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The subjective experiences of people who regularly receive depot neuroleptic medication in the community

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Abstract

Little has been written on the subjective experiences of people who receive depot injections in the community. The authors of this paper have identified distinct gaps in the literature in terms of the views of service users regarding this particular intervention. Existing studies tend to focus upon the side effects of depot neuroleptic medication and the attitudes of Community Mental Health Nurses (CMHNs) towards administering depot medication and issues of compliance and non-compliance. Mental health nurses are frequently perceived as adhering solely to a biomedical approach to patient care in their practice and the therapeutic aspects of their role is frequently unacknowledged. This paper explores how, within the process of giving a depot injection, CMHNs are able to carry out an assessment of their client's needs as well as being someone who is consistent, reliable and supportive. This means that the process of giving a depot injection may be considered as a therapeutic intervention. Qualitative data were obtained through the administration of a semi- structured interview schedule that was constructed and consisted of a range of questions that elicited service users views and opinions related to their experiences of receiving depot neuroleptic medication in the community. The relationship between patient and nurse, as this study reveals, was one that was not only therapeutic, but also provided a forum where psychosocial and clinical issues could be discussed and explored. Crucially, the service users felt they did have a role and an influence in the delivery of their care.

Keywords: community care, depot injections, medication, mental health, psychiatric nursing, therapeutic interventions

Introduction

Schizophrenia is often considered the most serious of psy- chiatric conditions (Watkins 2002). It usually occurs in late adolescence or early adulthood. Some people make a full recovery, some may experience relapse and others may become resistant to treatment. Neuroleptic medication is used in the management of the condition, helping to reduce symptoms, and for many, preventing relapse (Smith *et al*. 2002). Community Mental Health Nurses (CMHNs) are involved in the administration of depot injections and may run clinics in the community. Their role is important in assisting clients to maintain optimum levels of well-being thus avoiding distress and potential hospitalization.

For some time, the government has been encouraging an approach to health and social care that involves practitioners being more responsive to the views of service users in relation to their experiences of inpatient and community care. For instance, the *NHS and Community Care Act* (Department of Health 1990a) and the *Care Programme Approach* (Department of Health 1990b) in the UK, calls for more attention to be paid to detailed and holistic assessments of the needs of all individuals suffering from severe and enduring mental illness. Priori- ties include housing, employment, education, medical and psychiatric care, social networks and risk assessment. More recent publications have outlined government strategies which aim to tackle issues pertinent to users, carers and significant others regarding mental health provision through the *National Service Frameworks* (Department of Health 1999a) and *Our Healthier Nation* (Department of Health 1999b). Despite this drive by the policy makers, there still appears to be gaps in the literature. This study presents the views of service users diagnosed with schizophrenia and living in the community. The main focus was to establish their perceptions and views about receiving regular depot injections.

Review of the literature

The health literature considered in the review was accessed using *Cumulative Index of*

Nursing & Allied Health Lit- erature (1982–2005), *Literature Reference for Psychology* (1991–2005) and *National Library of Medicine* (1966– 2005). A search of the Social Sciences literature was conducted using *International Bibliography of the Social Sciences* (1966–2005). The keywords mental health, schizophrenia, psychosis and depot medication and depot neuroleptic medication were used. Results from the various electronic searches totalled 35. These were checked and duplicate articles identified and excluded. The remaining 22 articles that specifically addressed depot neuroleptic medication issues and psychosis were logged and classified. Further information was obtained from published books, dissertation abstracts and conference proceedings related to the field of study. The review process was guided by methods used in the research literature (Gould 1994). Thus a critical analysis of each paper involved a visual search for themes that were categorized. A total of three key themes emerged from the review. These themes are used as a structure to discuss the content of the published papers.

Attitudes of CMHNs

A majority of the papers that were examined explored the attitudes of CMHNs to give depot medication. One paper looked at sexuality issues, with a main focus upon sexual dysfunctions that may be associated with taking depot medication. Over 60% of patients mentioned medication in relation to sexual problems. However, none of the respondents in this study were routinely asked by practitioners about medication in relation to sexuality issues (McCann 2000). Another study exploring the attitudes of practitioners found that 17% of CMHN respondents had encountered clients becoming sexually aroused during the administration of a depot injection and many practitioners reported feeling uncomfortable (Cort *et al*. 2001). Another paper examined ethical concerns and discussed the meaning that CMHNs attribute to the administering of depot medication. The findings suggested that care planning and consultation with patients was imperative in enhancing patient autonomy (Svedberg *et al*. 2000). More recently, a study involving 70 CMHNs reported that 23% found little time for consultations, 34% felt that depot injections were old-fashioned and 44% thought that they were stigmatizing (Patel *et al*. 2005).

Professional roles

One study that looked at the period spent with patients discovered that the average time spent with a person receiving their depot injection in the clinic was between 1 and 4 min (Muir-Cochrane 2001). Other studies looked at the role of practitioners in assessing side effects and educating people about their medication. Another study investigated the nurses' role in assessing the experience of pain and discomfort at the injection site and its relation to patients' refusal of depot injections (Bloch *et al*. 2001). Thirty-four people were interviewed and the results showed that depot injections caused pain, which was most intense immediately after the injection. The pain declined after 2 days and disappeared by the 10th day. The participants reported that Zuclopenthixol was more painful than other depot medications.

Some studies considered the role of nurse practitioners in relation to the administration of depot neuroleptic medication. A national survey of 640 nurse practitioners found that although 61% gave depots regularly, 70% had received no mental health training in the previous 5 years. Just over half said that they regularly monitor for adverse side effects. Furthermore, where mental health support is concerned, a very large number (96%) had no contact with a psychiatrist, while 37% said that they had some contact with a CMHN. This is despite the fact that 40% of people attending primary care services were found to be experiencing mental health problems (Gray *et al*. 1999).

Compliance issues

Although several studies investigated the issues involved in adherence with medication regimens (Kemp *et al*. 1996), it emerged that few studies specifically looked at non-compliance with depot medication in relation to service users' views. Of the studies that did consider the topic, Angermeyer *et al*. (1999) canvassed 307 patients to deter- mine their views of medication. The perceived benefits of taking medication proved to be the main reason for patients' compliance. Non-compliance was owing to unwanted side effects and a lack of acceptance of the necessity of pharmacological treatment. Conversely, a positive relationship with the nurse giving the injection and a posi- tive attitude of significant others, such as family members, towards neuroleptic treatment contributed to patients' medication compliance. A case for providing psycho- education in enhancing adherence was presented. Another study (Azrin & Teichner 1998) considered the use of an educational programme for medication compliance involv- ing the patient alone and the patient with a family member. The group of patients that received the training alone had a 73% adherence rate. However, adherence increased to 93% in the group that involved a family member in the programme. Fenton *et al*. (1997) recognized the importance of social supports and the quality of the therapeutic alliance as determinants that may affect adherence with medication regimens. They suggest a health belief model and potential interventions to improve the likelihood of collaboration. Jarboe (2002) discussed risks related to relapse and re-hospitalization and outlined the increased cost of care. Furthermore, the author recognizes the impor- tance of the assessment of patient attitudes and expecta- tions about their medication and the provision of educational interventions.

In relation to the current literature outlined above, it became apparent that several studies relating to medication focussed upon side effects, staff attitudes and compliance issues. However, there appeared to be a distinct lack of information around engagement and of potential therapeutic activity between the nurse and patient in the clinical environment. Moreover, there was little mention of services user views and opinions, and scant discussion or recognition of the valuable role of the CMHNs.

The study

This study had two aims. The first aim was to examine the subjective experiences of people receiving regular depot injections living in the community. Second, the authors of this study wished to examine the perceived role and responsibilities of the CMHN, from a client perspective, in giving depot medication.

Methods

Sample and context

The sample consisted of 10 people who regularly attended a London health clinic to receive their depot injection (Table 1). The participants were unknown to the research- ers. The depot clinic was held in a clinical room within the health centre. Many of the clients had attended this clinic for a number of years. Some of the clients had weekly injections, while others received their injections every 2 weeks, monthly or every 6 weeks. The participants of the study received depot injections consisting of neuroleptic medication in the form of Depixol, Clopixol, Modecate and Rispiridone.

In terms of the inclusion and exclusion criteria, the authors included all people who chose to take part in the study and were regularly attending the clinic. Prior to con- ducting the study, the authors liaised with the staff at the health clinic and with the manager of the community mental health team responsible for the care of the clients. Appropriate rooms were then booked for the purpose of carrying out the interviews. The authors decided to distribute leaflets and information about the study for clients to respond to. They did not randomly select the participants to be involved in the study. Once the clients came forward, a suitable time for the participants and researchers were agreed.

**Table 1 here **

Semi-structured interviews consisting of 20 questions that were designed specifically for the study (see Appendix 1) were utilized. We obtained some brief details from the participants about how long they had received psychiatric care and how many admissions to hospital they had. The schedule was arranged in such a way as to begin with general questions and then proceeds to more specific questions to elicit the experiences of the participants in terms of receiving depot injections. Subsequently, the questions addressed their relationship with the nurse administering their depot and their perception of the roles and responsibilities of the nurse. The interviews lasted for approximately 1 h. At the start of each interview, the authors reminded the participants that they could terminate the interviews at any time.

Participants were also encouraged to inform the interviewers of any distress they experienced during the interviews. The authors had devised a plan of action in the event of any distress occurring to the participants taking part in the study. The authors were granted ethical approval to carry out this study by the local Health Authority Research Ethics Committee.

Results

The interviews were tape recorded and the information transcribed. All of the transcriptions were scrutinized and corrections made to the texts. The data generated by the semi-structured interviews utilized analysis techniques such as data reduction, data display and conclusion drawing/ verification (Miles & Huberman 1994). Meanings were sought that involved noting regularities, patterns, explanations, possible configurations, causal flows and propositions. Following analysis of the data, the authors identified five themes: therapeutic relationship; role of the CMHN; knowledge and information; relapse prevention; and other sources of support.

Therapeutic relationship

Many of the participants taking part in this study spoke of the depot clinic as being a ‘secure place’ or ‘somewhere safe to go’ [Respondent (R) 6, R9, R2]. Some stated that it was ‘enjoyable’ and a ‘nice place to go’ (R7, R3, R1). Another participant talked at length about the effects of the depot injection. ‘It sorts me out’ he said. This participant also stated that going to the clinic itself helped him ‘calm down’ and gave him ‘a purpose’ (R5). Many of the participants stated that the depot clinic and, in particular, the CMHN, had ‘a stable and a consistent presence’ (R4, R1, R8). This often brought about a sense of security for the participants.

The participants all expressed that they preferred one person to be administering the depot on a regular and consistent basis. It was rather difficult, some expressed, if there was a different person each time. One participant said they had little choice in terms of who gave the depot injection, as there was the same person each time (R6). However, most considered the fact that it was the same person every week as very positive. One participant stated that the CMHN was ‘reliable and always there for me’ (R1). Another expressed that the presence of a reliable practitioner brought about ‘a sense of order’ for them (R4).

These views highlight the nurse’s role as one that creates a secure base whereby the patient can explore and communicate their experiences. Therefore, the nurse may spend quality time with the patient in a considerate and respectful manner and enable the patient to feel secure and safe. This process involves the nurse staying with the patient in their distress by experiencing and reflecting upon it (Watkins 2001).

Role of the CMHN

Mental health nurses are often perceived as having a unique role as the administrator of medication. This is the case in both ward and community settings. However, the nurse’s role will also overlap with other mental health practitioners, such as social workers and occupational therapists. In the context of both a ward setting and a community mental health team, for example, nurses will address social issues including housing, family interventions, relapse prevention and so forth. When asked about the role of the CMHN, many of the participants were unsure as to what this consisted of. However, when the participants referred to the CMHN administering their depot, they seemed to attribute a number of roles to them. This person, it seemed, had an important role within the secure atmosphere of the clinic. Some of the participants stated that they felt that the CMHN administering their depots spent quality time with them. One participant said, ‘I feel I have enough time to raise any- thing, family things or whatever. Sometimes it’s not necessary, but it’s there if I need it’ (R4). The participants indicated that they had time to receive their depot and talk about a variety of other issues if they wished. Some of the participants stated they did not need to raise other issues as they had enough support elsewhere, but the majority expressed how much they valued the CMHN.

Six of the people interviewed stated that they felt their psychiatrists did not give them enough time. They would occasionally see their psychiatrist on a one-to-one basis, but this was rare. Some of the participants stated that the psychiatrist, although pleasant, seemed in a hurry, as one participant expressed:

> I feel they are in a rush and they are nice. But I feel I don’t want to take up too much time. It is often the case, though, that I want information about things, especially medication. (R1)

All of the participants spoke of the particular skills and attributes of the person giving their depot injection. As stated above, the participants appeared to consider the CMHN as a reliable, consistent and stable practitioner. One participant said of the CMHN, ‘he’s very reliable, always there for me and is kind' (R8). The clients seemed to value the role of the CMHN administering their medica- tion. The nurse is 'just ordinary', one person said, 'they are interested in me' (R3). The participants also placed emphasis upon the other people attending the clinic for their depot. One person said the clinic was 'pleasant' because he could see his friends, and they, along with the nurse, pro- vided a 'nice place to go where I see people I know and where I feel safe' (R5).

One participant stated that their previous depot injection medication produced side effects that affected their libido. They felt shy about addressing these issues with their psychiatrist. It was much easier to speak to the person giving their injection, they said. The authors asked the participants if they felt embarrassed when receiving their injection. All the participants stated they felt no embarrassment. 'I don't feel embarrassed talking to the nurse either', one participant said (R4). Another person stated that she didn't feel embarrassed because she felt comfortable with the nurse giving the injection, 'I feel secure and safe with them, I know them and there is no need to feel shy' (R2).

Knowledge and information

Many participants expressed that their psychiatrists were useful in terms of informing them about the biological facts of medication. One participant, for instance, stated how his psychiatrist had referred to the participant's tongue as 'moving about' while he was taking the antipsychotic medication Sulpiride, and attributed a complicated and medicalized name to this physical side effect. The participant found this difficult to comprehend, 'a funny name', as the participant recalled. This participant said that the CMHN, however, seemed to have 'a lot of knowledge about medication and at the same time, "says it in an everyday way" ' (R2). Six of the participants said that they were frequently embarrassed about asking the psychiatrist questions about medication. Often the only opportunity to ask questions was in the Care Programme Approach meeting where there were a number of other practitioners present. At the depot clinic, however, they were able to ask the CMHN about medication. It was easier to ask the CMHN at the depot clinic where, as one person said, ‘no one is staring at you’ (R4).

Another participant stated that they faced a dilemma with their housing. This person had become very anxious and spoke to the CMHN at the depot clinic. Speaking to the CMHN seemed beneficial:

> All I needed was a few minutes of reassurance and the nurse, while giving me the injection, suggested I call this particular person. It was the way they said it that made me feel much better. (R3)

Several of the participants stated that although they went to the clinic to receive their medication, they could raise other matters of concern, such as benefits or family issues. They seemed to imply the clinic was a safe forum in which to discuss these issues. In addition, many expressed they could tell the nurse about the things that had happened to them on a daily basis. One participant said that she looked forward to going to get her injection, not because of the injection itself, but because she could tell the nurse about the day centre she went to:

> The nurse giving me the jab first told me about the day centre, so I like to tell them all about it when I see them at the clinic. (R1)

Relapse prevention

It has been postulated that one of the most potent aspects of recovery is hope (Coleman 2000). Other themes in the recovery literature include: being believed in and encouraged; developing perspective on the past; taking personal responsibility for one’s life; acting to rebuild one’s life; changing other people’s expectations of what one can achieve; developing new meaning and purpose in life; and developing valued relationships and roles. All of these attributes could serve as catalysts for building confidence and self-esteem as well as providing protection against the harm caused by stress (Perkins & Repper 2003). Determining the experiences of people is fundamental to the recovery process. In the present study, people spoke about how they felt valued within their relationship with the CMHN. Participants also alluded to the importance of trust and reliance upon the practitioner working with them:

> Your questions have helped me to think about my care and how much I rely upon the nurse giving me my injection. Not many people have asked me about what I really think about things. (R5)

Other sources of support

In the area of mental health, there has been a call to challenge medicalization with its focus on biological treatment and cure. Some critics highlight the problems associated with a preoccupation with treatments and argue that a person's rights are often only seen in terms of the right to refuse treatment (Turner-Crowson & Wallcraft 2002). Most people involved in this study were able to articulate their views and opinions about their experiences of neuroleptic medication. They were given the opportunity to discuss important issues and concerns. Some spoke of the beneficial effects. One participant found his medication helped to keep him on an 'even keel' and he felt more stable mentally:

> I think it levels me out. I think compared to the days when I used to smoke dope and when I used to go up and down quite a bit you know. One day is pretty much the same as another now. (R4)

What became clear from the results of the current study was that people with mental health problems needed to be seen as having skills, abilities and aspirations and not just diagnoses.

When dealing with the subject of medication, we need to recognize that people with psychosis have a richness of experiences that deserves attention through proper engagement strategies, a detailed assessment of concerns and appropriate and responsive plans of care.

In this study, most people said that they did not usually talk to anyone in their immediate family about medication matters. People would often turn to friends as a source of information, checking out ideas, companionship and support. One woman, who had a network of friends consisting mainly of other women with a diagnosis of schizophrenia, was able to confide in and find support from her friends. They were able to compare experiences:

> I just ask them a few questions, for instance – what medication are you on, how do you feel about it, do you get any side effects? To find out how my friends are getting on with their lives and then compare it with mine . . . (R2)

Sadly, some people said they had no friends. Others would identify family members as possible confidants but with some reservations:

> I try to talk to my sister, she should understand. But other people don't want to know about my situation. They get a bit worried about what I might do . . . it's difficult. The good thing is my CMHN knows about medication things. (R7)

It appeared that, generally, people would either not talk about medication at all with anyone, or would carefully chose someone to confide in, usually a close friend and not necessarily a family member.

Some of the people interviewed spoke of receiving support from their partner and this seemed to be important within the relationship. Sometimes, their partner found it difficult to communicate how they were feeling:

> The only support you can get is if that person is willing to talk. Steve is not the type of person who likes to talk to strangers and has made that quite clear about any- thing 'I

> don’t take my problems to anybody, I sort them out in my own head’ he is that type; he is not into this sort of thing. (R6)

One man saw the limitations of family involvement in his circumstances and alluded to the problems associated with stigma:

> Cultural differences get in the way. Only once my brother helped me. Culturally the only thing the family will help you with is getting married. It will take some- time to change. (R8)

Following the individual interviews, participants were asked whether it had been useful to talk about medication issues. A majority of people agreed that it was constructive and some indicated that they would perhaps like more time to expand upon their thoughts and experiences:

> It’s good to talk to my CPN. Although they are very busy at the clinic with other people, they have enough time for me. (R7)

Discussion

The aims of this study were to explore the subjective experiences of people who received regular depot injections. It is often considered that the nursing practice of giving depot injections is entrenched within a biomedical framework and may be oppressive towards those who regularly receive them. Currently, mental health nurses are responsible for the administration, and psychiatrists for the prescribing, of a variety of medications to treat mental illness, although this is owing to changes with current recommendations for nurses to take on the role of prescribing (Department of Health 2005a), which is now common practice in the United States (Nolan *et al*. 2004). Within the mental health multidisciplinary team, the role of administering medica- tion is unique to nurses (Hamblet 2000). However, mental health nurses may be accused of adhering to a purely biomedical framework in their care of clients experiencing mental health problems (Phillips 2006).

In addition, the intervention of administering a depot injection may be considered as a kind of ‘conveyor belt’ for those who both give and receive depot injections. One of the studies on the role of those giving injections, e.g. stated that the average time spent with patients within the depot clinic was between 1 and 4 min. Consequently, there is obviously a need to avoid this ‘conveyor belt syndrome’ within depot clinics, so that adequate time can be spent with each client. Perhaps one suggestion is to provide space within the depot clinic where patients can meet. Many of the participants in this study emphasized how they enjoyed seeing other people attending the clinic. In the clinic where the study was carried out, clients were often given a particular time to see the nurse giving the depot, so there was enough time spent with each person to avoid a rushed atmosphere.

This study revealed that despite being frequently required to practice within a biomedical framework, the role of the CMHN was multiple. They were well placed to carry out assessments of patients, provide knowledge and information about resources and ultimately spend quality time with patients. The quality time the CMHN spent with patients, enabled a therapeutic relationship to develop that went beyond one that is based purely on a biological inter- vention. This presents a challenge to the biomedical frame- work within which nurses administer medication and are merely concerned with issues regarding compliance and non-compliance.

With regard to compliance, there has been a recent report indicating an incentive to pay clients living in the community to take their medication (Laurance 2007). This practice has been used widely in the United States for varying types of medication, especially those with unpleasant side effects. A study in Britain has suggested the usefulness of the incentive, which has resulted in a significant reduction in hospital admissions (Laurance 2007). However, there have been ethical concerns around issues of coercion and the effect upon the nurse and patient therapeutic relationship. The study outlined in this paper has revealed that the clients interviewed appeared to benefit from attending the depot clinic in ways that went beyond a biomedical intervention. If clients can see the palpable benefits of their treatment, they are more likely to readily receive it. If financial incentives to encourage clients to comply with their treatments are introduced, what does that say about the quality of care people with mental health problems receive? Awarding clients financially for taking their depot medication may well reduce the value of the relationship between client and nurse, perhaps from a relationship that is about honesty and trust to one that is unavoidably based on coercion. If there is a risk of the depot clinic being like a ‘conveyor belt’, financial incentives may further magnify the depersonalization already in place.

The secure base that nurses can provide for the patients in their care is vital, especially at a time when the role of the mental health nurse is being re-examined (Clarke 2006; Holmes 2006). In 2005 the chief nursing officer, Chris Beasley, announced a major review of mental health nursing, intended to give the profession a clear direction. This was in response to major government reforms includ- ing ‘Choosing Health’ and the Mental Health Bill. The resulting document, ‘From values to action’ (Department of Health 2005b), was a major consultation about the changing role of the mental health nurse. Another document, the depression and anxiety report proposed that nurses, along with occupational therapists, could train as ‘psychological therapists’ to produce a workforce that can more effectively deliver a psychological, person-centred model to those diagnosed with mental illness (Layard 2006). Yet, it is clear that mental health nurse are currently in the position to deliver effective therapeutic skills even when they are required to work within a biomedical framework, as revealed in this study. Therapeutic skills are fundamental to the role of the mental health nurse and much needed by those experiencing mental distress.

Limitations of the study

The sample was small ($N = 10$) and represented only people attending a depot clinic in one part of London. The participants were non-randomly chosen. It would be impossible to make generalized claims about all people with a diagnosis of schizophrenia. However, the aims of the project were not to generalize to the wider population but to explore some of the issues that were perhaps important to people with psychosis. To explore and document what it might feel like for a person with a psychotic illness, to make their way in the world, and still maintain hope and courage is important. Also, the first hand accounts of the experiences of people can make a valuable contribution to an area about which very little is known. Moreover, the processes involved in 'tapping into' a person's psychotic experiences and emerging with moving and illuminating personal details is valuable in enabling clients and practitioners to collaborate in formulating appropriate responses to important aspects of the person's life.

Conclusion and implications for practice

Living with schizophrenia can present people with an array of apparently insurmountable problems, not only concerning the distress associated with symptoms of the illness, but also with issues such as poverty, unemployment, housing, stigma and discrimination. With the growth of the user movement in the USA and UK, more interest and energy is being spent on the notion of recov- ery as a model of good practice, as opposed to the perhaps rather 'fatalistic' views proposed by the medical model. It would then seem reasonable to identify potential 'windows of opportunity' with regard to therapeutic interventions occurring along the well/ill continuum of experience. Furthermore, treatment, case management and rehabilitation are what helpers may do to facilitate recovery. Medication is one important aspect within a bio-psychosocial framework.

This study was concerned with asking service users about their experiences of receiving depot injections. The authors were somewhat surprised at what the participants said in terms of their positive experiences. During the process of receiving their depot, the participants stated that it was a useful forum in which to receive information about their medication and local resources. Some stated that they often did not feel they could ask their psychiatrist about the effects of medication especially with regard to sexual functioning. Participants also stated that they were more likely to find out about supportive services in the local area from their CMHN administering their depots than from others responsible for their care. All the participants emphasized the important role of the CMHN. They were not just 'injection administrators' working on some kind of 'production line'. CMHNs were perceived as reliable, honest and trustworthy. They gave the participants information that other people did not. The CMHN gave the partici- pants direction in some of the dilemmas they faced. The depot clinic was, according to the participants, a safe and secure base. However, it seemed that this was not just because of its pleasant atmosphere. It was also because of the CMHN in their role as a dependable and consistent practitioner. It was clear that the nurse–patient relationship in the context of the depot giving process was in itself therapeutic. The present study enabled people with a medical diagnosis of schizophrenia, who are often perceived as marginalized and disenfranchised, to express important views and opinions related to fundamental aspects of care and therapeutic activity. The participants were indeed on the receiving end of an intervention entrenched within a biomedical framework, but it also consisted of a stable and therapeutic relationship with their CMHN.

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Table 1

Characteristics of the sample

Variables	*n* (%)
Sex	
Male	5 (50.0)
Female	5 (50.0)
Age: mean (year)	46.5
Ethnicity	
White UK	5 (50.0)
Black Caribbean	2 (20.0)
White European	1 (10.0)
Black African	2 (20.0)
Clinical diagnosis	
Schizophrenia	8 (80.0)
Schizo-affective disorder	2 (20.0)
Service contact	
0–5 years	3 (30.0)
6–10 years	2 (20.0)
11–15 years	3 (30.0)
16–20 years	1 (10.0)
>20 years	1 (10.0)
Previous admissions: mean	6.4