas. The psychiatrist respondent supported this when he suggested that '*psychiatrists follow what ever particular interest they have about the pathology of the illness*'. The problem with this practice is the lack of accountability to both the patient and the organisation. A care pathway may help to audit the prescription of medication for people suffering from schizophrenia and show differences but may be ineffective in ensuring psychiatrists stay within agreed protocols.

Although there are no specific causative factors that can wholly explain the condition of schizophrenia, increasing evidence is pointing towards structural brain abnormalities such as reduced grey matter volume and enlarged lateral ventricles (Zipursky & Kapur 1998, Hafner 1998). Various tests can be performed to detect neurological changes such as Magnetic Resonance Imaging and Positron Emission Tomography (Travis & Kerwin 1997). Some respondents identified the possible use of these tests and a care pathway could indicate when these tests should be carried out for the prediction of a more accurate diagnosis. For example, patients with bipolar disorders do not record differences in grey matter volume (compared to schizophrenia) (Zipursky *et al.* 1997). Further research may indicate the most appropriate methods of treatment for the different types of disorder and these could be standardised on a care pathway. However, this advancement in treatment remains entirely speculative and one that is not currently part of routine practice.

The development of the care pathway prompted a general awareness of the lack of milestones in the treatment of schizophrenia. A precise audit of previous inpatient treatment for patients with schizophrenia would be a further step towards enabling the identification of milestones and outcomes of usual practice. Developing and implementing medication protocols would be more difficult as evidenced by the development of a care pathway in this study. The types of medical language used to describe people suffering from schizophrenia antagonised some respondents into rejecting the content of the care pathway. However, the care pathway could be a mechanism by which to introduce more modern forms of detection and diagnosis and so aid the treatment of schizophrenia.

In this section, issues relating to the management, configuration and training of mental health professionals have been considered. A care pathway may have some success in areas such as making care practices transparent. However this is reliant on professionals knowing what they do for people with schizophrenia. In others areas a care pathway may offer false hopes such as the increased ability to manage psychiatric care and professionals. The potential of a care pathway to shape professionals to deliver care in a standardised way may be blunted by the strongly held views on individualised care. A limiting factor in evaluating the benefits of a care pathway is their infancy of development but evidence from this study offers only a limited potential for psychiatric services.

Limitations of the study

The researcher will now identify a number of different approaches that could be undertaken if a similar study was to be undertaken again. The study conclusions also identify a number of different lines of enquiry that would inform the debate on care pathway development and implementation. The following section will outline some of the mistakes encountered in carrying out this study and suggest some alternative research methods and approaches for future research.

The first intention of the research design was to attempt to test a care pathway within a quasi-experimental design for people suffering from schizophrenia. However, the difficulties of developing this type of design were apparent when the researcher attempted to apply this method to the particular context. Two of the major difficulties were identifying what exactly was being developed and secondly, organising the team to implement the care pathway. An action orientated ethnographic research method was chosen to best suit this research setting. However, the products of such an analysis have been criticised for producing subjective '*impressionistic data*' (Mobley 1997), '*trivial generalisations*' (Atkinson 1990) and '*unrealistic expectations*' (Knafl & Howard 1984). Although both ethnographic accounts (Hammersley 1992) and action research studies have as their goal to develop theory, it has not been the intention of this research study to produce conclusive explanations or extend theory. Rather to describe the process of

developing the care pathway with the care team and bring to light the issues as described by the study participants.

Collecting freely expressed perspectives from all respondents proved to be a difficult process. For some respondents, the researcher was perceived as a potential threat to their professional culture. The researcher had to adopt a progressive entry procedure by taking a neutral position to the many issues that were raised. This allowed the researcher to gradually gain insider views on the mechanics of compartmentalising the various roles and tasks of the team. Becker (1970) suggests that the researcher take a particular stand on a set of issues and for these to be explicit during the course of the research study. By doing this it clearly shows any possible motivation for carrying out the research. This would have been very difficult for the researcher because co-operation was required for the working group process and for the implementation of the care pathway. Establishing trust and confidence from participants and respondents transpired through intensive contact with the study site and close relationships with key informants.

Many have noted the need to involve all clinician groups in the development of the care pathway (Dykes 1997b). However, findings from this study suggest that not all clinicians were willing to engage with the development of a care pathway and compliance with implementing the care pathway was low. This spanned across all professional groups studied and it was difficult for the participants to accept that it was a research study centred on the use and

development of care pathways. This could be due to the perceived threat of a care pathway in controlling work processes. Alternatively, professions may have perceived a care pathway to break down tasks into a routine that could be performed by other professional groups. The researcher was reliant on a few research confederates who were able to persuade others to engage with the study. For example, George and Steve were fundamental to securing access to the ward staff. For other participants, such as Giles and Simon the researcher developed close friendships and so gained more involvement than would be expected. For example, the researcher would engage with normal social discourse and then weave in issues relating to the study. Opinions would then be noted down at the end of the working day.

The findings of this research approach corroborate some of the characteristics of action research. Namely, the process of action research changes in response too organisational and professional pressure (Hart & Bond 1996) and the products of action research being determined by all parties. The researcher intended to use an empowering strategy, but resorted to a top-down researcher led project management style. The project raised the collective consciousness of the workings of psychiatric professionals and so in many ways fitted the enhancement approach to action research (Holter & Schwartz-Barcott 1993). Various questions were raised such as '*what interventions do you use, at what time and under what conditions for people with schizophrenia*' or '*in what ways do you interact with other professional groups*'. It could be argued that a far greater understanding of the role of

psychiatric staff has been achieved. However, the research study has not sought to generate or test theory, rather to advance and explicate a series of views regarding psychiatric care pathways. In many ways, this research study used an eclectic approach to action research using whatever tools were appropriate at the time to carry out the study. For example, the researcher approached the site with a defined problem (technical approach) but then worked on a series of tasks to empower the study participants (enhancement approach). This ultimately led to a perceived clash of interest and may have fuelled disengagement and lack of interest with the research process.

Although the researcher appreciated the complexities and configurations of organisational culture (Meek 1988, Handy 1993) and change process management (Lewin 1958), it was unsurprising that the implementation process, *'ground to a halt'*. For example, Zac identified that the research process was *'on the shoulders of one person'*. The nature of a care pathway introduces change to the culture of the organisation and so the process of change should have been targeted at different levels. Moss Kanter *et al.* (1992) identifies that change can be targeted at both an individual level and more globally, through the structure of the organisation. Further, the researcher under-estimated the impact of examining professional roles given the local political difficulties within the Trust. The researcher could have used the Innovation Readiness Scale (Snyder-Halpern 1998) to determine the ability of the organisation to partake in and support the study. On the part of the researcher, there was little appreciation of how far the impact of care

pathways would reveal the sensitivities held by professional groups towards this innovation. However, the problems of implementation were also due to the instability of the change environment, to the nature of care pathways and the poorly directed change process. The sudden change of staff at the start of the project was so unexpected and dramatic on the success of developing the care pathway that it ultimately led to the implementation phase of the care pathway project being discontinued.

The study could have been improved if the researcher had developed the care pathway away from the study site. A research process could then collect views on the care pathway but also track professional themes in its development. Possibly the researcher would not have experienced the poor level of engagement particularly at the implementation stage of the study. In retrospect the working group process was not sufficiently helpful to develop the care pathway and more often led to professional degradation and confusion when describing roles and interventions. A working group may be more effective when staff groups are stable and feel motivated to engage with a project described in this study.

The researcher was known by many of the hospital management and clinical staff and spending time on the ward at the start of the study proved to be successful in paving the way to the larger study. Although the researcher collected only initial impressions, it served to desensitise the staff to the involvement of the researcher. Working group meetings were established and

the researcher became active in the facilitation parts of developing the care pathway. At times the researcher challenged some of the perceptions of psychiatric care within the working groups and this gave rise to the criticism that the researcher was taking a biased view. On one occasion, Simon accused the researcher of taking an anti-psychologist view in representing the account in the working group minutes. It may well be more appropriate to carry out action research studies with staff cultures that are unknown to the researcher, although this would compromise some of the benefits of qualitative interviewing such as close proximity to the study issues (King 1994). Other difficulties occurred when the researcher was over eager to collect information about people's impressions of care pathways and the necessity to gain taped interviews. It became apparent that 'endurance' and 'negotiation' was essential in this particular study context.

It has often been noted that researchers have all to gain from carrying out research at the expense of the people who give their time to answering questions and being studied (Fryer & Feather 1994). To some extent this is true of this research study. The researcher carried out the study and left the organisation with little contact with the respondents who he had built firm relationships with. Although the researcher expressed warm thanks to the participants there was a feeling that people had been assembled for the explicit purpose of studying them during this social experiment. However, the organisation as a whole gained a great deal from the study. A different conception of psychiatric care was developed which empowered the

workforce to question present service provision. Punch (1986) would argue that a process of emancipation far outweighs the disadvantages to potentially unwilling or exploited participants. It led to members of the hospital staff successfully bidding for further research funding to carry out additional research into care pathways and provided the facilitator of the newly funded project with 'hands-on' knowledge on how to develop and implement care pathways. Johnson (1992) argues that researchers should actively disseminate findings in order to justify the research process. The researcher had done this both before (Jones 1995) and following the study (Jones 1999).

During the working group process, the researcher would spend time observing and listening to conversations and noting down issues that appeared relevant to the study objectives. Although the working group meetings occurred at set times, there was little structure to the development of the care pathway. Decisions about implementing the care pathway occurred spontaneously. This made being a systematic participant observer difficult and the researcher had to capitalise on unexpected incidents and issues in the field. Archbold (1986) prompts the researcher to accept these ambiguities and for preliminary analysis to re-focus the research process further. This led to an iterative process to occur between data collection and analysis.

Much criticism has been directed on the role of the researcher and the part they play in influencing respondent's views (Paterson 1994). This criticism

implies that respondents play a passive role in this exercise when experiences from this study found some respondents to be confrontational with the researcher. Respondents would often contest various issues relating to their role and function. These were usually prompted by naive questions from the researcher or were a reactive response to the occasional but unintentional brusque manner by which the researcher attempted to gain access to the various departments in the hospital, and the community team.

The researcher was enabled to carry out the study by the general manager of the Trust although this created a set of problems for the researcher to develop trust with the respondents and participants. Many of the staff in the hospital and community team knew the researcher at both a professional and friendship level. However, respondents also identified the study as being supported by the management of the Trust and felt uneasy about divulging information that could, conceivably, be used against them by the researcher. One suggestion would be for the researcher to '*guarantee subject confidentiality*' (Archbold 1986: 158) but this was problematic given the difficulties in developing the care pathway. In the field notes, the researcher recorded many discussions with the hospital manager detailing various individuals who were obstructing the care pathway project. As this study has demonstrated, this was necessary to ensure that the care pathway project was completed. The researcher experienced disappointment however when the care pathway project had to be prematurely discontinued due to the eventual lack of engagement and the possible negative effect on patient

outcomes. For example large parts of the care process were left unaccounted for thus placing both the service and the patient at risk. This was an unexpected occurrence and demonstrated some of the pitfalls in carrying out this type of study, which is so dependent on engagement from staff. The sense of disappointment also helped the researcher to see more clearly the dual role of both being a researcher and a project manager. This was a source of stress for the researcher because he was working to two sets of objectives.

Given that care pathway development and multi-professional care is under-researched, this led to the researcher asking questions that on reflection were naive and uninformative. For example the researcher spent time asking respondents about the characteristics of usual care. The findings do not represent the vision of more elaborate questions such as how professionals negotiate care pathways for their own professional protection. This possibly illustrates the lack of focus on the part of the researcher when he entered the research setting. Future research enquiry may be more structured in learning how specific occupational groups respond to the introduction of a care pathway. This may deliver service benefits for organisations when attempting to implement a care pathway.

However, the study did collect data on the more obvious possibilities of care pathways such as the effect of standardised care and an enhanced managerial perspective on care. Hammersley (1992: 70) identified '*sufficiency*

of evidence’to determine credibility and centrality of major research themes. This research study has demonstrated both the occurrence and diversity of the individualised-standardised care continuum, and for this to be significant for the potential acceptance of care pathways within psychiatry. This finding, although unsurprising, is extremely relevant given the moves to standardised care provision.

Qualitative research has the potential to amass considerable amounts of social data and selecting the information to include in the final analysis was determined by both pragmatic and ethical considerations. The researcher developed strong relationships with key personnel in the hospital management structure and some of the confidential information disclosed could not be included in the final analysis. There was also the difficulty in estimating whether sufficient information had been collected and if this would be detailed adequately to form interesting themes for discussion. This resulted in the researcher possibly carrying out too many interviews and logging conversations and observations beyond the needs of the research study.

The process of developing and implementing the care pathway was through an action orientated research process and the working group meetings could have been presented as singular case studies or key events. Describing the issues that were addressed in the working groups may have provided a clearer view of how and why the care pathway was developed in this

particular way. Robson (1995) suggests that key events can illuminate the context of ethnographic research. However, it was important to connect the themes through the whole of the data set and provide interrelationships between inter and intra professional relations across the study site. Moreover, a considerable amount of data collection occurred outside of the working group meetings and this added clarity to the developed themes.

The presentation of ethnographic accounts is often criticised for the tendency to omit detailed contextual information concerning the environment (Garfinkel 1967) and method (Sandelowski 1986) in which issues were collected and how themes are linked to one another (Keddy *et al.* 1996). However, unlike grounded theory, this account has attempted to demonstrate links to the wider socio-political environment. Collecting this type of information has resulted in data being sought through numerous sources. Respondents may not always have been aware that they were divulging information, although they were all informed that a research study was taking place. For example the researcher would listen to conversations in the ward office or community team about the tensions of integrated working. On other occasions, the researcher would collect information from social gatherings where health professionals would discuss cases and psychiatric care. There has been some attempt to distinguish between overt and covert data collection strategies and how this information has contributed towards the themes. The overall attempt however is to present an account of the issues and processes that the researcher and participants experienced during the time of the study.

Other research approaches

There is a paucity of research into the development of care pathways within psychiatry. It is often assumed in the literature that care pathways are just 'produced' with consultation from clinicians. This study has explored one method of developing the care pathway and indicates the potential for different research methods and approaches. Moreover, the research approach described in this study started from a position of limited knowledge on how to implement a care pathway within mental health services and more informative lines of enquiry could be usefully followed.

The care pathway could have been developed in isolation from the study ward and subsequently imposed on the staff groups. By applying Lipsky's (1980) '*street level bureaucracy*', the researcher could explore how staff groups re-order the components of the care pathway to suit their own needs within the organisation. Alternatively, the care pathway could have been developed through a Delphi style study. The Delphi technique aims to gain consensus around a set of issues through an iterative process (Linstone & Turoff 1975). This approach could be adapted to show incremental changes across the professional groups or whether different professional groups develop and agree the outcomes of care pathway in similar ways. For example, many respondents in the study commented on the possible advantages of creating the care pathway within the confines of their own professional group.

Whilst the study has detailed the various issues, there has been no attempt to quantify these views across the professional groups. The issues could be assembled into a Likert scale to assess clinician or manager's perceptions of the change to care pathways. Applying this type of research method may provide knowledge on the 'readiness' of certain hospital and community Trusts to adopt the use of care pathways. For organisations wishing to apply care pathways, the use of this research method may enable change protagonists to target those areas most susceptible to change.

The research study could have used expert panels or focus groups to develop the care pathway as opposed to the clinicians on the ward and community team. Alternatively, a purchased 'of-the shelf' care pathway (Andolina 1995) could be customised to match UK health care policy and practice. This may have produced a more informed care pathway but one which was unacceptable to the staff group. Comparing the two care pathways developed in different ways may provide knowledge on how best to implement them in practice.

A research approach that ascertained the views of service users in both developing and being cared for and treated with a care pathway would extend the knowledge base for service user involvement in the UK. Although only seven clients were admitted onto the care pathway, the study findings would have benefited from a more informed view on the service users' perceptions of the positive and negative effects of care pathways. Some studies have

found that patients record a greater level of care satisfaction if they know the expected hospital treatment plan (Courtney *et al.* 1997, Weiland 1997).

However this study added little to the knowledge on how in-patients with schizophrenia will progress along a care pathway, if outcomes will be achievable, or if community resources such as suitable supported housing could be effectively mobilised. Future implementation studies may be interested in identifying the 'hidden costs' of care (e.g. awaiting housing) when patients remain in hospital beyond clinical need.

Given the difficulties in establishing trusting relationships with certain respondents, more informed and less constrained views may have been gained from the use of a respondent diary. The diary technique has been used extensively in health research (Verbrugge 1980, Hickey *et al.* 1991) and could be used to chart the developmental problems as a concurrent activity in the working group process. Intensive interviewing used within this study produced retrospective accounts of care pathway development, often collected weeks and months from the actual experience. The diary method may reverse bias inherent in the researcher-respondent relationship and in the recollection of events. Ross *et al.* (1994) suggests that respondents record events that are typical of the observed effects. Alternatively, respondents could be encouraged to record a diversity of cases to illustrate the extremes of care pathway development and implementation.

The majority of studies have employed quasi-experimental designs exerting varying degrees of control over the sampling procedure, Independent variable and use of statistical tests of significance (Cook 1998). Campbell *et al.* (1998) suggests a publication bias towards those studies that report positive results for care pathways. Future research studies need to employ a randomised controlled trial (RCT) to test the effects of a care pathway. Health technology assessment champions the RCT to evaluate the effectiveness of new treatment methods (Stein & Milne 1998). However, the problems of conducting a RCT may be difficult to reverse due to the practical problems of control group contamination and randomisation of staff / patients to deliver the experimental effect. For example many wards are situated within close proximity to one another and to a certain extent, staff work across different wards. Comparing the effect of a care pathway on wards located in different hospitals would be compromised by differences in ward culture.

Recommendations

In this section the researcher will briefly examine some recommendations for the commissioning of services, practice and future research. It is important to reflect that a great deal of political change has occurred from beginning this study to the end and so in some ways the future for care pathways and their application has been laid out. Care pathways for example have been identified as one of the strands in the commissioning and delivering services within the reformed NHS (Department of Health 2002a).

Commissioning agencies

The abolition of Health Authority structures and a devolved commissioning service to a Primary Care Trust (PCT) herald a significant shift in front line care delivery and control. A PCT will be able to provide services within the primary care area but also link up the secondary care services through a care pathway. Likewise a PCT will commission and 'performance manage' secondary care services to ensure targets are met. A care pathway has been identified as a vehicle to carry out this function.

A commissioning agency could also use a care pathway to shape education and training for specific types of disorders or services. This type of training may sit outside the traditional make up of professional groups. The delivery of care may focus more on the interventions that are used as opposed to the profession that is traditionally commissioned to provide it. A care pathway may help to reshape this agenda.

Managers of care

Respondents identified a care pathway as a tool to check on the delivery of interventions and whether progress was being made to reach agreed upon outcomes. Although this was not particularly recognised as a positive feature for their application in psychiatric care by clinicians, a care pathway would have wider managerial relevance. Recent legislation has called for greater controls over the way hospitals manage the care episode (Department of Health 2000). Hospital services will need to demonstrate that they have tools

to manage variations that occur within diagnostic groups. Local service managers will therefore have a greater ability to spot and rectify variations and so ensure costs and quality of care are met. Although the number of managers interviewed for this study was very small, a care pathway would offer a manager of services many worthwhile benefits such as controlling the workforce to deliver health and social care outcomes.

A care pathway may enable a manager to redesign service delivery to meet pre-set outcomes of care. In this study respondents were able to demonstrate that large parts of the care process could be broken down and reassembled within a care pathway structure. Although respondents offered both negative and positive opinions on this process, it does offer a different mechanism to manage service delivery.

Future research

Future research should build on the qualitative understanding of how a care pathway can be developed and the different options for this. For example the researcher could develop a care pathway and then present to psychiatric professions with a view to collecting data on changing the care pathway. A research process would possibly be more informed by having a clear research question such as how and in what ways professions change the care pathway to fit their practice requirements. Alternatively a research study could begin to explore the patients experience of following a care pathway.

A research study would need to be mindful of the environment in which the care pathway was going to be implemented. The researcher may wish to examine how different professions in a more quantified dimension experienced a care pathway being put into practice and examining any variations. For example, it may be found that it is only when nurse vacancies become unstable does the implementation of a care pathway become problematic.

It is important for future research to be cognisant of the complexities of change management. On reflection, this researcher was naïve in his awareness of managing the change process within the project and so much more could be explored in future studies. For example, future research could look at different styles of implementation such as care pathways implemented by clinicians to those implemented by management staff. Data could then be collected on the outcomes of implementation such as compliance in the staff groups in using the care pathway and comparing this to the success in meeting the outcomes for patients.

Psychiatric professionals

Respondents in this study did experience a sense of greater understanding over what they did but also an enhanced view of the role of others within the team. This would have clear benefits for themselves and the patients they serve. It would help them also to seek out the evidence to support their ways of working and generally respondents were positive about accepting this

responsibility. Respondents spoke highly of what they did and a care pathway could be used to teach them although not at the expense of diminishing the individualised conceptions of care. Much more needs to be done to demystify the nature of care pathways if they are to be accepted by clinicians.

Conclusion

This study has been able to demonstrate many difficulties in developing and implementing care pathways and indicates their introduction to psychiatric care is premature. In many respects there is a lack of knowledge to support the full spectrum of psychiatric care and treatment. A care pathway also leads to conflict and tension within the MDT. The observations and interviews collected from the respondents are unique to the study context, but their relevance to the business of psychiatry is profound. Respondents were involved in an exercise that departed from traditional care practices and so challenged their conceptions of care and treatment. The use of a standardised protocol conflicted with the way clinicians have been taught to provide individualised patient care.

Government commitment towards clinical protocols, investment in information technology and a modernisation of mental health services has added stimulus to finding new ways to deliver quality mental health care. The relevance of care pathways for practice shares many of the aspirations of the Government legislation such as the search for quality, equity of services across the UK and a curtailment of variable practice. Respondents were able to identify how a

care pathway made MDT working more cohesive and the management of care more accountable although psychiatric care was not changed. As some of the findings illustrate, respondents have been guided to these views by the managerial agenda pursued over the last two decades.

This discussion has pulled together the main problems and barriers encountered in constructing a care pathway for the in-patient treatment of schizophrenia. The main obstacles encountered in this study reflected those described in the literature: professional resistance to exposing practice; concerns about the mechanistic nature of the care pathway and its threat to individualised care; inter-professional rivalry and defensiveness over roles and functions; above all, absence of information on interventions and outcomes to inform the pathway components. A number of recommendations for practice, managers and research have also been made by drawing on some of the research findings but also the wider political context within the reformed NHS.

A critical synopsis has been provided on the research methods used and approach taken within this study. Limitations of the study highlighted a number of different techniques that could be employed for future research. It has been the general argument that care pathway development and implementation research should be carried out using ethnographic principles within an action research process. In the light of expected and unexpected events occurring within the study, a research strategy that was adaptable to a changeable set of circumstances was important. The use of qualitative

methods has been useful given the absence of qualitative studies exploring the contextual changes for psychiatric care pathways within NHS Trusts. It is suggested that the approaches used within this study could inform future studies in care pathway research.

References

- Abdullah, S.N. (1995) Towards an individualized client's care: Implication for education. The transcultural approach. *Journal of Advanced Nursing* 22: 715-720.
- Abreu, B.C., Seale, G., Podlesak, J. & Hartley, L. (1996) Development of critical paths for post-acute brain injury rehabilitation. *American Journal of Occupational Therapy* 50: 417-427.
- Aidroos, N. (1991) Use and effectiveness of psychiatric nursing care plans. *Journal of Advanced Nursing* 16: 177-181.
- Allen, D.G. (1985) Nursing research and social control: alternative models of science that emphasise understanding and emancipation. *Image: The Journal of Nursing Scholarship* XVIII: 58-64.
- Alty, A. & Rodham, K. (1998) The ouch! factor: problems in conducting sensitive research. *Qualitative Health Research* 8(2): 275-282.
- American Psychiatric Association (1997) Practice guidelines for the treatment of patients with schizophrenia. *American Journal of Psychiatry* 154: 1-63.
- Anders, R.L., Tomai, J.S., Clute, R.M., Olson, T. (1997) Development of a scientifically valid coordinated care path. *Journal of Nursing Administration* 27(5): 45-52.
- Andolina, K. (1995) *Mental Health Critical Path / CareMap Tools and Case Management Systems*. South Natick, The Center for Case Management.
- Andrews, G. & Teeson, M. (1994) Smart versus dumb treatment: services for mental disorders. *Current Opinion in Psychiatry* 7: 181-185.

- Andreason, N.C. (1991) Assessment issues and the cost of schizophrenia. *Schizophrenia Bulletin* 17: 475-481.
- Anthony, P. & Crawford, P. (2000) Service user involvement in care planning: the mental health nurse's perspective. *Journal of Psychiatric & Mental Health Nursing* 7: 425-434.
- Altschul, A.T. (1972) *Patient / Nurse Interaction: A Study of Interaction Patterns in Acute Psychiatric Wards*. London: Churchill Livingstone.
- Archbold, P. (1986) 'Ethical issues in qualitative research'. In: W.C. Chenitz & J.M. Swanson eds. *From Practice to Grounded Theory*. California: Addison Wesley Publishing.
- Ardvern, P. (1999) Safeguarding care gains: a grounded theory study of organisational change. *Journal of Advanced Nursing* 29(6): 1370-1376.
- Arkell, S. (1997) Managed care: the benefits and implications for clinical practice. *British Journal of Nursing* 6(4): 230-233.
- Aronson, B. & Maljanian, R. (1996) Critical path education: necessary components and effective strategies. *Journal Continuing Education Nursing* 27(5): 215-9.
- Atkinson, P. (1990) *Ethnographic Imagination: Textual Constructions of Reality*. London: Routledge.
- Atkinson, P. (1992) The ethnography of a medical setting: reading, writing, and rhetoric. *Qualitative Health Research* 2(4): 451-474.
- Audit Commission (1997) *Finders, Keepers. The Management of Staff Turnover in NHS Trusts*. London: HMSO.

- Austin, N. & Dopson, S. (1997) 'Introduction'. In: N. Austin & S. Dopson eds. *The Clinical Directorate*. Oxon: Radcliffe Medical Press.
- Baker, M.R. (1998) 'Challenging ignorance'. In: M. Baker & S. Kirk eds. *Research and Development for the NHS*. Oxon: Radcliffe Medical Press.
- Baker, A. & Perkins, D.A. (1995) 'Managing people and teams'. In: J.J. Glynn & D.A. Perkins eds. *Managing Health Care*. London: W.B. Saunders Company.
- Baldry, J.A. & Deborah, R. (1995) Introduction of integrated care pathways to a neuro-rehabilitation unit. *Physiotherapy* 81: 432-434.
- Banister, P., Burman, E., Parker, I., Taylor, M., Tindall, C. (1995) *Qualitative Methods in Psychology. A Research Guide*. Philadelphia: Open University Press.
- Barker, P. (1989) Reflections on the philosophy of caring in mental health. *International Journal of Nursing Studies* 26(2): 131-141.
- Barker, P.J., Reynolds, W., Stevenson, C. (1997) The human basis of psychiatric nursing: theory and practice. *Journal of Advanced Nursing* 25: 660-667.
- Barker, P.J., Keady, J., Croom, S., Stevenson, C., Adams, T. & Reynolds, W. (1998) The concept of serious mental illness: modern myths and grim realities. *Journal of Psychiatric & Mental Health Nursing* 5: 247-254.
- Barker, P. (2000) Reflections on caring as a virtue ethic within an evidence-based culture. *International Journal of Nursing Studies* 37: 329-336.
- Barker, P.J. & Walker, L. (2000) Nurses' perceptions of multidisciplinary teamwork in acute psychiatric settings. *Journal of Psychiatric & Mental Health Nursing* 7: 539-546.

- Barnes, T.R.E., McEvedy, C.J.B. & Nelson, H.E. (1996) Management of treatment resistant schizophrenia unresponsive to clozapine. *British Journal of Psychiatry* 169 (suppl. 31): 31-40.
- Barnette, J.E. & Clendenen, F. (1996) Making the transition to critical pathways - a community behavioural health centre's approach. *Best Practices and Benchmarking in Healthcare* 1(3): 147-56.
- Beattie, A. (1995) 'War and peace amongst the health tribes'. In: K. Soothill, L. Mackay & C. Webb eds. *Interprofessional Relations in Health Care*. London: Edward Arnold.
- Bebbington, P.E. (1995) The content and context of compliance. *International Clinical Psychopharmacology* 9 (suppl. 5): 41-50.
- Becker, H.S. (1970) 'Whose side are we on?' In: W.J. Filstead ed. *Qualitative Methodology*. Chicago: Markham Publishing.
- Benner, P. (1984) *From Novice to Expert*. Addison-Wesley, California.
- Benton, D. (1995) The role of managed care in overcoming fragmentation. *Nursing Times* 91(29): 25-28.
- Berry, A.J. & Metcalf, C.L. (1986) Paradigms and practices: the organization of the delivery of nursing care. *Journal of Advanced Nursing* 11: 589-597.
- Betemps, E.J. & Ragiell, C. (1994) Psychiatric epidemiology: facts and myths on mental health and illness. *Journal of Psychosocial Nursing* 32(5): 23-28
- Biller, A.M. (1992) Implementing nursing case management. *Rehabilitation Nursing* 17(3): 144-146.

- Bindman, J., Beck, A., Glover, G., Thornicroft, G., Knapp, M., Leese, M., Szmukler, G. (1999) Evaluating mental health policy in England. *British Journal of Psychiatry* 175: 327-330.
- Birchwood, M.J., Hallett, S.E. & Preston, M.C. (1989) *Schizophrenia. An Integrated Approach to Research & Treatment*. London: Longman Group.
- Birchwood, M. (1999) Psychological and social treatments: course and outcome. *Current Opinion in Psychiatry* 12: 61-66.
- Black, F. (1992) *Primary Nursing. An Introductory Guide*. London: King's Fund Centre.
- Bland, R.C., Parker, J.H., Orn, H. (1976) Prognosis in schizophrenia. A ten year follow up of first admissions. *Archives General Psychiatry* 33: 949-954.
- Bond, S., Balogh, R., McKeever, M. (2001) Care pathways: an integrated clinical record or management information tool. *Journal of Integrated Care Pathways* 5: 54-63.
- Boulton, D. & Hammersley, M. (1996) 'Analysis of unstructured data'. In R. Sapsford & V. Jupp eds. *Data Collection and Analysis*. London: Sage.
- Bowers, J. (1996) 'Hanging around and making something of it: Ethnography'. In: J. Haworth ed. *Psychological Research. Innovative Methods and Strategies*. London: Routledge.
- Boyle, M. (1990) *Schizophrenia - A Scientific Delusion*. London: Routledge.
- Bracken, P. & Thomas, P. (1998) A new debate in mental health. *Openmind* 89: 5-6.

- Bradshaw, P.L. (1995) The recent health reforms in the United Kingdom: some tentative observations on their impact on nurses and nursing in hospitals. *Journal of Advanced Nursing* 21: 975-979.
- Brandon, D. (1991) 'User power'. In: P.J. Barker & S. Baldwin eds. *Ethical Issues in Mental Illness*. London: Chapman & Hall.
- Bray, J. (1999) An ethnographic study of psychiatric nursing. *Journal of Psychiatric & Mental Health Nursing* 6: 297-305.
- Brenner, H.D., Dencker, S.J., Goldstein, M. (1990) Defining treatment refractoriness in schizophrenia. *Schizophrenia Bulletin* 16: 551-561.
- Brooking, J.I. & Ritter, S.A.H. (1992) 'Schizophrenia'. In: J.I. Brooking, S.A.H Ritter, B.L. Thomas eds. *A Textbook of Psychiatric and Mental Health Nursing*. Edinburgh: Churchill Livingstone.
- Brooks, I. (1996) Using rituals to reduce barriers between sub-cultures. *Journal of Management in Medicine* 10(3): 23-30.
- Broome, A. (1980) *Managing Change*. London: MacMillan.
- Bryman, A. (1989) *Research Methods and Organisational Studies*. London: Unwin Hyman.
- Buchanan, D. & Huczynski, A. (1990) *Organisational Behaviour: An Introductory Text*. Englewood: Prentice Hall.
- Buckingham, C.D. & Adams, A. (2000) Classifying clinical decision making: a unifying approach. *Journal of Advanced Nursing* 32(4): 981-989.
- Bumgarner, S.D. & Evans, M.L. (1999) Clinical care map for the ambulatory laparoscopic cholecystectomy patient. *Journal of PeriAnesthesia Nursing* 14(1): 12-16.

- Burgess, R.G. (1991) 'Approaches to field research'. In: R.G. Burgess ed. *Field Research: A Sourcebook and Field Manual*. London: Routledge.
- Burgess, R.G. (1984) *In the Field*. London: Allen & Unwin.
- Burns, T., Beadsmore, A., Bhat, A.V., Oliver, A. & Mathers, C. (1993) A controlled trial of home-based acute psychiatric services 1: clinical and social outcome. *British Journal of Psychiatry* 163: 49-54.
- Burns, T. & Priebe, S. (1999) Mental health care failure in England. *British Journal of Psychiatry* 174: 191-192.
- Butler, T. (1993) *Changing Mental Health Services*. London: Chapman & Hall.
- Butterworth, T. (1994) Working in partnership: a collaborative approach to care. The review of mental health nursing. *Journal of Psychiatric and Mental Health Nursing* 1: 41-44.
- Byne, T. & Padfield, C.F. (1990) *Social Services*. Oxford: Butterworth-Heinemann.
- Caldock, K. (1993) The community care White Paper: a nursing perspective. *British Journal of Nursing* 2(11): 592-597.
- Campbell, H., Hotchkiss, R., Bradshaw, N. & Porteous, M. (1998) Integrated care pathways. *British Medical Journal* 316: 133-137.
- Cardno, A.G. & McGuffin, P. (1996) Aetiological theories of schizophrenia. *Current Opinion in Psychiatry* 9: 45-49.
- Carey, S. & Hall, D.J. (1999) Psychiatrists views of evidence-based psychiatric practice. *Psychiatric Bulletin* 23: 159-161.

- Carpenter, W.T., Heinrichs, D.W., Wagman, A.M.I. (1988) Deficit and non-deficit forms of schizophrenia: the concept. *American Journal of Psychiatry* 145: 578-583.
- Carr, W. (1986) Theories of theory and practice. *Journal of Philosophical of Education* 20(20): 177-186.
- Carr, W. & Kemmis, S. (1986) *Becoming Critical: Education, Knowledge and Action Research*. London: Falmer Press.
- Cassell, C. & Symon, G. (1994) 'Qualitative research in work contexts'. In: C. Cassell & G. Symon eds. *Qualitative Methods in Organisational Research*. London: Sage.
- Chadwick, P. & Lowe, C.F. (1990) The measurement and modification of delusional beliefs. *Journal of Consulting and Clinical Psychology* 58: 225-232.
- Chan, P.A. & Rudman, M.J. (1998) Paradigms for mental health nursing: fragmentation or integration. *Journal of Psychiatric & Mental Health Nursing* 5: 143-146.
- Chan, S.W. & Wong, K.F. (1999) The use of critical pathways in caring for schizophrenic patients in a mental hospital. *Archives Psychiatric Nursing* 13(3): 145-153.
- Chang, P.L., Huang, S.T., Hsieh, M.L., Wang, T.M., Chen, J.I. Kuo, H.H., Chuang, Y.C., Chang, C.H. (1997) Use of the transurethral prostatectomy clinical path to monitor health outcomes. *Journal of Urology* 157(1): 177-183.
- Chavasse, J. (1981) From task assignment to patient allocation: a change evaluation. *Journal of Advanced Nursing* 6: 137-145.

- Cheah, J. (1998) Clinical pathways: changing the face of patient care delivery in the next millennium. *Clinician in Management* 7: 78-84.
- Chenitz, W.C. (1986) 'The informal interview'. In: W.C. Chenitz & J.M. Swanson eds. *From Practice to Grounded Theory*. California: Addison-Wesley Publishing.
- Chinn, P.L. & Kramer, M.K. (1991) *Theory and Nursing - A Systematic Approach*. St. Louis: Mosby.
- Chua, S.E., Wright, I.C., Poline, J-B., Liddle, P.F., Murray, R.M., Frackowiak, R.S.J., Friston, K.J. & McGuire, P.K. (1997) Grey matter correlates of syndromes in schizophrenia. *British Journal of Psychiatry* 170: 406-410.
- Clare, L. & Singh, K. (1994) Preventing relapse in psychotic illness: a psychological approach to early intervention. *Journal of Mental Health* 3: 541-550.
- Clark, C.M., Steinbinder, A., Anderson, R. (1994) Implementing clinical paths in a managed care environment. *Nursing Economics* 12(4): 230-234.
- Clarke, L. (1991) 'Ideological themes in mental health nursing'. In: P.J. Barker & S. Baldwin eds. *Ethical Issues in Mental Health*. London: Chapman & Hall.
- Clifford, P. & Craig, T. (1989) *Case Management Systems for the Long Term Mentally Ill*. London: National Unit for Psychiatric Research and Development.
- Closs, S.J. & Cheater, F.M. (1999) Evidence for nursing practice: a clarification of the issues. *Journal of Advanced Nursing* 30(1): 10-17.
- Coffey, R.J., Richards, J.S. & Remmert, C.S. (1992) An introduction to critical paths. *Quality Management in Health Care* 1: 45-54.

- Coffey, A. & Atkinson, P. (1996) *Making Sense of Qualitative Data. Complementary Research Strategies*. London: Sage Publications.
- Cohen, E.L. (1991) Nursing case management. Does it pay? *Journal of Nursing Administration* 21(4): 20-25.
- Cohen, E.L. & Cesta, T.G. (1993) *Nursing Case Management: From Concept to Evaluation*. St. Louis: Mosby.
- Cohen, J., Stock, M., Andersen, P., Everts, E. (1997) Critical pathways for head and neck surgery. Development and implementation. *Archives Otolaryngol Head Neck Surgery* 123: 11-14.
- Cook, T.H. (1998) The effectiveness of inpatient case management. *Journal of Nursing Administration* 28(4): 36-46.
- Cooke, H. (1993) Boundary work in the nursing curriculum: a case of sociology. *Journal of Advanced Nursing* 18: 1990-1998.
- Conant, L.H. (1967) Closing the theory-practice gap. *Nursing Outlook* 15(11): 37-39.
- Conley, R.R. & Buchanan, R.W. (1997) Evaluation of treatment-resistant schizophrenia. *Schizophrenia Bulletin* 23: 663-674.
- Conley, R.R., Tamminga, C.A., Bartko, J.J., Richardson, C., Peszke, M., Lingle, J., Hegerty, J., Love, R., Gounaris, C., Zaremba, S. (1998) Olanzapine compared with chlorpromazine in treatment-resistant schizophrenia. *American Journal of Psychiatry* 155(7): 914-920.
- Couchman, W. (1995) Joint education for mental health teams. *Nursing Standard* 10(7): 32-34.

- Courtney, L., Gordon, M. & Romer, L. (1997) A clinical path for adult diabetes. *Diabetes Education* 23(6): 664-671.
- Cormack, D. (1976) *Psychiatric Nursing Observed*. London: RCN Publication.
- Cotton, P. & Sullivan, F. (1999) Perceptions of guidelines in primary and secondary care: implications for implementation. *Journal of Integrated Care* 3(2): 79-83.
- Cowman, S. (1993) Triangulation: a means of reconciliation in nursing research. *Journal of Advanced Nursing* 18: 788-792.
- Cox, D. (1991) 'Health service management – a sociological view: Griffiths and the non-negotiated order of the hospital'. In: J. Gabe, M. Calnan, M. Bury eds. *The Sociology of the Health Service*. London: Routledge.
- Creed, F., Mbaya, P., Lancashire, S., Tomensom, B., Williams, B., Holme, S. (1997a) Cost effectiveness of day and inpatient psychiatric treatment: results of a randomised controlled trial. *British Medical Journal* 314(7091): 1381-1387.
- Creed, F., Tomenson, B., Anthony, P. & Tramner, M. (1997b) Predicting length of stay in psychiatry. *Psychological Medicine* 27: 961-966.
- Creek, J. (1998) *Occupational Therapy: New Perspectives*. London: Whurr.
- Crook, J.A. (2001) How do expert mental health nurses make on-the-spot clinical decisions? A review of the literature. *Journal of Psychiatric and Mental Health Nursing* 8: 1-5.
- Crosby, R.L. (1987) Community care of the chronically mentally ill. *Journal of Psychosocial Nursing* 25(1): 33-37.

Crummer, M.B. & Carter, V. (1993) Critical pathways - the pivotal tool. *Journal of Cardiovascular Nursing* 7: 30-37.

Currie, L. & Harvey, G. (1998) Care pathways development and implementation. *Nursing standard* 12(30): 35-38.

Currie, L. (1999) Researching care pathway development in the United Kingdom: stage 1. *NT Research* 4(5): 378-384.

Cutcliffe, J.R. (1997) The nature of expert psychiatric nurse practice: a grounded theory study. *Journal of Clinical Nursing* 6: 325-332.

Davidson, L. & McGlashan, T.H. (1997) Treated outcomes in severe and enduring mental disorders. *Current Opinion in Psychiatry* 10: 183-186.

Davidge, M., Elias, S. & Jayes, B. (1993) *Survey of English Mental Illness Hospitals*. Birmingham: Health Services Management Centre.

Davies, L.M. & Drummond, M.F. (1990) The economic burden of schizophrenia. *Psychiatric Bulletin* 14: 522-525.

Davies, L.M. & Drummond, M.F. (1994) Economics and schizophrenia: the real cost. *British Journal of Psychiatry* 165 (suppl. 25): 18-21.

Davies, C. (2000) Getting health professionals to work together. *British Medical Journal* 320(7241): 1021-1022.

Davis, M.Z. (1986) 'Observation in natural settings'. In: W.C. Chenitz & J.M. Swanson eds. *From Practice to Grounded Theory*. California: Addison-Wesley Publishing.

Dawson, P.J. (1997) A reply to Kevin Gournay's 'Schizophrenia: a review of the contemporary literature and implications for mental health nursing theory,

practice and education'. *Journal of Psychiatric and Mental Health Nursing* 4: 1-7.

Dean-Barr, S. (1994) 'Nursing diagnosis: New Opportunities'. In: R.M. Carroll-Johnson & M. Paquette eds. *Classification of Nursing Diagnoses*. Philadelphia: J.B. Lippincott.

Degeling, P., Kennedy, J., Hill, M. (1998) Do professional subcultures set the limits of hospital reform? *Clinician in Management* 7: 89-98.

De La Cuesta, C. (1983) The nursing process from development to implementation. *Journal of Advanced Nursing* 8: 365-371.

De Luc, K. (2000) Care pathways: an evaluation of their effectiveness. *Journal of Advanced Nursing* 32(2): 485-496.

Delisi, L.E. (1992) The significance of age of onset for schizophrenia. *Schizophrenia Bulletin* 18: 209-215.

Dent, M. (1991) 'Autonomy and the medical profession: Medical audit and management control'. In: D. Smith, H. Knights & H. Willmott eds. *White-collar Work: The Non-manual Labour Process*. London: Macmillan.

Dent, M. (1999) Professional judgement and the role of clinical guidelines and evidence-based medicine (EBM): Netherlands, Britain and Sweden. *Journal of Interprofessional Care* 13(2): 151-164.

Department of Health (1989) *Caring for People. Community Care in the Next Decade and Beyond*. London: HMSO.

Department of Health & Social Security (1986) *Mix and Match: A Review of Nursing Skills Mix*. London: HMSO.

Department of Health (1990) *NHS & Community Care Act*. London: HMSO.

Department of Health (1991a) *Research for Health: A Research and Development Strategy for the NHS*. London: HMSO.

Department of Health (1991b) *The Patients Charter. Raising the Standard*. London: HMSO.

Department of Health (1994a) *Working in Partnership. Report of the Review of Mental Health Nursing*. London: HMSO.

Department of Health (1994b) *Better Off in the Community? The Care of People who are Seriously Mentally Ill*. London: HMSO.

Department of Health (1995a) *The Mental Health (Patients in the Community) Act*. London: HMSO.

Department of Health (1995b) *Building Partnerships for Success. Community Care Development Programmes*. London: HMSO.

Department of Health (1995c) *Building Bridges. Guide to Arrangements for Inter-agency Working for the Care and Protection of Severely Mentally Ill People*. London: HMSO.

Department of Health (1996) *Towards an Evidence-Based Health Service*. London: HMSO.

Department of Health (1997) *The New NHS. Modern, Dependable*. London: HMSO.

Department of Health (1998a) *A First Class Service. Quality in the New NHS*. London: HMSO.

Department of Health (1998b) *National Service Frameworks*. HSC(98)074, LASSL(98)6. London: HMSO.

- Department of Health (1998c) *Modernising Mental Health Services. Safe, Sound and Supportive*. London: HMSO.
- Department of Health (1999) *A National Service Framework for Mental Health*. London: HMSO.
- Department of Health (2000) *The NHS Plan*. London: HMSO.
- Department of Health (2002a) *Shifting the Balance of Power: The Next Steps*. London: HMSO.
- Department of Health (2002b) *Acute Inpatient Care Provision*. London: HMSO.
- Detre, T. & McDonald, M.C. (1997) Managed care and the future of psychiatry. *Archives General Psychiatry* 54: 201-204.
- Dey, (1993) *Qualitative Data Analysis*. London: Routledge.
- Dopson, S. & Waddington, I. (1996) Managing social change: a process-sociological approach to understanding social change within the National Health Service. *Sociology of Health & Illness* 18: 525-550.
- Drury, V., Birchwood, M., Cochrane, R. & Macmillan, F. (1996a) Cognitive therapy and recovery from acute psychosis: a controlled trial. 1. Impact on psychotic symptoms. *British Journal of Psychiatry* 169: 593-601.
- Drury, V., Birchwood, M., Cochrane, R. & Macmillan, F. (1996b) Cognitive therapy and recovery from acute psychosis: a controlled trial. 2. Impact on recovery time. *British Journal of Psychiatry* 169: 602-607.
- Duffy, M.E. (1987) Methodological triangulation: a vehicle for merging quantitative and qualitative research methods. *Image* 19(3): 130-133.

Dunn, J., Rodriguez, D., Novak, J.J. (1994) Promoting quality mental health care delivery with critical care plans. *Journal of Psychosocial Nursing and Mental Health Services* 32(7): 25-29.

Dykes, P.C. (1997a) 'An introduction to critical pathways'. In: P.C. Dykes & K. Wheeler eds. *Planning, Implementing and Evaluating Critical Pathways*. New York: Springer Publishing Company.

Dykes, P.C. (1997b) 'Designing and implementing critical pathways: an overview'. In: P.C. Dykes & K. Wheeler eds. *Planning, Implementing and Evaluating Critical Pathways*. New York: Springer Publishing Company.

Dykes, P.C. & Wheeler, K. (1999) Evidence-based practice for nurse practitioners with clinical pathways. *Clinical Excellence for Nurse Practitioner* 3(5): 291-297.

Eason, P. & Wilcockson, J. (1996) Intuition and rational decision-making in professional thinking: a false dichotomy? *Journal of Advanced Nursing* 24(4): 667-673.

Eastman, N. (1996) Inquiry into homicides by psychiatric patients: systematic audit should replace mandatory inquiries. *British Medical Journal* 313(7064): 1069-1071.

Eastman, N. (1997) The Mental Health (Patients in the Community) Act 1995. A clinical analysis. *British Journal of Psychiatry* 170: 492-496.

Eckman, T.A. & Liberman, R.P. (1990) A large scale field test of a medication management program for people with schizophrenia. *Journal of Psychosocial Rehabilitation* 13: 31-35.

- Edwards, B. (1998) 'Fifty years of the NHS'. In: K. Holdaway & H. Kogan eds. *The Healthcare Management Handbook*. London: Kogan Page Ltd.
- Edwards, J.N.T. (1999) A potential role for integrated care pathways in resource management. *Journal of Integrated Care* 3: 90-92.
- Ellis, B.W. (1997) Integrated care pathways: implications for clinical risk management. *Health Care Risk Report* 3(6): 13-15.
- Ellis, B.W. & Johnson, S. (1999) The care pathway: a tool to enhance clinical governance. *British Journal of Clinical Governance* 4(2): 61-71.
- Elston, M.A. (1991) 'The politics of professional power: Medicine in a changing health service'. In: J. Gabe, M. Calnan, M. Bury eds. *The Sociology of the Health Service*. London: Routledge.
- Erkel, E.A. (1993) The impact of case management in preventive services. *Journal of Nursing Administration* 23(1): 27-32.
- Etheredge, M.L. (1986) The maps for managed care. *Definition* 1(3): 1-3.
- Ethridge, P. & Lamb, G.S. (1989) Professional nursing case management improves quality, access and costs. *Nursing Management* 20(3): 30-35.
- Eve, R., Golton, I., Hodgkin, P., Munro, P., Musson, G. (1996) Beyond guidelines: promoting clinical changes in the real world. *Journal of Management in Medicine* 10(1): 16-25.
- Faherty, B. (1990) Case management - the latest buzzword: what it is, and what it isn't. *Caring* 9: 20-22.
- Falconer, J.A., Roth, E.J., Sutin, J.A., Strasser, D.C., Chang, R.W. (1993) The critical path method in stroke rehabilitation: lessons from an experiment in

cost containment and outcome improvement. *Quality Review Bulletin* 19: 8-16.

Farley, K. (1995) The COPD critical pathway: a case study in progress. *Quality Management in Health Care* 3: 43-54.

Farrington, A. (1997) Strategies for reducing burnout in nursing. *British Journal of Nursing* 6: 44-50.

Faundiller, S.H. (1991) How case management is changing the picture. *American Journal of Nursing* 91: 64-80.

Fawcett, J. (1989) *Analysis and Evaluation of Conceptual Models of Nursing*. Philadelphia: F.A. Davis Co.

Fawcett, J. (1998) Care planning: best tool for the job? *Nursing in Critical Care* 3: 89-97.

Fealy, G.M. (1997) The theory-practice relationship in nursing: an exploration of contemporary discourse. *Journal of Advanced Nursing* 25: 1061-1069.

Fealy, G.M. (1999) The theory-practice relationship in nursing: the practitioners' perspective. *Journal of Advanced Nursing* 30(1): 74-82.

Fenton, W.S. (1997) Course and outcome in schizophrenia. *Current Opinion in Psychiatry* 10: 40-44.

Fetterman, D.M. (1989) *Ethnography. Step by Step*. California: Sage.

Finlay, L. (1997) *The Practice of Psychosocial Occupational Therapy*. Cheltenham: Stanley Thomas.

Firth-Cozens, J. (2001) Multidisciplinary teamwork: the good, bad, and everything in between. *Quality in Health Care* 10: 65-69.

- Flynn, R. (1992) *Structures of Control in Health Management*. London: Routledge.
- Forchuk, C. & Reynolds, W. (2001) Clients' reflections on relationships with nurses: comparisons from Canada and Scotland. *Journal of Psychiatric and Mental Health Nursing* 8: 45-51.
- Ford, R., Durcan, G., Warner, L., Hardy, P., Muijen, M. (1998) One day survey by the mental health act commission of acute adult psychiatric inpatient wards in England and Wales. *British Medical Journal* 317: 1279-1283.
- Foster, P. (1996) 'Observational research'. In: R. Sapsford & V. Jupp eds. *Data Collection and Analysis*. London: Sage.
- Fralic, M.F. (1992) The nurse case manager: focus, selection, preparation, and measurement. *Journal of Nursing Administration* 22(11): 13-14,46.
- Franz, M., Lis, S., Pluddemann, K. & Gallhofer, B. (1997) Conventional versus atypical neuroleptics: subjective quality of life in schizophrenic patients. *British Journal of Psychiatry* 170: 422-425.
- French, B. (1995) The role of outcomes in the measurement of nursing. *Nurse Researcher* 2(4): 5-13.
- Freire, P. (1972) *Pedagogy of the Oppressed* (transl. M.B. Ramos). Middlesex: Penguin.
- Fryer, D. & Feather, N.T. (1994) 'Intervention techniques'. In: C. Cassell & G. Symon eds. *Qualitative Methods in Organisational Research*. London: Sage.
- Fulop, N.J., Koffman, J., Carson, S., Robinson, A., Pashley, D., Coleman, K. (1996) Use of acute psychiatric beds: a point prevalence survey in North and South Thames regions. *Journal of Public Health Medicine* 18: 207-216.

- Funk, S.G., Champagne, M.T., Weiss, R.A., Tornquist, E.M. (1991) Barriers: the barriers to research utilisation scale. *Applied Nursing Research* 4(1): 39-45.
- Garfinkel, H. (1967) *Studies in Ethnomethodology*. Englewood: Prentice-Hall.
- Gadacz, T.R., Adkins, R.B. & O'Leary, J.P. (1997) General surgical clinical pathways: an introduction. *American Surgery* 63(1): 107-10.
- Geddes, J. & Wessely, S. (2000) Clinical standards in psychiatry. *Psychiatric Bulletin* 24: 83-84.
- Geraty, R., Hendren, R. & Flaa, C. (1992) Ethical perspectives on managed care as it relates to child and adolescent psychiatry. *Journal of American Academy Child Adolescent Psychiatry* 31: 398-402.
- Gerrish, K. (2000) Individualized care: its conceptualization and practice within a multiethnic society. *Journal of Advanced Nursing* 32(1): 91-99.
- Gibbs, I., McCaughan, D. & Griffiths, M. (1991) Skill mix in nursing: a selective review of the literature. *Journal of Advanced Nursing* 16: 242-249.
- Gibjels, H. (1995) Mental health nursing skills in an acute admission environment: perceptions of mental health nurses and other mental health professionals. *Journal of Advanced Nursing* 21: 460-465.
- Gibbs, B., Lonowski, L., Meyer, P.J., Newlin, P.J. (1995) The role of the clinical nurse specialist and the nurse manager in case management. *Journal of Nursing Administration* 25(5): 28-34.
- Gibson, T. & Heartfield, M. (1996) Critical pathways: a critical analysis. *International Journal of Nursing Practice* 2: 189-193.

- Giger, J.N. & Davidhizar, R. (1990) Transcultural nursing assessment: a method for advancing nursing practice. *International Nursing Reviews* 37: 199-202.
- Gilbody, S. & House, A. (1999) Variations in psychiatric practice. *British Journal of Psychiatry* 175: 303-305.
- Gilloran, A.J., McGlew, T., McKee, K., Robertson, A. & Wight, D. (1993) Measuring the quality of care in psychogeriatric wards. *Journal of Advanced Nursing* 18: 269-275.
- Glaser, B.G. & Strauss, A.L. (1967) *The Discovery of Grounded Theory*. Chicago: Aldine.
- Glenister, D. (1994) Patient participation in psychiatric services: a literature review and proposal for a research strategy. *Journal of Advanced Nursing* 19: 802-811.
- Goble, R. (1997) 'Multi-professional education in Europe'. In: A. Leathard ed. *Going Inter-Professional. Working Together for Health and Welfare*. London: Routledge.
- Godfrey, M. (1996) User and carer outcomes in mental health. *Outcomes Briefing* 8: 17-20.
- Goffman, E. (1961) *Asylums*. New York: Doubleday & Co.
- Goldstein, J.M. (1993) Sampling bias in studies of gender and schizophrenia: A reply. *Schizophrenia Bulletin* 19: 9-14.
- Goodwin, D.R. (1994a) Nursing case management activities. How they differ between employment settings. *Journal of Nursing Administration* 24(2): 29-34.

- Goodwin, D.R. (1994b) Critical pathways in home healthcare. *Journal of Nursing Administration* 22(2): 35-40.
- Gournay, K. (1995) Training and education in mental health nursing. *Mental Health Nursing* 15(6): 12-14.
- Gournay, K. (1996) Schizophrenia: a review of the contemporary literature and implications for mental health nursing theory, practice and education. *Journal of Psychiatric and Mental Health Nursing* 3: 7-12.
- Gordon, C. (1986) 'Psychiatry as a problem of democracy'. In P. Miller & N. Rose eds. *The Power of Psychiatry*. Oxford: Polity Press.
- Gordon, N.S. (1998) Influencing mental health nursing practice through the teaching of research and theory: a personal critical review. *Journal of Psychiatric & Mental Health Nursing* 5: 119-128.
- Gottlieb, L.D., Roer, D., Jega, K., St. Pierre, J.D., Dobbins, J., Dwyer, M., Lewis, S., Manus, D. (1996) Clinical pathway for pneumonia: development, implementation and initial experience. *Best Practices and Benchmarking in Healthcare* 1(5): 262-265.
- Gray-Toft, P.A. & Anderson, J.G. (1981) Organisational stress in the hospital. Development of a model for diagnosis and prediction. *Health Services Research* 19: 753-77.
- Greenwood, R.J., McMillan, T.M., Brooks, D.N., Dunn, G., Brock, D., Dinsdale, S., Murphy, L.D., Price, J.R. (1994) Effects of case management after severe head injury. *British Medical Journal* 308: 1199-1205.

- Gregor, C., Pope, S., Werry, D., Dodek, P. (1996) Reduced length of stay and improved appropriateness of care with a clinical path for total knee or hip arthroplasty. *Journal of Quality Improvement* 22(9): 617-628.
- Griffiths, R. (1983) *NHS Management Enquiry Report*. London: DHSS.
- Griffiths, R. (1988) *Community Care: Agenda for Action. A Report for the Secretary of State for Social Services*. London: HMSO.
- Grimshaw, J. & Russell, I. (1993a) Achieving health gain through clinical guidelines. Developing scientifically valid guidelines. *Quality in Health Care* 2: 243-248.
- Grimshaw, J. & Russell, I. (1993b) Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 342: 1317-1321.
- Guba, E.G. & Lincoln, Y.S. (1989) *Fourth Generation Evaluation*. California: Sage.
- Guiliano, K. & Poirier, C. (1991) Nursing case management: critical pathways to desirable outcomes. *Nursing Management* 22: 52-55.
- Haddock, G. & Lewis, S. (1996) New psychological treatments in schizophrenia. *Advances in Psychiatric Treatment* 2: 110-116.
- Hadorn, D.C., Baker, D., Hodges, J.S. & Hicks, N. (1996) Rating the quality of evidence for clinical practice guidelines. *Journal of Clinical Epidemiology* 49: 749-754.
- Hafner, H. (1998) Neurodevelopmental disorder and psychosis: one disease or major risk factor? *Current Opinion in Psychiatry* 11: 17-18.

- Hainsworth, D.S., Lockwood-Cook, E., Pond, M., Lagoe, R.J. (1997) Development and implementation of clinical pathways for stroke on a multihospital basis. *Journal of Neuroscience Nursing* 29(3): 156-162.
- Hall, B.A. (1996) The psychiatric model: a critical analysis of its undermining effects on nursing in chronic mental illness. *Advances Nursing Science* 18: 16-26.
- Hall, J. (2001) A qualitative survey of staff responses to an integrated care pathway pilot study in a mental healthcare setting. *NT Research* 6(3): 696-705.
- Hale, C. (1995a) Case management and managed care. *Nursing Standard* 9(19): 33-35.
- Hale, C. (1995b) Key terms in managed care. *Nursing Times* 91(29): 29.
- Hale, C. (1995c) Research issues in case management. *Nursing Standard* 9(44): 29-32.
- Hale, C. (1997) 'Issues in the evaluation of multidisciplinary pathways of care'. In: J. Wilson ed. *Integrated Case Management. The Path to Success*. Oxford: Butterworth-Heinemann.
- Hale, C., Crofts, L. & Stokoe, L. (1999) Managed care, case management and multidisciplinary pathways of care: a selective review for the RCN R&D priority-setting exercise. *NT Research* 4(5): 366-376.
- Ham, C. & Hill, M. (1984) *The Policy Process in the Modern Capitalist State*. Norfolk: Harvester Press.
- Hamilton, C., McQuarrie, B., Izatt, S., McIntaggart, S., Cardella, C. & Cattam, D. (1989) *Care Map Directory*. Toronto: Toronto Hospital.

- Hammersley, M. (1992) *What's Wrong With Ethnography*. London: Routledge.
- Hammersley, M. & Atkinson, P. (1995) *Ethnography. Principles in Practice*. London: Routledge.
- Handy, C. (1993) *Understanding Organisations*. London: Penguin Books.
- Harold, A.M. (1977) Psychiatrists and nurses in a Scottish hospital: a research note on conflict and its resolution in the ward situation. *Scottish Journal of Sociology* 2: 87-96.
- Harrison, G. & Eaton, W. (1997) Evidence into practice: the case for knowledge utilization in the evidence-based revolution. *Current Opinion in Psychiatry* 10: 147-148.
- Hart, E. (1996) Action research as a professionalizing strategy: issues and dilemmas. *Journal of Advanced Nursing* 23: 454-461.
- Hart, E. & Bond, M. (1995) *Action Research for Health & Social Care: A Guide to Practice*. Buckingham: Open University Press.
- Hart, E. & Bond, M. (1996) Making sense of action research through the use of a typology. *Journal of Advanced Nursing* 23: 152-159.
- Heacock, D. & Brobst, R.A. (1994) A multidisciplinary approach to critical path development: a valuable CQI tool. *Journal Nursing Care Quality* 8(4): 38-41.
- Healey, A., Knapp, M., Astin, J., Beecham, J., Kemp, R., Kirov, G. & David, A. (1998) Cost effectiveness evaluation of compliance therapy for people with psychosis. *British Journal of Psychiatry* 172: 420-424.
- Health Advisory Service (1997) *Voices in Partnership. Involving Users and Carers in Commissioning and Delivering Mental Health Services*. London: HMSO.

- Hewison, A. (1999) The new public management and the new nursing: related by rhetoric? Some reflections on the policy process and nursing. *Journal of Advanced Nursing* 29(6): 1377-1384.
- Heyman, T. (1994) Clinical protocols are the key to quality health care delivery. *International Journal of Health care Quality Assurance* 7: 14-17.
- Hickey, T., Akiyama, H. & Rakowski, W. (1991) Daily illness characteristics and health care decisions of older people. *Journal of Applied Gerontology* 10(2): 169-183.
- Higgins, R., Hurst, K., Wistow, G. (1999) Nursing acute psychiatric patients: a quantitative and qualitative study. *Journal of Advanced Nursing* 29(1): 52-63.
- Higgs, J. & Jones, M. (1995) *Clinical Reasoning in the Health Professions*. Oxford: Butterworth Heineman.
- Hill, B. & Michael, S. (1996) The human factor. *Journal of Psychiatric & Mental Health Nursing* 3: 245-248.
- Hindler, C. (1999) The supervision register: 19 months after its introduction. *Psychiatric Bulletin* 23: 15-19.
- Hoffman, P.A. (1993) Critical path method: an important tool for coordinating critical care. *Journal of Quality Improvement* 19: 235-246.
- Holle, M.L., Rick, C., Sliefert M.K., Stephens, K. (1995) Integrating patient care delivery. *Journal of Nursing Administration* 25: 32-37.
- Horn, S.D., Chambers, A.F., Phoebe, D., Sharkey, P.D. & Horn, R.A. (1989) Psychiatric severity of illness. A case mix study. *Medical Care* 27: 69-83.
- House of Commons Health Committee (1994) *Better off in the Community? The Care of People who are Seriously Mentally Ill*. London: HMSO.

- Howell, V. & West, P. (2000) The national mental health acute in-patient practice development network. *The Mental Health Review* 5(1): 12-16.
- Holliday, I. (1995) *The NHS Transformed*. Manchester: Baseline Books.
- Holter, I.M. & Schwartz-Barcott, D. (1993) Action research: what is it? How has it been used and how can it be used in nursing? *Journal of Advanced Nursing* 18: 298-304.
- Homan, C. (1994) Critical Path Network. *Hospital Case Management* 10: 135-138.
- Hughes, C.C. & Kennedy, D. (1983) 'Beyond the germ theory: Reflections on relations between medicine and the behavioural sciences'. In: J. Ruffin ed. *Advances in Medical Social Science*. New York: Gordon & Breach.
- Hughes, D. & McGuire, A. (1992) 'Legislating for health. The changing nature of regulation in the NHS'. In: R. Dingwall & P. Fenn eds. *Quality and Regulation in Health Care. International Experiences*. London: Routledge.
- Hugman, R. (1995) 'Contested territory and community services'. In: K. Soothill, L. Mackay & C Webb eds. *Interpersonal Relations in Health Care*. London: Edward Arnold.
- Hummelvoll, J.K. & Severinsson, E.I. (2001) Imperative ideals and the strenuous reality: focusing on acute psychiatry. *Journal of Psychiatric and Mental Health Nursing* 8: 17-24.
- Hunter, D. (1995) Panacea or placebo. *Health Service Journal* 105: 22-24.
- Hunter, D.J. & Fairfield, G. (1997) Managed care: disease management. *British Medical Journal* 315: 50-53.

Humphreys, J. & Quinn, F.M. (1994) *Health Care Education. The Challenge of the Market*. London: Chapman & Hall.

Hurst, K. (1995) *Progress with Patient Focused Care*. Leeds: Nuffield Institute for Health.

Hurst, K. (1996) The managerial and clinical implications of patient-focused care. *Journal of Management in Medicine* 10(3): 59-77.

Hwu, H-G., Tan, H., Chen, C-C. & Yeh, L-L. (1995) Negative symptoms at discharge and outcome in schizophrenia. *British Journal of Psychiatry* 166: 61-67.

Hyams, A.L., Brandenburg, J.A., Lipsitz, S.R., Shapiro, D.W., Brennan, T.A. (1995) Practice guidelines and malpractice litigation: a two way street. *Annals Internal Medicine* 122: 450-455.

Hyers, T.M., Hull, R.D., Weg, J.G. (1992) Antithrombotic therapy for venous thromboembolic disease. *Chest* 102: 408s-425s.

Ignatavicius, D.A. & Hausman, K.A. (1995) *Clinical Pathways for Collaborative Practice*. Philadelphia: W.B. Saunders Company.

Ireson, C.L. (1997) Critical pathways: effectiveness in achieving patient outcomes. *Journal of Nursing Administration* 27(6): 16-23.

Jackson, R. & Feder, G. (1998) Guidelines for clinical guidelines. *British Medical Journal* 317, 427-428.

Jakes, S., Rhodes, J. & Turner, T. (1999) Effectiveness of cognitive therapy for delusions in routine clinical practice. *British Journal of Psychiatry* 175: 331-335.

- Janssen, P.M.P., Jonge, J.D., Bakker, A.B. (1999) Specific determinants of intrinsic work motivation, burnout and turnover intentions: a study among nurses. *Journal of Advanced Nursing* 29(6): 1360-1369.
- Jaspers, K. (1959) *General Psychopathology* (trans. J. Hoenig & M. Hamilton, 1963). Manchester: Manchester University Press.
- Jayaram, G., Tien, A.Y., Sullivan, P., Gwon, H. (1996) Elements of a successful short stay inpatient psychiatric service. *Psychiatric Services* 47(4): 407-412.
- Jenner, E.A. (1998) A case study analysis of nurses' roles, education and training needs associated with patient-focused care. *Journal of Advanced Nursing* 27: 1087-1095.
- Jenner, F.A., Antonio, C.D., Monterio, J.A. & Cunha-Olieira, J.A. (1993) *Schizophrenia. A Disease or Some Ways of Being Human*. Sheffield: Sheffield Academic Press.
- Jenny, J. & Logan, J. (1992) Knowing the patient: one aspect of clinical knowledge. *Image - Journal of Nursing Scholarship* 24(2): 254-258.
- Johns, A.L. (1961) *A Study of the Psychiatric Nurse*. London: E & S Livingstone.
- Johnson, M.J. (1975) *Doing Field Research*. New York: The Free Press.
- Johnson, T.J. (1972) *Professions and Power*. London: Macmillan.
- Johnson, M. (1992) A silent conspiracy?: some ethical issues of participant observation in nursing research. *International Journal of Nursing Studies* 29(2): 213-223.

- Johnson, S. (1995) Pathway to the heart of care quality. *Nursing Management* 1(8): 26-27.
- Johnstone, E.C. & Lang, F.H. (1994) Onset, course and outcome of schizophrenia. *Current Opinion in Psychiatry* 7: 56-60.
- Johnstone, P. & Zolese, G. (1999) Systematic review of the effectiveness of planned short hospital stays for mental health care. *British Medical Journal* 318(7195): 1387-1390.
- Jones, A. (1995) An analysis of case management - the utility of human resources, but to what end? *Journal of Nursing Management* 3: 143-149.
- Jones, A. (1999) Pathways of care in the inpatient treatment of schizophrenia: an experimental project. *Mental Health Care* 2(6): 194-197.
- Jones, C., Cormac, I., Mota, I., Campbell, C. (1999) *Cognitive Behaviour Therapy for Schizophrenia* (Cochrane Review). In: The Cochrane Library, Issue 1, 1999. Update Software, Oxford.
- Jones, D. (1997) Building the information infrastructure required for managed care. *Image: Journal of Nursing Scholarship* 29(4): 377-381.
- Jones, R. & Waite, T. (1995) Atlantic crossing. *Health Service Journal* 105: 25.
- Jordan, S., Hardy, B., Coleman, M. (1999) Medication management: an exploratory study into the role of community mental health nurses. *Journal of Advanced Nursing* 29(5): 1068-1081.
- Kane, J.M., Honigfield, G., Singer, J. (1988) Clozapine for the treatment resistant schizophrenic: a double blind comparison with chlorpromazine. *Archives of General Psychiatry* 45: 789-796.

- Kane, J.M. (1996) Factors which can make patients difficult to treat. *British Journal of Psychiatry* 169 (suppl. 31): 10-14.
- Kasper, J.A., Hoge, S.K., Feucht-Haviar, T., Cortina, J. & Cohen, B. (1997) Prospective study of patients' refusal of antipsychotic medication under a physician discretion review procedure. *American Journal of Psychiatry* 154(4): 483-489.
- Kavanagh, S. (1997) Purchasers, providers and managed care: developments in the mental health market place. *Current Opinion in Psychiatry* 10: 153-159.
- Kemp, R., Haywood, P., Applewhaite, G., Everitt, B. & David, A. (1996) Compliance therapy in psychotic patients: randomised controlled trial. *British Medical Journal* 312(7027): 345-349.
- Kemp, R., Kirov, G., Everitt, B., Hayward, P., David, A. (1998) Randomised controlled trial of compliance therapy. *British Journal of Psychiatry* 172: 413-419.
- Kendell, R.E. (1993) 'Schizophrenia'. In: R.E. Kendell ed. *Companion to Psychiatric Studies*. Edinburgh: Churchill Livingstone.
- Kendrick, T., Sibbald, B., Burns, T. & Freeling, P. (1991) Role of general practitioners in care of the long-term mentally ill patients. *British Medical Journal* 302: 508-510.
- Kennedy, A. (1996) Attila the hun: leadership as a change agent. *Hospital Management Quarterly* 17(3): 29-37.
- Kim, H.S. (1993) Identifying alternative linkages among philosophy, theory and method in nursing science. *Journal of Advanced Nursing* 18: 793-800.

- Kimberlin, L. & Bregman, J. (1996) Postconceptual age as the basis for neonatal case management. *Neonatal Network* 15(2): 5-13.
- King, I.M. (1981) *A Theory of Nursing: Systems, Concepts, Process*. New York: John Wiley & Sons.
- King, N. (1994) 'The qualitative research interview'. In: C. Cassell & G. Symon eds. *Qualitative Methods in Organisational Research*. London: Sage.
- Kitchiner, D. & Bundred, P. (1996) Integrated care pathways. *Archives of Diseases in Childhood* 75: 166-168.
- Kitchiner, D., Davidson, C., Bundred, P. (1996) Integrated care pathways: effective tools of continuous evaluation of clinical practice. *Journal of Evaluation in Clinical Practice* 2: 65-69.
- Klein, R. (1989) *The Politics of the NHS*. Essex: Longman Group.
- Klerman, G.L. (1986) The National Institute of Mental Health - Epidemiological Catchment Area (NIMH-ECA) program. *Social Psychiatry Psychiatrica Epidemiology* 21: 159-166.
- Kluiter, H. (1997) Inpatient treatment and care arrangements to replace or avoid it - searching for an evidence-based balance. *Current Opinion in Psychiatry* 10: 160-167.
- Knafl, K.A. & Howard, M.J. (1984) Interpreting and reporting qualitative research. *Research in Nursing and Health* 7: 17-24.
- Knapp, M. (1997) Costs of schizophrenia. *British Journal of Psychiatry* 171: 509-518.
- Knapp, M. (1999) Schizophrenia: improving cost effectiveness. *Mental Health Research Review* 6: 4-9.

- Knapp, M. & Kavanagh, S. (1997) Economic outcomes and costs in the treatment of schizophrenia. *Clinical Therapeutics* 19(1): 128-138.
- Koch, T. (1994a) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing* 19: 976-986.
- Koch, T. (1994b) Beyond measurement: fourth-generation evaluation in nursing. *Journal of Advanced Nursing* 20: 1148-1155.
- Koch, T. (1996) Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing* 24: 174-184.
- Kollef, M.H., Shapiro, S.D., Silver, P., St. John, R.E., Prentice, D., Sauer, S., Aherns, T.S., Shannon, W. & Baker-Clinkscale, D. (1997) A randomised, controlled trial of protocol-directed versus physician-directed weaning from mechanical ventilation. *Critical Care Medicine* 25(4): 567-574.
- Kowal, N.S. & Delaney, M. (1996) The economics of a nurse-developed critical pathway. *Nursing Economics* 14: 156-161.
- Krauss, J.B. (1994) How well will we manage care? *Archives of Psychiatric Nursing* 8: 339.
- Kuipers, E. (1996) The management of difficult to treat patients with schizophrenia using non-drug therapies. *British Journal of Psychiatry* 169 (suppl. 31): 41-51.
- Lago, R.J. & Aspling, D.L. (1996) Enlisting physician support for practice guidelines in hospitals. *Health Care Management Review* 21(4): 61-7.

- Lancashire, S., Haddock, J. & Carrier, N. (1997) Effects of training in psychological interventions for community psychiatric nurses in England. *Psychiatric Services* 48: 39-41.
- Lang, F.H., Johnstone, E.C., Murray, G.D. (1997) Service provision for people with schizophrenia. II. Role of the general practitioner. *British Journal of Psychiatry* 171: 165-168.
- Latini, E.E. & Foote, W. (1992) Obtaining consistent quality patient care for the trauma patient by using a critical pathway. *Critical Care Nursing Quarterly* 15(3): 51-55.
- Latini, E.E. (1996) Trauma critical pathways: a care delivery system that works. *Critical Care Nursing Quarterly* 19(1): 83-87.
- Lauri, S. (1982) Development of the nursing process through action research. *Journal of Advanced Nursing* 7: 301-307.
- Lawrence, M. & Williams, T. (1996) Managed care and disease management in the NHS. *British Medical Journal* 313: 125-126
- Lawson, M.J., Lapinski, B.J. & Velasco, E.C. (1997) Tonsillectomy and adenoidectomy pathway plan of care for the pediatric patient in day surgery. *Journal of PeriAnesthesia Nursing* 12(6): 387-395.
- Laxade, S. & Hale, C.A. (1995a) Managed care 1: an opportunity for nursing. *British Journal of Nursing* 4(5): 290-294.
- Laxade, S. & Hale, C.A. (1995b) Managed care 2: an opportunity for nursing. *British Journal of Nursing* 4(6): 345-350.
- Layton, A. (1993) Planning individual care with protocols. *Nursing Standard* 8(1): 32-34.

- Lee, R.M. (1993) *Doing Research on Sensitive Topics*. London: Sage.
- Lee, D.T.F., Mackenzie, A.E., Dudley-Brown, S., Chin, T.M. (1998) Case management: a review of the definitions and practices. *Journal of Advanced Nursing* 27: 933-939.
- Lees, P. & Stafford, P. (1996) 'Casemix, coding and contracting: A beginner's guide'. In: P. Lees ed. *Navigating the NHS: Core Issues for Clinicians*. Oxon: Radcliffe Medical Press.
- Lego, S. (1992) Biological psychiatry and psychiatric nursing in America. *Archives of Psychiatric Nursing* 6: 147-150.
- Lego, S. (1997) A critique of Gounay's position on nursing theory and models. *Journal of Psychiatric and Mental Health Nursing* 4: 64-66.
- Lehman, A.F. & Steinwachs, D.M. (1998) Translating research into practice: the schizophrenia patient outcomes research team (port) treatment recommendations. *Schizophrenia Bulletin* 24: 1-10.
- Leiba, T. (1997) 'Inter-professional approaches to mental health care'. In: A. Leathard ed. *Going Inter-Professional. Working Together for Health and Welfare*. London: Routledge.
- Lelliott, P. (2000) Clinical standards and the wider quality agenda. *Psychiatric Bulletin* 24: 85-89.
- Lewin, K. (1958) *Group decision and social change*. In: E. Maccoby, T. Newcomb & E.Hartley eds. *Readings in Social Psychology*. New York: Methuen.

- Lieberman, P.B., Wiitala, S.A., Elliott, B., McCormick, S., Goyette, S.B. (1998) Decreasing length of stay: are there effects on outcomes of psychiatric hospitalization. *American Journal of Psychiatry* 155(7): 905-909.
- Lincoln, Y.S. (1992) Fourth generation evaluation. The paradigm revolution and health promotion. *Canadian Journal of Public Health* 83(1): 6-10.
- Lindstrom, L.H. (1996) Clinical and biological markers for outcome in schizophrenia. *Neuropsychopharmacology* 14(35): 23S-26S.
- Linstone, H.A. & Turoff, M. (1975) *The Delphi Method: Techniques and Applications*. Massachusetts: Addison Wesley Publishing.
- Lipsky, J. (1980) *Street Level Bureaucracy*. New York: Sage.
- Littlejohns, P. (1999) Clinical governance and NICE: a close relationship. *British Journal of Clinical Governance* 4(4): 125-127.
- Lofland, J. & Lofland, L.H. (1984) *Analysing Social Settings. A Guide to Qualitative Observation and Analysis*. California: Wadsworth Publishing Co.
- Long, A.F. (1994) Guidelines, protocols and outcomes. *International Journal of Health Care Quality Assurance* 7(5): 4-7.
- Lord, J. & Littlejohns, P. (1996) Development of an instrument to assess staff perceptions of the impact of trust-based clinical audit programmes. *Journal of Clinical Effectiveness* 1(3): 83-89.
- Lovejoy, N.C. & Matteis, M. (1997) Cognitive-behavioural interventions to manage depression in patients with cancer: research and theoretical initiatives. *Cancer Nursing* 20(3): 155-167.
- Lowe, C. (1998) Care pathways: have they a place in the new 'National Health Service'? *Journal of Nursing Management* 6: 303-306.

- Lumsden, K. & Hagland, M. (1993) Mapping Care. *Hospitals and Health Networks*. 20: 34-40.
- Lupton, D. (1997) Doctors on the medical profession. *Sociology of Health & Illness* 19(4): 480-497.
- Lydeard, S. & George, S. (1996) 'Managing quality through outcome measurement and audit'. In: P. Lees ed. *Navigating the NHS: Core Issues for Clinicians*. Oxon: Radcliffe Medical Press.
- Lyon, J.C. (1993) Models of nursing care delivery and case management: clarification of terms. *Nursing Economics* 11(3): 163-169.
- Lyons, J.S., O'Mahoney, M.T., Miller, S.I., Neme, J., Kabat, J., Miller, F. (1997) Predicting readmission to the psychiatric hospital in a managed care environment: implications for quality indicators. *American Journal of Psychiatry* 154(3): 337-340.
- Lyons, H. (1998) 'Healthcare management - An international perspective'. In: K. Holdaway & H. Kogan eds. *The Healthcare Management Handbook*. London: Kogan Page.
- Mackenzie, A., Lee, D.T.F., Dudley-Brown, S. & Chin, T.M. (1998) Case management in Hong Kong: evaluation of a pilot project in community nursing. *Journal of Clinical Nursing* 7: 291-292.
- Macpherson, R., Jerrom, B. & Hughes, A. (1996) A controlled study of education about drug treatment in schizophrenia. *British Journal of Psychiatry* 168: 709-717.
- Madhok, R. (1999) Implications of US managed care for the British NHS: a personal view. *Journal of Integrated Care* 3: 93-99.

- Mangen, S.P. (1982) *Sociology and Mental Health*. London: Penguin.
- Manthey, M., Ciske, K., Robertson, P., Harris, I. (1970) Primary nursing. *Nursing Forum* 9(1): 65-83.
- Maloney, R. & Maggs, C. (1999) A systematic review of the relationships between written nursing care planning, record keeping and patient outcomes. *Journal of Advanced Nursing* 30(1): 51-57.
- Mari, J.J & Streiner, D. (1999) *Family Interventions for People with Schizophrenia* (Cochrane Review). In: The Cochrane Library, Issue 1, 1999. Update Software, Oxford.
- Marshall, M. (1990) *Social Work with Older People*. London: Macmillan.
- Mark, A. (1997) 'Working in teams'. In: N. Austin & S. Dopson eds. *The Clinical Directorate*. Oxon: Radcliffe Medical Press.
- Markova, I.S. & Berrios, G.E. (1992) The meaning of insight in clinical psychiatry. *British Journal of Psychiatry* 160: 850-860.
- Marram, G.D., Flynn, K.T., Abaravich, W., Carey, S. (1976) *Cost Effectiveness of Primary and Team Nursing*. Massachusetts: Contemporary.
- Mason, J. (1994) 'Linking qualitative and quantitative data analysis'. In: A. Bryman & R.G. Burgess eds. *Analyzing Qualitative Data*. London: Routledge.
- Mason, J. (1997) 'Sorting, organizing and indexing qualitative data'. In: J.M. Morse ed. *Qualitative Researching*. London: Sage.
- Mason, A., Drummond, M. & Towse, A. (1999) Joint disease management ventures in the UK. *Journal of Integrated Care* 3: 71-78.

- Maslach, C. & Jackson, S.E. (1982) 'Burnout in health professions: A social psychological analysis'. In: G.S. Sanders & J. Suls eds. *Social Psychology of health & Illness*. Hillsdale: Erlbaum.
- Matrone, J.S. (1990) *The effect of a staff development program on nursing case management competencies and patient outcomes in the acute care setting*. CINAHL. Boston: Boston College.
- Matrunola P. (1996) Is there a relationship between job satisfaction and absenteeism? *Journal of Advanced Nursing* 23, 827-834.
- May, C. (1992) Nursing work, nurses' knowledge, and the subjectivication of the patient. *Sociology of Health and Illness* 14(4): 32-43.
- May, C. & Fleming, C. (1997) The professional imagination: narrative and the symbolic boundaries between medicine and nursing. *Journal of Advanced Nursing* 25: 1094-1100.
- May, K.A. (1989) 'Interview techniques in qualitative research: Concerns and challenges'. In: J.M. Morse ed. *Qualitative Nursing Research: A Contemporary Dialogue*. Rochville, Aspen.
- Mayer, C., Kelterborn, G. & Naber, D. (1995) Age of onset of schizophrenia: relations to psychopathology and gender. *British Journal of Psychiatry* 162: 665-671.
- Maxwell, R.J. (1995) Why rationing is on the agenda. *British Medical Bulletin* 51(4): 761-768.
- Maynard, A. & Bloor, K. (1995) Help or hindrance? The role of economics in rationing health care. *British Medical Bulletin* 51(4): 854-868.

- McCrone, P. & Weich, S. (1996) Mental health care costs: paucity of measurement. *Social Psychiatry Psychiatr Epidemiol* 31: 70-77.
- McDermott, G. (1998) The care programme approach: a patient perspective. *NTResearch* 3(1): 47-63.
- McEvoy, J.P., Hogarty, G.E., Steingard, S. (1991) Optimal dose of neuroleptic in acute schizophrenia. *Archives of General Psychiatry* 48: 739-754.
- McFarland, G.K. & McFarlane, E.A. (1993) 'Preface'. In: G.K. McFarland & E.A. McFarlane eds. *Nursing Diagnosis & Intervention*. St. Louis: Mosby.
- McGlashan, T.H. (1988) A selective review of recent North American long-term follow up studies of schizophrenia. *Schizophrenia Bulletin* 14: 515-542.
- McGlashan, T.H. & Fenton, W.S. (1993) Subtype progression and pathophysiologic deterioration in early schizophrenia. *Schizophrenia Bulletin* 19: 71-85.
- McGorry, P., Curry, C. & Elkins, K. (1997) Psychosocial interventions in mental health disorders: developing evidence-based practice. *Current Opinion in Psychiatry* 10: 173-177.
- McGrath, A., Reid, N. & Boore, J. (1989) Occupational stress in nursing. *International Journal of Nursing Studies* 26: 343-358.
- McQueen, J. & Milloy, S. (2001) Why clinical guidelines or care pathways in mental health? *Journal of Integrated Care Pathways* 5(2): 44-53.
- McIver, S. (1999) Public involvement in primary care: implications for primary care groups. *NT Research* 4(4): 245-256.
- McKenzie, C.B., Torkelson, N.G. & Holt, M.A. (1989) Care and cost: nursing case management improves both. *Nursing Management* 20(10): 30-34.

- McNicol, M. (1992) Achieving quality improvement by structured patient management. *Quality in Health Care* 1: 40-41.
- Meek, V.L. (1988) Organizational culture: origins and weaknesses. *Organisational Studies* 9: 453-473.
- Melchior, M.E.W., Bours, G.J.J.W., Schmitz, P. & Wittich, Y. (1997) Burnout in psychiatric nursing: a meta-analysis of related variables. *Journal of Psychiatric & Mental Health Nursing* 4: 193-201.
- Melia, K. (1987) *Learning and Working. The Occupational Socialisation of Nurses*. London: Tavistock Publications.
- Meltzer, H.Y. (1997) Treatment-resistant schizophrenia - the role of clozapine. *Current Medical Research and Opinion* 14(1): 1-20.
- Mental Health Foundation (1994) *Creating Community Care*. London: Mental Health Foundation.
- Menzies, I.E.P. (1970) *The Functioning of Social Systems as a Defence Against Anxiety. A Report on a study of the Nursing Service of a General Hospital*. London: Tavistock Institute of Human Relations.
- Meyer, J.E. (1993) New paradigm research in practice: the trials and tribulations of action research. *Journal of Advanced Nursing* 18: 1066-1072.
- Miles, A. (1977) Staff relations in psychiatric hospitals. *British Journal of Psychiatry* 130: 84-88.
- Miles, M.B. & Huberman, A.M. (1994) *Qualitative Data Analysis*. California: Sage Publications.
- Mobley, C. (1997) Towards a new definition of accountability. *Journal of Contemporary Ethnography* 26(1): 75-97.

- Mohan, J. (1996) Accounts of the NHS reforms: macro-, meso- and micro-level perspectives. *Sociology of Health & Illness* 18(5): 675-698.
- Mohr, W.K. (1999) Deconstructing the language of psychiatric hospitalisation. *Journal of Advanced Nursing* 29(5): 1052-1059.
- Morgan, G. (1993) The implications of patient focused care. *Nursing Standard* 7(52): 37-39.
- Morrall, P.A. (1997) Professionalism and community psychiatric nursing: a case study of four mental health teams. *Journal of Advanced Nursing* 25: 1133-1137.
- Morris, E. & Mylotte, A. (1995) The management of childhood asthma through care pathways. *Nursing Times* 91(48): 36-37.
- Morris, M., Levenback, C., Burke, T.W., Dejesus, Y., Lucas, K.R., Gershenson, D.M. (1997) An outcomes management programme in gynecologic oncology. *Obstetric Gynecology* 89(4): 485-492.
- Morris, M. (1996) Improving the standards of care delivery in mental health. *British Journal of Nursing* 5: 265-266.
- Morrison, P. & Burnard, P. (1991) *Caring & Communicating. The Interpersonal Relationship in Nursing*. London: Macmillan.
- Morrison, D.P. (1996) Management of treatment refractory schizophrenia. *British Journal of Psychiatry* 169 (suppl. 31): 15-20.
- Morse, J.M. (1991) Negotiating commitment and involvement in the nurse-patient relationship. *Journal of Advanced Nursing* 16(4): 455-468.
- Morse, J.M. & Field, P.A. (1996) *Nursing Research. The Application of Qualitative Approaches*. London: Chapman & Hall.

- Mosher, C., Cronk, P., Kidd, A. (1992) Upgrading practice with critical pathways. *American Journal of Nursing* 92(1): 41-44.
- Moss Kanter, R., Steen, B., & Hicks, J. (1992) *The Challenge of Organisational Change*. London: Unwin.
- Muluk, S.C., Painter, L., Sile, S., Rhee, R.Y., Makaroun, M.S., Steed, D.L., Webster, M.W. (1997) *Journal of Vascular Surgery* 25(1): 84-93.
- Muijen, M. (1999) Acute hospital care: ineffective, inefficient and poorly organised. *Psychiatric Bulletin* 23: 257-259.
- Murray, N. & McChesney, R. (1998) Change management: a case study from intensive care. *Managing Clinical Nursing* 2: 69-76.
- Musfeldt, C. & Hart, R. (1993) Physician-directed diagnostic and therapeutic plans: a quality cure for America's health-care crisis. *Journal of the Society for Health Systems* 4(1): 80-87.
- National Institute of Health (1994) *Plain Talk about Depression*. National Institute of Health: US Dept HHS Publications 94-3561.
- National Institute for Clinical Excellence (2002) *Guidance on the use of Newer (atypical) Antipsychotic Drugs for the Treatment of Schizophrenia*. NICE Technology Appraisal Guidance No. 43. London: NICE.
- Neidig, J.R., Megel, M.E. & Koehler, K.M. (1992) The critical path: an evaluation of the applicability of nursing case management in the NICU. *Neonatal Network* 11(5): 45-52.
- Neilson, T., Peet, M., Ledsham, R. & Poole, J. (1996) Does the nursing care plan help in the management of psychiatric risk? *Journal of Advanced Nursing* 24: 1201-1206.

Nelson, S. (1995) Following pathways in pursuit of excellence. *International Journal of Health Care Quality Assurance* 8(7): 19-22.

Newel, B.A. (1994) Our new system makes nurses better teachers. *Registered Nurse* 57: 21-24.

Newman, B. (1995) Enhancing patient care: case management and critical pathways. *Australian Journal of Advanced Nursing* 13(1):16-24.

NHS Management Executive (1993) *Improving Clinical Effectiveness*. Leeds: NHS Management Executive.

NHS Executive (1996a) *Partnerships with Industry for Disease Management: General Approach*. London: NHS Executive.

NHS Executive (1996b) *Clinical Guidelines: Using Clinical Guidelines to Improve Patient Care Within the NHS*. Leeds: NHS Executive.

NHS Executive (1996c) *Guidance on Supervised Discharge (Aftercare Under Supervision) and Related Provisions*. London: HMSO.

NHS Executive (1996d) *Burdens of Disease: A Discussion Document*. London: NHS Executive.

NHS Executive (1998) *Information for Health: An Information Strategy for the Modern NHS 1998-2005*. Leeds: HMSO.

Nolan, P., Oyebode, F. & Liburd, M. (1998a) A survey of patients placed on the supervision register in one mental health trust. *International Journal of Nursing Studies* 35: 65-71.

Nolan, M.T., Harris, A., Kufta, A., Opfer, N., Turner, H. (1998b) Preparing nurses for the acute care case manager role: educational needs identified by

existing case managers. *The Journal of Continuing Education in Nursing* 29(3): 130-134.

Nolan, P. (1993) *A History of Mental Health Nursing*. London: Chapman & Hall.

Nolan, P. & Hopper, B. (1997) Mental health nursing in the 1950's and 1960's revisited. *Journal of Psychiatric & Mental Health Nursing* 4: 333-338.

Nolan, M. & Grant, G. (1993) Action research and quality of care: a mechanism for agreeing basic values as a precursor to change. *Journal of Advanced Nursing* 18: 305-311.

Norman, I.J. (1998) The changing emphasis of mental health and learning disability nurse education in the UK and ideal models of its future development. *Journal of Psychiatric and Mental Health Nursing* 5: 41-51.

O'Connor, F.W. (1991) Symptom monitoring for relapse prevention in schizophrenia. *Archives of Psychiatric Nursing* 5(4): 193-201.

Ogilvie-Harris, D.J., Botsford, D.J. & Hawker, R.W. (1993) Elderly patients with hip fractures: improved outcome with the use of care maps with high-quality medical and nursing protocols. *Journal of Orthopaedic Trauma* 7(5): 428-437.

Olfson, M., Weissman, M.M., Gottlieb, J.F. (1997) Essential roles for psychiatry in the era of managed care. *Archives of General Psychiatry* 54: 206-208.

Olivas, G.S., Togno-Armanasco, V.D., Erickson, J.R., Harter, S. (1989) Case management: a bottom-line care delivery model. Part 1: The concept. *Journal of Nursing Administration* 19(11): 16-20.

- Olsen, D.P. (1994) The ethical considerations of managed care in mental health treatment. *Journal of Psychosocial Nursing* 32(3): 25-28.
- Olsen, D.P. (1995) Ethical cautions in the use of outcomes for resource allocation in the managed care environment of mental health. *Archives of Psychiatric Nursing* IX(4): 173-178.
- Onyett, S., Heppleston, T., Bushnell, D. (1994) *The Organisation and Operation of Community Mental Health Teams in England. A National Survey*. London: The Sainsbury Centre for Mental Health.
- Onyett, S., Pillinger, T., Muijen, M. (1995) *Making Community Mental Health Teams Work*. London: The Sainsbury Centre for Mental Health.
- Opie, A. (1997) Thinking teams thinking clients: issues of discourse and representation in the work of health care teams. *Sociology of Health & Illness* 19(3): 259-280.
- Osser, D.N. (1990) A systematic approach to pharmacotherapy in patients with neuroleptic resistant psychosis. *Hospital & Community Psychiatry* 40: 921-927.
- Palacios-Araus, L., Herran, A., Sandoya, M., Gonzalez, de la Huebra, E., Vazquez-Barquero, J.L., Diez-Manrique, J.F. (1995) Analysis of positive and negative symptoms in schizophrenia. *Acta Psychiatrica Scandinavica* 92: 178-182.
- Parker, H. (2001) The role of occupational therapists in community mental health teams: generic or specialist? *British Journal of Occupational Therapy* 64: 609-611.

- Pateman, B. (1998) Computer-aided qualitative data analysis: the value of NUD*IST and other programs. *Nurse Researcher* 5(3): 77-89.
- Paterson, B.L. (1994) A framework to identify reactivity in qualitative research. *Western Journal of Nursing Research* 16(3): 301-316.
- Patterson, M. & Hayes, S. (1977) Verbal communication between students in multidisciplinary health teams. *Medical Education* 11: 205-9.
- Patton, M.Q. (1980) *Qualitative Evaluation Methods*. California: Sage.
- Pearson, S.D., Goulart-Fisher, D., Lee, T.H. (1995) Critical pathways as a strategy for improving care: problems and potential. *Annals Internal Medicine* 123: 941-948.
- Pearson, S.D., Lee, T.H., McCabe-Hassan, S., Dorsey, J.L., Goldhaber, S.Z. (1996) A critical pathway to treat proximal lower-extremity deep vein thrombosis. *The American Journal of Medicine* 100: 283-289.
- Peck, E. (1995) On the team. *Health Service Journal* 6 April: 28-29.
- Peplau, H.E. (1952) *Interpersonal Relations in Nursing*. New York: G.P. Putnam & Sons.
- Perkins, R. (2001) What constitutes success? *British Journal of Psychiatry* 179: 9-10.
- Perrin, J. (1988) *Resource Management in the NHS*. Wokingham: Van Nostrand Reinhold.
- Perry, M.A. (2000) Reflections on intuition and expertise. *Journal of Clinical Nursing* 9: 137-145.

- Persons, J.B., Thase, M.E. & Crits-Christoph, P. (1996) The role of psychotherapy in the treatment of depression. *Archives General Psychiatry* 53: 283-290.
- Petryshen, P.R. & Petryshen, P.M. (1992) The case management model: an innovative approach to the delivery of patient care. *Journal of Advanced Nursing* 17: 1188-1194.
- Pietroni, P.C. (1991) Stereotypes or archetypes-the languages of health and social care. *Journal of Interprofessional Care* 6(1): 7-16.
- Pietroni, P. (1997) 'Inter-professional teamwork: Its history and development in hospitals, general practice and community care (UK)'. In: A. Leathard ed. *Going Inter-Professional. Working Together for Health and Welfare*. London: Routledge.
- Pilgrim, D. (1983) 'Politics, psychology and psychiatry'. In: D. Pilgrim ed. *Psychology and Psychotherapy. Current Trends and Issues*. Henley: Routledge.
- Porter, S. (1993) The determinants of psychiatric nursing practice: a comparison of sociological perspectives. *Journal of Advanced Nursing* 18: 1559-1566.
- Porter, S. & Ryan, S. (1996) Breaking the boundaries between nursing and sociology: a critical realist ethnography of the theory-practice gap. *Journal of Advanced Nursing* 24: 413-420.
- Potter, D. (1998) Managed care. A view from down under. *Nursing Management* 4(10): 11-13.
- Punch, M. (1986) *The Politics and Ethics of Fieldwork*. California: Sage.

- Radwin, L.E. (1996) 'Knowing the patient': a review of research on an emerging concept. *Journal of Advanced Nursing* 23: 1142-1146.
- Ramos, M.C. (1992) The nurse-patient relationship: themes and variations. *Journal of Advanced Nursing* 17: 496-506.
- Ramos, M.C. & Ratcliff, C. (1997) The development and implementation of an integrated multidisciplinary clinical pathway. *Journal Wound Ostomy Continence Nursing* 24(2): 66-71.
- Ranger, S. (1986) *Functioning of the Multi-disciplinary Team: A Study of 3 Teams in a Psychiatric Rehabilitation Setting* (Dissertation). London: Institute of Psychiatry.
- Rasmussen, N & Gengler, T. (1994) Clinical pathways: The route to better communication. *Nursing* 24(2): 47-49.
- Reay, R. (1986) Bridging the gap: a model for integrating theory and practice. *British Journal of Social Work* 16: 49-64.
- Redfern, S.J. & Norman, I.J. (1994) Validity through triangulation. *Nurse Researcher* 2(2): 42-56.
- Redfern, S. (1996) Individualised patient care: a framework for guidelines. *Nursing Times* 92(5): 33-36.
- Reed, J. (1992) Individualised nursing care: some implications. *Journal of Clinical Nursing* 1: 7-12.
- Retsas, A. & Nolan, M. (1999) Barriers to nurses' use of research: an Australian hospital study. *International Journal of Nursing Studies* 36: 335-343.

Rew, L. (1991) Intuition in psychiatric/mental health nursing. *Journal of Child and Adolescent Psychiatric and Mental Health Nursing* 4: 110-115.

Ribeiro, S.C.M., Tandon, R., Ricoy, R., Mazzara, C., Craig, K. & Greden, J.

(1992) Clinical predictors of 1 year outcome in schizophrenia.

Psychopathology 25: 331-334.

Richards, J. & Lockett, T. (1996) 'An introduction to priority setting in the NHS'. In: P. Lees ed. *Navigating the NHS: Core Issues for Clinicians*. Oxon: Radcliffe Medical Press.

Richards, T. (1998) Disease management in Europe. *British Medical Journal* 317: 426-427.

Riches, T., Stead, L. & Espie, C. (1994) Introducing anticipated recovery pathways: a teaching hospital experience. *International Journal of Quality and Management* 7: 21-24.

Rietz, C., Erickson, S. & Deshpande, J.K. (1997) Clinical pathways and case management in anesthesia practice. New tools and systems for the evolving healthcare environment. *AANA Journal* 65(5): 460-467.

Ritchie, J., Dick, D., Lingham, R. (1994) *The Report of the Inquiry into the Care and Treatment of Christopher Clunis*. London: HMSO.

Rittman, M. (1993) Social organisation of length of stay of psychiatric patients. *Journal of Psychosocial Nursing* 31(5): 21-27.

Robinson, J.A., Robinson, K.J. & Lewis, D.J. (1992) Balancing quality of care and cost effectiveness through case management. *ANNA Journal* 19: 182-188.

Robson, C. (1995) *Real World Research*. Oxford: Blackwell Publishing Ltd.

- Roebuck, A. (1998) Critical pathways: an aid to practice. *Nursing Times* 94(35): 50-51.
- Rolfe, G. & Phillips, L-M. (1995) An action research project to develop and evaluate the role of an advanced nurse-practitioner in dementia. *Journal of Clinical Nursing* 4(5) 289-293.
- Rolfe, G. (1996) Going to extremes: action research, grounded practice and the theory-practice gap in nursing. *Journal of Advanced Nursing* 24: 1315-1320.
- Rosenberg, W. & Donald, A. (1995) Evidence based medicine: an approach to clinical problem-solving. *British Medical Journal* 310: 1122-1125.
- Rosenhan, D.L. (1992) 'On being sane in insane places'. In J.M. Morse ed. *Qualitative Health Research*. California: Sage.
- Ross, M.M., Rideout, E.M., Carson, M.M. (1994) The use of the diary as a data collection technique. *Western Journal of Nursing Research* 16(4): 414-425.
- Rossi, A., Mancini, F., Stratta, P., Mattei, P., Gismondi, R., Pozzi, F., Casacchia, M. (1997) Risperidone, negative symptoms and cognitive deficit in schizophrenia: an open study. *Acta Psychiatrica Scandinavica* 95: 40-43.
- Royal College of Nursing (1990) *Quality Patient Care the Dynamic Standard Setting System*. Middlesex: Scutari.
- Royal College of Nursing (1992) *Task Focused Hospitals or Patient Focused Care?* London: Royal College of Nursing.
- Royal College of Nursing (1998) *In-patient Mental Health Services in Inner London: 1997 Census*. London: Royal College of Nursing.

- Royal College of Psychiatrists (1996) *Report of the Confidential Inquiry into Homicides and Suicides by Mentally Disordered Offenders*. London: RCP.
- Royce, R. (1997) *Managed Care. Practice and Progress*. Oxon: Radcliffe Medical Press.
- Rudisill, P.T., Phillips, M. & Payne, C.M. (1994) Clinical paths for cardiac surgery patients: a multi-disciplinary approach to quality improvement outcomes. *Journal of Nursing Care Quality* 8: 27-33.
- Ryan, P., Ford, T., Clifford, P. (1991) *Case Management and Community Care*. London: Research & Development for Psychiatry.
- Sackett, D.L., Rosenberg, W.M.C., Gray, J.A.M., Haynes, R.B., Richardson, W.S. (1996) Evidence based medicine: what it is and what it isn't. *British Medical Journal* 312: 71-72.
- Sainsbury Centre (1997) *Pulling Together. The Future Roles and Training of Mental Health Staff*. London: The Sainsbury Centre for Mental Health.
- Salmond, S.W. (1990) In-hospital case management. *Orthopaedic Nursing* 9(1): 38-40.
- Salter, B. & Snee, N. (1997) Power dressing. *Health Service Journal* 13th. February: 30-31.
- Sandelowski, M. (1986) The problem of rigor in qualitative research. *Advances in Nursing Science* 8(3): 27-37.
- Sandelowski, M. (1995) Sample size in qualitative research. *Research in Nursing & Health* 18: 179-183.
- Sandelowski, M. (1997) 'To be of use': enhancing the utility of qualitative research. *Nursing Outlook* 45(3): 125-132.

- Sandhu, B.K., Duquette, N., Kerouac, S., Rouiller, L. (1992) Case management. The nursing business of care or cost. *Nursing Quebec* 12(5): 39-44.
- Salvage, J. & Smith, R. (2000) Doctors and nurses: doing it differently. *British Medical Journal* 320(7241): 1019-1020.
- Sanson-Fisher, R.W., Poole, A.D., Harker, J. (1979) Behavioural analysis of ward rounds within a general hospital psychiatric unit. *Behavioural Res Therapy* 17: 333.
- Schlesinger, M., Dorwart, R.A., Epstein, S.S. (1996) Managed care constraints on psychiatrists' hospital practices: bargaining power and professional autonomy. *American Journal of Psychiatry* 153(2): 256-260.
- Schatzman, L. & Strauss, A.L. (1973) *Field Research. Strategies for a Natural Sociology*. New Jersey: Prentice-Hall.
- Schoenenberger, R.A., Pearson, S.D., Goldhaber, S.Z., Lee, T.H. (1996) Variation in the management of deep vein thrombosis: implications for the potential impact of a critical pathway. *The American Journal of Medicine* 100: 278-282.
- Schon, D. (1983) *The Reflective Practitioner. How Professionals Think in Action*. Guildford: Biddles Ltd.
- Schriefer, J. (1995) Managing critical pathway variances. *Quality Management in Health Care* 3(2): 30-42.
- Schroeder, C. (1993) Nursing's response to the crisis of access, costs and quality in health care. *Advances in Nursing Science* 16: 1-20.

- Searson, F. (2001) Introducing bedside handovers. In: R. Winters & C. Munn-Giddings eds. *A Handbook for Action Research in Health and Social Care*. London: Routledge.
- Seedhouse, D. (1994) *Ethics: The Heart of Health Care*. Chichester: John Wiley & Sons.
- Shamian, J., Hagen, B., Hu, T-W., Fogarty, T.E. (1994) The relationship between length of stay and required nursing care hours. *Journal of Nursing Administration* 24(7/8): 52-58.
- Sharfstein, S.S. (1997a) Cost-effectiveness of psychiatric care. *American Journal of Psychiatry* 154: 723-724.
- Sharfstein, S.S. (1997b) The future of psychiatry. *Archives General Psychiatry* 54: 212-213.
- Sharma, T. & Kerwin, R. (1996) Biological determinants of difficult to treat patients with schizophrenia. *British Journal of Psychiatry* 169 (suppl. 31): 5-9.
- Shera, W. (1996) United States looks for answers in the new care blueprints. *Care Plan* March, 23-24.
- Sherif, M. (1935) A study of some factors in perception. *Archives of Psychology* 27, no. 187.
- Shaw, I. (1997) Assessing quality in health care services: lessons from mental health nursing. *Journal of Advanced Nursing* 26: 758-764.
- Sherman, H. & Flatley, M. (1980) Dissecting the hospital stay: a method for studying patient staging in hospital care. *Medical Care* 18: 715-730.
- Sherman, J.J. & Johnson, P.K. (1994) CNS as unit-based case manager. *Clinical Nurse Specialist* 8(2): 76-80.

- Shiell, A., Kenny, P., Farnworth, M.G. (1993) The role of the clinical nurse coordinator in the provision of cost-effective orthopaedic services for elderly people. *Journal of Advanced Nursing* 18: 1424-1428.
- Shikiar, M.S. & Warner, P. (1994) Selecting financial indices to measure critical path outcomes. *Nursing Management* 25(9): 58-60.
- Shore, M.F. & Beigel, A. (1996) The challenges posed by managed behavioural health care. *New England Journal of Medicine* 334(2): 116-118.
- Silverman, D. (1985) *Qualitative Methodology and Sociology*. Aldershot: Gower Publishing.
- Silverman, D. (1987) *Communication and Medical Practice*. London: Sage.
- Silverman, D. (1993) *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London: Sage.
- Sims, D. (1997) Joint training in nursing and social work: a healthy alliance. *Managing Clinical Nursing* 1: 150-152.
- Smith, G.B. (1997) Critical pathway and patient and family teaching protocol for major depression. *Nursing Case Management* 2(1): 23-32.
- Snyder-Halpern, R. (1998) Measuring organizational readiness for nursing research programs. *Western Journal of Nursing Research* 20(2): 2223-237.
- Social Services Inspectorate (1991) *Care Management and Assessment: Managers' Guide*. London: HMSO.
- Social Services Inspectorate (1995) *Social Services Departments and the Care Programme Approach: An Inspection*. London: HMSO.

Southwick, K. (1995) Strategies for healthcare excellence. Montclair Baptist and AtlantiCare break new ground with care paths for psych patients. *COR Healthcare Resources* 8(2): 1-8.

Spicker, P., Anderson, I., McGilip, R. (1995) Pathways through psychiatric care: the experiences of psychiatric patients. *Health and Social Care in the Community* 3(6): 343-352.

Spitzer, M. & Mundt, C. (1994) Interchanges between psychology and psychiatry: the continental tradition. *Current Opinion in Psychiatry* 7: 417-422.

Spradley, P. (1979) *Participant Observation*. New York: Rinehart & Winston.

St. Elizabeth's Medical Center (1995) *Multi-disciplinary Plan of Care For The Patient With Axis 1 Schizophrenia*. Boston: St. Elizabeth's Medical Center.

Stake, R. (1995) *The Art of Case Study Research*. California: Sage.

Stamps, P.L. & Piedmonte, E.B. (1986) *Nurses and Work Satisfaction: An Index for Measurement*. Ann Arbor: Health Administration Press.

Standing Nursing and Midwifery Advisory Committee (1999) *Addressing Acute Concerns*. London: HMSO.

Stein, L.I. (1967) The doctor/nurse game. *Archives of General Psychiatry* 16: 699-703.

Stein, K. & Milne, R. (1998) 'The NHS R&D health technology assessment programme'. In: M. Baker & S. Kirk eds. *Research and Development for the NHS*. Oxon: Radcliffe Medical Press.

Stephens, R. (1997) 'Setting up pathways in mental health'. In: J. Wilson ed. *Integrated Case Management. The Path to Success*. Oxford: Butterworth-Heinemann.

- Strauss, J.S. & Carpenter, W.T. (1972) The prediction of outcome in schizophrenia. I: characteristics of outcome. *Archives General Psychiatry* 17: 739-746.
- Svensk, U. (1996) Disease management at the system level - an effective way to improve health care. *International Journal of Health Care Quality Assurance* 9(7): 4-8.
- Suhonen, R., Valimaki, M. & Katajisto, J. (2000a) Individualized care in a Finnish healthcare organisation. *Journal of Clinical Nursing* 9: 218-227.
- Suhonen, R., Valimaki, M. & Katajisto, J. (2000b) Developing and testing an instrument for the measurement of individual care. *Journal of Advanced Nursing* 32(5): 1253-1263.
- Sullivan, P.J. (1993) Occupational stress in psychiatric nursing. *Journal of Advanced Nursing* 18: 591-601.
- Swanson, J.M. (1986) 'The formal qualitative interview for grounded theory'. In: W.C. Chenitz & J.M. Swanson eds. *From Practice to Grounded Theory*. California: Addison-Wesley.
- Tahan, H. (1993) The nurse case manager in acute care settings. *Journal of Nursing Administration* 23(10): 53-61.
- Tahan, H.A. & Cesta, T.G. (1994) Developing case management plans using a quality improvement model. *Journal of Nursing Administration* 24(12): 49-58.
- Tahan, H.A. & Cesta, T.G. (1995) Evaluating the effectiveness of case management plans. *Journal of Nursing Administration* 25(9): 58-63.

- Tanner, C.A., Benner, P., Chesla, C., & Gordon, D.R. (1993) The phenomenology of knowing the patient. *Image: Journal of Nursing Scholarship* 25: 273-280.
- Tarrier, N., Beckett, R., Harwood, S., Baker, A., Yusupoff, L. & Ugarteburu, I. (1993) A trial of two cognitive-behavioural methods of treating drug resistant residual psychotic symptoms in schizophrenic patients. *British Journal of Psychiatry* 162: 524-532.
- Tarrier, N., Yusupoff, L., Kinney, C., McCarthy, E., Gledhill, A., Haddock, G., Morris, J. (1998) Randomised controlled trial of intensive cognitive therapy for patients with chronic schizophrenia. *British Medical Journal* 317: 303-307.
- Tarrier, N., Wittkowski, A., Kinney, C., McCarthy, E., Morris, J. & Humphreys, L. (1999) Durability of the effects of cognitive-behavioural therapy in the treatment of chronic schizophrenia: 12 month follow-up. *British Journal of Psychiatry* 174: 500-504.
- Taylor, P.J. (1995) 'Schizophrenia and the risk of violence'. In: S. Hirsch & D. Weinberger eds. *Schizophrenia*. Oxford: Blackwell Science.
- Taylor, D., Mir, S. & Kerwin, R. (2000) Prescribing in schizophrenia. *Psychiatric Bulletin* 24: 106-108.
- Test, M.A. & Stein, L.L. (1980) Alternative to hospital treatment. *Archives General Psychiatry* 37, 409-412.
- Thomas, B. (1997) 'In-patient mental health nursing care'. In: B. Thomas, S. Hardy, P. Cutting eds. *Mental Health Nursing. Principles and Practice*. Chicago: Mosby.

- Thompson, K.S., Griffith, E.E.H. & Leaf, P.J. (1990) A historical review of the madison model of community care. *Hospital & Community Psychiatry* 41(6): 625-634.
- Thorell-Ekstrand, I. & Bjorvell, H. (1995) Nursing students' experience of care planning activities in clinical education. *Nurse Education Today* 15, 196-203.
- Tingle, J. (1995) Clinical protocols and the law. *Nursing Times* 91(29): 27-28.
- Tobin, C.R., Sabatte, E., Sandhu, A.S., Penafiel, E. (1998) A neonatal care map based on gestational age. *Neonatal Network* 17(2): 41-51.
- Tollefson, G.D., Beasley, C.M., Tran, P.V., Street, J.S., Krueger, J.A., Tamura, R.N., Graffeo, K.A. & Thieme, M.E. (1997) Olanzapine versus haloperidol in the treatment of schizophrenia and schizoaffective and schizophreniform disorders: results of an international collaborative trial. *American Journal of Psychiatry* 154(4): 457-465.
- Tonges, M. (1990) 'ProACT: The professionally advanced care team model'. In: G.G. Mayer, M.J. Madden & I. Lawrence eds. *Patient Care Delivery Models*. Rockville: Aspen.
- Towell, D. & Harries, C. (1979) *Innovations in Patient Care: An Action Research Study of Change in a Psychiatric Hospital*. London: Croom Helm.
- Townend, M. (1997) Mental health pathways to care. *Journal of Psychiatric and Mental Health Nursing* 4: 149-150.
- Tunmore, R. (1997) 'Looking forward'. In: B. Thomas, S. Hardy, P. Cutting eds. *Mental Health Nursing. Principles and Practice*. Chicago: Mosby.
- Travis, M.J. & Kerwin, R. (1997) Neuroimaging. *Current Opinion in Psychiatry* 10: 16-25.

- Tremblay, M-A. (1991) 'The key informant technique: A non-ethnographic application'. In: R. G. Burgess ed. *Field Research: A Sourcebook and Field Manual*. London: Routledge.
- Trist, E.L. & Bamforth, K.W. (1951) 'Some social and psychological consequences of the longwall method of coal-getting'. In: R. Glaser ed. *Classic Readings in Self Management: Teamwork*. Chicago: Organisational Design and Development Inc.
- Trnobranski, P.H. (1995) Implementation of community care policy in the United Kingdom: will it be achieved? *Journal of Advanced Nursing* 21: 988-995.
- Turner, B.S. (1987) *Medical Power and Social Knowledge*. London: Sage.
- Tyrer, P. (1998) Cost effective or profligate community psychiatry. *British Journal of Psychiatry* 172: 1-3.
- Tyrer, P., Evans, K., Gandhi, N., Lamont, A., Harrison-Read, P., Johnson, T. (1998) Randomised controlled trial of two models of care for discharged psychiatric patients. *British Journal of Psychiatry* 316(7125): 106-109.
- Tyrer, P., Coid, J., Simmonds, S., Joseph, P., Marriott, S. (1999) *Community Mental Health Teams for People with Severe Mental Illnesses and Disordered Personality* (Cochrane Review). In: The Cochrane Library, Issue 1, 1999. Update Software, Oxford.
- UKCC (1992) *Scope of Professional Practice*. London: UKCC.
- Uzark, K., Frederick, C., Lamberti, J.J., Worthen, M. H., Ogino, M.T., Mainwaring, R.D., Moore, J.W. (1998) Changing practice patterns for children

- with heart disease: a clinical pathway approach. *American Journal of Critical Care* 7(2): 101-105.
- van Os, J., McKenzie, K. & Jones, P. (1997) Cultural differences in pathways to care, service use and treated outcomes. *Current Opinion in Psychiatry* 10: 178-182.
- Velasco, F.T., Ko, W., Rosengart, T., Altorki, N., Lang, S., Gold, J.P., Krieger, K.H., Isom, O.W. (1996) Cost containment in cardiac surgery: results with a critical pathway for coronary bypass surgery at the New York Hospital-Cornell Medical Centre. *Best Practice Benchmarking HealthCare* 1(1): 21-28.
- Verbrugge, L. (1980) Health diaries. *Medical Care* 18(1): 73-95.
- von Otter, C. (1991) 'The application of market principles to healthcare'. In D.J. Hunter ed. *Paradoxes of Competition for Health*. Leeds: Nuffield Institute for Health Services Studies.
- Voepel-Lewis, T. & Malviya, S. (1997) Evaluation of a case management model for preanesthesia screening. *Journal of PreAnesthesia Nursing* 12(6): 396-401.
- Walsh, K. (1997) Encounters, endings and temporality in psychiatric nursing. *Journal of Advanced Nursing* 25: 485-491.
- Walton, P. (2000) Psychiatric hospital care - a case of the more things change, the more they remain the same. *Journal of Mental Health* 9(1): 77-88.
- Waterman, H., Water, K., Awenat, Y. (1996) The introduction of case management on a rehabilitation floor. *Journal of Advanced Nursing* 24: 960-967.

- Waters, K. (1985) Team nursing. *Nursing Practice* 1: 7-15.
- Waters, K.R. & Easton, N. (1999) Individualized care: is it possible to plan and carry it out. *Journal of Advanced Nursing* 29(1): 79-87.
- Webb, C. (1989) Action research: philosophy, methods and personal experiences. *Journal of Advanced Nursing* 14: 403-410.
- Webster, R. (1995) Research for a happy ending. *Nursing Management* 1: 23.
- Wedderburn Tate, C. (1996) Managed care scare. *Nursing Management* 2(8): 20-21.
- Weiland, D.E. (1997) Why use clinical pathways rather than practice guidelines. *American Journal of Surgery* 174(6): 592-595.
- West, E. & Newton, J. (1997) Clinical guidelines. An ambitious national strategy *British Medical Journal* 315: 324.
- Wheeler, K. (1997) 'Critical pathways in home care: Developing a psychiatric home care program'. In: P.C. Dykes & K. Wheeler eds. *Planning, Implementing and Evaluating Critical Pathways*. New York: Springer Publishing Co.
- White, S.J. (1997) Evidence-based practice and nursing: the new panacea? *British Journal of Nursing* 6(3): 175-178.
- Wieczorek, P. (1995) Developing critical pathways for the operating room. *AORN Journal* 62(6): 925-927,929.
- Wieselgren, I-M. & Lindstrom, L.H. (1996) A prospective 1-5 year outcome study in first-admitted and readmitted schizophrenic patients; relationship to heredity, premorbid adjustment, duration of disease and education level at index admission and neuroleptic treatment. *Acta Psychiatr Scand* 93: 9-19.

- Wigfield, A. & Boon, E. (1996) Critical care pathway development: the way forward. *British Journal of Nursing* 5(12): 732-735.
- Wilson, H.S. (1986) 'Usual hospital treatment in the United States community mental health system: A dispatching process'. In: W.C. Chenitz & J.M. Swanson eds. *From Practice to Grounded Theory*. California: Addison-Wesley Publishing.
- Wilson, J. (1995) Multi-disciplinary pathways of care: a tool for minimizing risk. *British Journal of Health care Management* 1: 720-722.
- Wilson, J. (1997a) 'Introduction to integrated care management - Introducing multidisciplinary pathways of care into an organisation through project, risk and change management'. In: J. Wilson ed. *Integrated Case Management. The Path to Success*. Oxford: Butterworth-Heinemann.
- Wilson, J. (1997b) 'Multidisciplinary pathways of care as a risk management tool - improving communication, documentation and collaboration of care delivery'. In: J. Wilson ed. *Integrated Case Management. The Path to Success*. Oxford: Butterworth-Heinemann.
- Wilson, M. (1996) 'Asking questions'. In R. Sapsford & V. Jupp eds. *Data Collection and Analysis*. London: Sage.
- Wing, J.K., Rix, S., Curtis, R.H., Beadsmoore, A. & Lelliott, P. (1998) Protocol for assessing services for people with severe mental illness. *British Journal of Psychiatry* 172: 121-129.
- Wistow, G., Knapp, M., Hardy, B. & Allen, C. (1992) From providing to enabling: local authorities and the mixed economy of care. *Public Administration* 70: 24-45.

- Witz, A. (1992) *Professions and Patriarchy*. London: Routledge.
- Wolfgang Fleischhacker, W. (1999) The psychopharmacology of schizophrenia. *Current Opinion in Psychiatry* 12: 53-59.
- Wurzbach, M.E. (1998) Managed care: moral conflicts for primary health care nurses. *Nursing Outlook* 46(2): 62-66.
- Yaksic, J.R., DeWoody, S. & Campbell, S. (1996) Case management of chronic ventilator patients: reduce average length of stay and cost by half. *Nursing Case Management* 1: 2-10.
- Young, A. (1994) *Law and Professional Conduct in Nursing*. Scutari, London.
- Young, B. (1996) 'Shared care or integrated care? Managing clinical services for chronic disease across the interfaces'. In: P. Lees ed. *Navigating the NHS: Core Issues for Clinicians*. Oxon: Radcliffe Medical Press.
- Zacharias, S., Rodriguez-Garcia, A., Honz, N. (1998) Development of an alcohol withdrawal clinical pathway: An interdisciplinary process. *Journal of Nursing Care Quality* 12(3): 9-18.
- Zander, K. (1988a) Nursing case management. Resolving the DRG paradox. *Nursing Clinics of North America* 23(3): 503-520.
- Zander, K. (1988b) Nursing case management: strategic management of cost and quality outcomes. *Journal of Nursing Administration* 18(5): 23-30.
- Zander, K. (1993) *Nursing Case Management*. New York: The American Nurses Association.
- Zander, K. & Etheridge, M.L. (1989) *Collaborative Care: Nursing Case Management*. Chicago: American Hospital Publishing.

Zipursky, R., Seeman, M.V., Bury, A., Langevin, R., Wortzman, G. & Katz, R. (1997) Deficits in gray matter volume are present in schizophrenia but not bipolar disorder. *Schizophrenia Research* 26: 85-92.

Zipursky, R.B. & Kapur, S. (1998) New insights into schizophrenia from neuroimaging. *Current Opinion in Psychiatry* 11: 33-37.

Appendix 1

Multi-disciplinary Care Pathways for In-patients with Schizophrenia

Framework For Use

Summary

- i) The care pathway is a single multi-disciplinary documentation package given equal legal status as usual care / progress notes.
- ii) The care pathway is completed by all care providers.
- iii) The care pathway replaces individualised discipline notes. Only care pathway documentation can be used for this pilot project.
- iv) All patient and process information to be written in the care pathway case note folder.

Description of use

- 1) The care pathway has 5 pre-identified problems commonly associated for in-patients with schizophrenia (>3 ads. 3 yrs.); disturbed psychotic state which may result in the patient becoming a danger to self or others; poor knowledge about illness process, symptoms & access to psychiatric services; poor compliance with medication; deficits in social and occupational functioning; problems in securing discharge arrangements.
- 2) Problems, interventions and outcomes not identified here are charted and delivered by exception. They are written on the 'Problems, Interventions & Outcomes Not Covered By The Care Pathway' form.
- 3) The problems identified are common to all professional groups. All professional groups work towards resolving these problems by delivering pre-specified interventions.
- 4) Eight groups of interventions (categories) have been identified; assessment on admission and throughout length of stay (LOS); teaching on admission and throughout LOS; discharge planning; psychosocial interventions; risk assessment & safety in hospital; Mental Health Act; medical treatmentPage 1s on admission and throughout LOS; occupational therapy & interventions throughout LOS.
- 5) The CPRN's, IPCM or allocated nurses (those aware of the principles of care pathways) will judge whether to make a daily entry into the 'multi-disciplinary notes' section. Allocated nurses who are unaware of the principles of care pathways must make a shift-by-shift entry on the daily progress of the patient. As far as practicable, pilot patients should be allocated to RN's who are aware of the principles of care pathways.
- 6) The care provider using this care pathway would not include information contained in the care pathway. Example the CPRN would not write in the MDT notes: *'the patient has a BPRS score of.....the patient appears to have little insight into their illness and reasons for admission'*.
- 7) Each discipline follows the care pathway and completes the interventions as prescribed. If the intervention is completed, the provider signs the document and dates it. For example, on Page 1 of the care pathway, if the CPRN completes the admission 'front sheet' within 2 hours of admission, s/he signs their name in the 'completed' column and inserts the date in the 'date'

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column. If the intervention cannot be completed, the provider looks at the variance tracking codes, selects the appropriate code and inserts it into the variance column. The provider completes the variance tracking sheet by inserting the date, written note on the variation, its code, action taken, signature and designation. For example, if the CPRN can not complete the admission 'front sheet' because the patient is too aggressive, the CPRN inserts a variance code for the patient being aggressive (A8) in the 'variance' column. S/he then goes to the variance tracking part of the folder, and completes the variance tracking form. It could read, *"unable to undertake assessment because the patient was too aggressive"* for the 'variation' part, and *"will re-assess in 4 hours time following medication"* for the 'action taken' part. Later, if the intervention can be delivered, the provider signs and dates the intervention to indicate it has been completed. If on subsequent attempts, the intervention is still unable to be delivered, it is recorded on the variance tracking form.

8) It is the responsibility of the IPCM (charge nurse / other mental health professional) to monitor the overall delivery of multi-disciplinary interventions within the care pathway (additional problems added) and for outcomes achieved. This may occur on a weekly basis (more if necessary). This will provide an up-to-date retrospective and concurrent audit of what needs to take place for outcomes to be achieved.

9) Each discipline follows the care pathway and audits the patient's progress to see if the patient achieves pre-determined outcomes of care. The documentation procedure for point 5 is applied here.

10) Care pathway documentation replaces daily note keeping. If changes in the patients condition occur and are not covered within the care pathway, this information would be documented in the 'multi-disciplinary notes section'. Examples may include: suicide attempt, physical / verbal aggression, absconsion, changes in levels of observation, changes in activity plans, alterations to psychological interventions.

11) If the patient is transferred to Bevan Ward (Psychiatric Intensive Care Unit) or any other acute admission ward, the care pathway is terminated and usual care documentation used.

Organisational changes to implement care pathways

1) 1 IPCM and 2 CPRN's have been identified for this pilot. Identified patients to follow this care pathway should be admitted by 1 of these three key personnel (if unavailable, another RN should complete the documentation). At the next available opportunity, the CPRN should check the documentation and update as specified on the care pathway. Roles for the OT, Psychologist, RMO, SHO have also been locally agreed.

2) All admitted patients (max. n=8) who fit the criteria for care pathways will be allocated to one of the 2 CPRN groups. To ensure the correct balance in group numbers, as 1 trial patient is admitted into a CPRN group, a patient from that group will be allocated to a non-CPRN group.

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3) To ensure CPRN / IPCM cover, annual leave will be planned in advance. For periods of annual leave, no additional patients will be admitted onto the pilot project.

4) 2 LW's have been identified to case manage the 8 prospective pilot patients. All patients admitted onto the care pathway will be allocated to an LW within the first week of admission.

5) There will be 1 centralised collection of documentation notes and these will be stored in the nursing office. Care pathway documentation will be identified with a sticker located in the middle of the folder stating that the patient is on a care pathway. The patient will also be identified by looking at the ward office patient information board. They must not be removed from the ward area.

6) Nurses who administer prescribed medication to pilot patients must be careful to record all refusals ect on the reverse of the medication chart. This information will be used for variance tracking purposes.

7) Either the IPCM or the CPRN should attend weekly management, ward and CPA rounds and complete the care pathway for pilot patients.

Pre-identified Problems on Admission & LOS

1) Disturbed Psychotic State Which May Result In The Patient
Becoming A Danger To Self Or Others

2) Poor Knowledge About Illness Process, Symptoms & Access
To Psychiatric Services

3) Poor Compliance with Medication

4) Deficits In Social & Occupational Functioning

5) Problems In Securing Discharge Arrangements: Accommodation,
Benefits, Support In The Community.

(Any other problems, chart and deliver by exception)

Problems, Interventions & Outcomes Not Covered By The Care Pathway

Problems	Interventions	Outcomes	Evaluation	Date & Desn.
Problem	Intervention	Outcomes	Evaluation	Date & Desn.

<u>Category (Assessment)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
<p>Assessment on Admission and Throughout LOS</p> <p>CPRN complete admission 'front sheet' within 2 hours of admission</p> <p>CPRN orientate patient to ward within 1 hour of admission.</p> <p>SHO initiates medical examination within 24 hours of admission.</p> <p>WC fax details of admission to GP & NWLT within 24 hours of admission.</p> <p>LW complete 'needs' assessment within 10 working days of admission.</p> <p>RMO ensures patient seen in first ward / management round following admission and then 2 weekly.</p>	<p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p>	<p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p>	<p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p> <p>*****</p>	
<p>If patient has more than 3 admissions in 12/12 RMO consider referral for rehab. team within 3 weeks of admission.</p> <p>Decision:</p> <p>CPRN document further assessment / untoward events in multi-disciplinary notes as required.</p>	<p>*****</p> <p>*****</p>	<p>*****</p> <p>*****</p>	<p>*****</p> <p>*****</p>	

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Category (Assessment)					Completed	Variance	Date	Comments
SHO re-assess mental state weekly and document in multi-disciplinary notes.					*****	*****	*****	
Completed.					*****	*****	*****	
Wk.					*****	*****	*****	
1					*****	*****	*****	
3					*****	*****	*****	
5					*****	*****	*****	
7					*****	*****	*****	
9					*****	*****	*****	
11					*****	*****	*****	
13					*****	*****	*****	
15					*****	*****	*****	
17					*****	*****	*****	
19					*****	*****	*****	
21					*****	*****	*****	
23					*****	*****	*****	
Wk.					*****	*****	*****	
2					*****	*****	*****	
4					*****	*****	*****	
6					*****	*****	*****	
8					*****	*****	*****	
10					*****	*****	*****	
12					*****	*****	*****	
14					*****	*****	*****	
16					*****	*****	*****	
18					*****	*****	*****	
20					*****	*****	*****	
22					*****	*****	*****	
24					*****	*****	*****	
Brief Psychiatric Rating Scale								
CPRN complete BPRS within 3 days of admission. Score:								
CPRN complete BPRS 2 weeks from admission. Score:								
CPRN complete BPRS 4 weeks from admission. Score:								
CPRN complete BPRS 6 weeks from admission. Score:								
CPRN complete BPRS 8 weeks from admission. Score:								
CPRN complete BPRS 10 weeks from admission. Score:								
CPRN complete BPRS 12 weeks from admission. Score:								
CPRN complete BPRS 14 weeks from admission. Score:								
CPRN complete BPRS 16 weeks from admission. Score:								
CPRN complete BPRS 18 weeks from admission. Score:								
CPRN complete BPRS 20 weeks from admission. Score:								
CPRN complete BPRS 22 weeks from admission. Score:								
CPRN complete BPRS 24 weeks from admission. Score:								

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Assessments)</u>					<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
OT complete initial assessment by 1st. week of admission.					*****	*****	*****	
OT complete aims and objectives to cover motivation, ADL needs and role/habits by 2nd. week of admission (document on 'problems not covered by care pathway' form).								
OT review aims and objectives weekly (document on care pathway).								
Completed.	Variance.	Date	Completed.	Variance.				
Wk.			Wk.					
3		4						
5		6						
7		8						
9		10						
11		12						
13		14						
15		16						
17		18						
19		20						
21		22						
23		24						
OT completes ADL assessment by 5th week of admission if decision made for supported accommodation (mental state reached plateau).								
IPCM raise need for PT service every 2 weeks from admission.								
Completed.	Variance.	Date	Completed.	Variance.				
2		4						
6		8						
10		12						
14		16						
18		20						
22		24						
If patient require PT referral, SHO writes letter within 5 working days of referral decision made.								

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Teaching)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
Teaching on Admission and Throughout LOS CPRN inform about advocacy services within 2 hours of admission. CPRN assess baseline knowledge on illness history; symptoms; support mechanisms; disease / medication management; levels of cognitive functioning within 3 days of admission. CPRN develop therapeutic alliance within 1 week of admission. If patient assessed to have impaired cognitive functioning, teaching / information input should be 10 minute sessions daily for each week on the programme. Content should be patient focused, directed towards changing behaviour, easy to understand.				
Teaching Programme No. 1) CPRN educate patient on reasons for hospital admission i.e. what has gone wrong, risk to self or others ect by 2nd. week of admission. By end of 2nd. week patient should show awareness of reasons for admission. No. 2) CPRN educate patient on reasons for medication and compliance by 3rd. week of admission. By end of 3rd. week, patient should demonstrate some knowledge of their medication, effects and side effects. No. 3) CPRN educate patient on symptoms of their disorder and explore patients' perceptions by 4th week of admission. By end of 4th. week, patient should state 3 symptoms causing them distress. No. 4) CPRN explore with the patient experiences and reasons for relapse by 5th. week of admission. By end of 5th. week, the patient should demonstrate their understanding of relapse by stating 3 symptoms particular to them. No. 5) CPRN educate the patient on how to access the psychiatric services, role of key worker, GP by 6th. week of admission.				

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<u>Category (Teaching)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
By end of 6th. week, the patient will demonstrate their understanding of mental health services by stating 2 access points. No. 6) If patient placed on section 2/3 of mental health act, CPRN spend 30 minutes each week to ensure understanding of rights (MHRT,advocacy services, solicitors). Patient will demonstrate awareness of MHA rights upon application. If any component of teaching programme unachieved, CPRN redeliver following 6 week block and document the corresponding number below on care pathway (only 1 component per week). Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____ Outcome No. _____				

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Discharge Planning)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
Discharge Planning CPRN identify patients named LW: _____ CPRN refer patient to NWLT within 24 hours of admission if no identified LW: _____ Duty worker assess patients' needs within 10 working days of admission and allocated to named LW: _____ CPRN arrange 1st. CPA within 7 working days of admission. 10 days for a formal admission. Date: _____ CPRN complete CPA form and distribute to relevant parties within 24 hours of completion. By 4th week of admission decision made for independent, supported or continuing rehabilitation accommodation. Decision: _____ Independent Housing If patient judged to be fit for independent accommodation, and patient has own flat, LW ensure this is habitable (inclusive of essential services) by 10th. week of admission. If patient requires flat, LW writes letter to HPU by 5th. week of admission informing them of need for temporary housing in 2 weeks time. If patient deemed vulnerable, but refuses supported accommodation & has no accommodation and ready for discharge, LW writes letter to HPU. LW secures increased support in the community. Supported Housing If patient deemed to be long term vulnerable, LW assess for type of supported accommodation. Type: _____ LW contact hostels to establish vacancy list. For hostels with vacancy, send out referrals by 5th. week (low support: Marsh Hill, Peter Bedford Trust). Identify hostels referred too: 1. _____ 2. _____				

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Discharge Planning)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
Low support accommodation to be secured by 12th week of admission. If more intensive support required, LW refer to Park Lodge, Nicholas House, Greenwood Road, Fuldon Road, Queensdown Road, Whiston Road by 5th week of admission. Identify hostels referred too: 1. 2. 3. 4. Accommodation to be secured by 16th week of admission. If patient requires supported accommodation and has forensic/drug history, LW refer to Greenwood Road or St. Martin of Tours by 5th. week of admission. Identify hostels referred too: 1. 2. 3. Accommodation to be secured by 16th. week of admission. If following first round of referral, no supported accommodation secured, LW re-establish vacancy list and make applications by 17th week of admission. Identify hostels referred too: 1. 2. 3. 4. Accommodation to be secured by 22nd. week of admission If accommodation not found by 22nd. week of admission, LW follow pathway to securing independent accommodation with increased community support.				

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Discharge Planning)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
<u>Rehabilitation</u> If patient requires Joshua / Homerton Row, RMO send referral by 5th. week of admission. Report received on these types of rehab. settings by 11th. week of admission. If accepted for Joshua / Homerton Row patient should be ready for transfer by 18th. week of admission. LW arrange final care planning meeting 1 week before expected discharge. Date set: _____ Date completed: _____ WC faxes details to GP within 2 hours of patient discharge.				
<u>Day care</u> OT and LW discuss referral plan for community services (Mind Employment, Day Centres, CPOT). Name of referring provider: _____ Type of services required: 1) _____ 2) _____ 3) _____ 4) _____ Referring provider makes application by 5th week of admission. By 10th week of admission, patient accepted into community services.				
<u>Benefits</u> By 1st. week of admission, CPRN establish if patient receiving benefits. Result _____ If patient not receiving income support, CPRN complete A1 booklet and return to DSS by 2nd week of admission. Patient to have received income support by 4th. week of admission.				

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

Category (Psychosocial Interventions)					Completed	Variance	Date	Comments
Psycho-social Interventions PT perform 1st. assessment three weeks from receipt of referral letter. PT perform 2 further weekly assessment sessions using either psychometric scales, problem focused interviewing or criterion based tests. PT draw up plan of care (problem areas to be addressed, interventions to be used and outcomes to be evaluated) within 1 week of completing assessment package (charted on care pathway documentation). Areas of intervention (voices work, delusion modification, social/emotional work, relapse prevention, coping with illness counselling, behavioural management work, family work). PT hold 10-20 weekly contact sessions starting 1 week from completion of assessment package (progress towards outcomes charted on care pathway documentation).					*****	*****	*****	
Session 1		Session 2			*****	*****	*****	
3		4			*****	*****	*****	
5		6			*****	*****	*****	
7		8			*****	*****	*****	
9		10			*****	*****	*****	
11		12			*****	*****	*****	
13		14			*****	*****	*****	
15		16			*****	*****	*****	
17		18			*****	*****	*****	
19		20			*****	*****	*****	
-								

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Risk Assessment & Safety in Hospital)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
<p>Risk Assessment & Safety in Hospital</p> <p>CPRN perform risk assessment within 1 hour of admission (components 8-16, 19-20 & rating scales).</p> <p>Patient remain ward based for first 24 hours of admission.</p> <p>If patient wishes to leave ward during and following first 24 hours (informal), CPRN re-assess mental state, risk factors and inform ward / duty doctor. Consider detention under MHA (document in notes).</p> <p>If mental state deteriorates and patient deemed to be at risk, unwilling to stay and ward doctor not present, CPRN consider using Section 5(4) nurses holding powers to secure safety of the patient (document in notes).</p> <p>If mental state appears stable and patient informal following first 48 hours, patient should be persuaded to spend time within hospital grounds.</p> <p>If mental state appears stable and patient informal following 1 week of admission, patient should be persuaded to spend time outside the hospital grounds.</p> <p>If mental state continues to improve, and patient informal following 2 weeks of admission, patient should be persuaded to spend periods of leave off the ward at home / friends.</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p> <p>Leave commenced _____ Leave ended _____</p>				

Multi-disciplinary Care Pathway for In-Patients with Schizophrenia

<u>Category (Risk assessment and safety in hospital)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
<p>If patient continues to exercise a problem in securing safety of self / others, CPRN re-assess factors weekly and document in risk assessment package.</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p>				
<p>If patient requires close / special observations, CPRN document reasons in notes and progress on forms (adhere to hospital policy).</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p> <p>Date commenced _____ Date ended _____</p>				
<p>If patient becomes absent without leave, CPRN document dates on care pathway (adhere to hospital policy).</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p> <p>Date AWOL _____ Date of return _____</p>				

<u>Category (Medical Treatments)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
Medical Treatments on Admission & LOS				
<u>On admission</u>				
If patient aggressive on admission / LOS, Px. Lorazepam PRN.				
If patient non-compliant on previous medication regimen at point of relapse, restart on same dose and drug type; if necessary increase over 6 week trial period.				
If patient relapsed on past medication regimen, Px Respiridone; if necessary increase over 10 week trial period.				
If patient exhibits side effects of medication, Px. Procyclidine 5mg BD.				
<u>After 10 weeks of admission</u>				
If patients mental state improved on typical neuroleptic over 10 week trial period, Px. appropriate depot formulation.				
If patients mental state not improved over 10 week trial period, Px. other class of neuroleptic such as Olanzapine and increase over 10 week trial period.				
If patients mental state not improved over 20 weeks of admission, SHO undertake complete review of medication history (document in multi-disciplinary notes).				
<u>By 20th. week of admission</u>				
If decision taken to Px. Clozapine, baseline WBC taken. If WBC normal, Px. Clozapine 12.5 mg initial dose (night) and increase by BNF limits for 28 days of treatment (split 450mg. / day max).				
SHO take weekly WBC's for first 18 weeks of trial and 2 weekly for duration of treatment.				
If patient shows intolerance to Clozapine or WBC abnormal, stop immediately and Px. the most effective past medication regimen, or any untried anti-psychotic medication.				

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Category (Medical Treatments)	Completed	Variance	Date	Comments
By 25th. week of admission				
If patients mental state improved on Clozapine treatment over 6 week trial period, continue to monitor over 6 month trial period.				
If patients mental state not improved on Clozapine treatment over 4 week trial period, increase dose and monitor over 6 month trial period.				
If patients mental state not improved over 6 months, Px. the most effective past medication regimen, or any untried anti-psychotic medication.				
RMO review medication regimen 2 weekly. Insert changes on medication chart.				
Completed	Variance	Completed	Variance	Date
1		2		
3		5		
7		9		
11		13		
15		17		
19		21		
23		25		
CPRN Ax. Px. medication as per chart. All refusals / omissions recorded on drug chart.				

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<u>Category (Occupational Therapy Treatments)</u>	<u>Completed</u>	<u>Variance</u>	<u>Date</u>	<u>Comments</u>
Occupational Therapy Interventions Throughout LOS By 2nd. week of admission, the patient will attend low level groups on the ward (Tuke ward project group; Activity group; Sports group; Pottery). Specify Groups To Attend: 1) 2) 3) 4) The patient will be monitored to ensure attendance in low level groups throughout hospital admission (document in multi-disciplinary notes). If patient refuses to attend low level groups, OT will examine reasons in 1-2-1 contact sessions by 3rd. week of admission. Patient attends groups following this 1-2-1 session work. By 5th. week of admission, patient will attend more structured high level groups such as skills based groups, creative groups and work skills groups (dependent on levels of functioning) Specify Groups To Attend: 1) 2) 3) 4) The patient will be monitored to ensure attendance in high level groups throughout hospital admission (document in multi-disciplinary notes). If patient refuses to attend more structured groups, OT will examine reasons in 1-2-1 contact sessions. 1-2-1 contact continues until patient's level of motivation improves. Patient attends structured sessions following this 1-2-1 contact work.				

<u>Category (mental Health Act)</u>	<u>Completed</u>	<u>Variance</u>	<u>Signed</u>	<u>Comments</u>
<u>Mental Health Act</u> <u>Patient admitted on Section 4 / placed on Section 5(2)</u> CPRN check legality of section papers upon receipt of application. CPRN read MHA rights to patients upon application (completed when patient able to understand). If RMO deems further detention required, CPRN ensures ASW and GP informed. CPRN inform patient about advocacy services (MIND, Patients Council). <u>Patient admitted / placed on Section 2/3</u> CPRN check legality of section papers upon receipt of application. CPRN read MHA rights to patients upon application (completed when patient able to understand). CPRN inform patient about advocacy services (MIND, Patients Council, Solicitors, Hospital Managers, MHRT). CPRN provide leaflet for appeal under sec 2/3. CPRN prepare report 5 days upon receipt of letter from MHA adm. <u>Consent to Treatment</u> If patient on section 3, consent to Tx. form (58) signed upon 3/12 of application. Date Section 3 applied:_____ 3/12 Tx. Date: _____ Consent to Tx. form signed: _____ If patient refuses Tx., CPRN contact Sec. 12 Doc. within 24 hours. Second Opinion form signed: _____				

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Category (Mental Health Act)					Completed	Variance	Date	Comments
Detained patients' leave under Section 17 If patient is detained, CPRN assess patients' suitability for leave and section 17 formed signed by RMO.					*****	*****	*****	
					*****	*****	*****	
					*****	*****	*****	
					*****	*****	*****	
					*****	*****	*****	
					*****	*****	*****	
					*****	*****	*****	
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