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Further Observations on the Practice of Community Care in Salford

Differences Between Community Psychiatric Nurses and Mental Health Social Workers

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Differences in the clinical characteristics of clients have not been found to account for the interprofessional differences in community psychiatric nurses' and mental health social workers' practice in Salford. We found the consultant-attached mental health social workers, who worked closely with the specialist psychiatric team and who received supportive supervision from their professional managers, maintained stable case-loads, but the primary-care attached community psychiatric nurses, who were isolated from the specialist psychiatric team, and who received little supportive supervision from their professional managers, carried case-loads of increasing size. Failure to improve the way in which services for the mentally ill in the community are co-ordinated is likely to perpetuate the worst characteristics of life in the old back wards into the era of 'community care'.

Much of the burden of providing care in the community is borne by social workers and community psychiatric nurses (CPNs), yet the kinds of service organisation and management required to facilitate such care remains unclear. The genericism of social work was generally criticised by mental-health professionals and consumers of services alike, who feared that the specialist social-work resources required by many mentally ill patients would be eroded as a result of demands made by other client groups (Wing, 1972; National Schizophrenia Fellowship, 1974). Little & Burkitt (1976) and Neill *et al* (1973) found that these fears had some foundation. The specialist/generic debate has continued until the present day, with few signs that any consensus on the best ways of organising mental-health social-work services has been reached (Challis & Ferlie, 1986).

The organisation of CPN services presents different, although similarly unresolved, problems. The main organisational debate centres around whether CPNs should be based in primary-care settings, or whether they should remain part of the specialist psychiatric service team, as advocated by the Select Committee on Community Care (House of Commons, 1985) and the Community Nursing Services Review panel (Cumberlege Report, 1986). The ways in which services are organised are likely to affect the kinds of clients and problems encountered by staff, and it is therefore imperative that the relationships between the organisation and management of services, and the ways in which individual clients are cared for, are examined.

Our previous work (Wooff *et al*, 1988) examined the context and content of work with individual clients undertaken by community psychiatric nurses (CPNs) and mental-health social workers (MHSWs) in Salford. The CPNs, who were primary-care based, were found to have applied, mainly, a biomedical model of care for clients with a diagnosis of 'schizophrenia', and to have provided simple psychotherapeutic support to their other clients. Mental-health social workers, who were hospital based, were found to have been concerned mainly with the social adjustment of their clients, and to have used counselling techniques extensively.

Clients' diagnoses were obtained from case-register data, which provided broad classifications based on International Classification of Diseases rubrics (Wing, 1970). The categories recorded on the register were those assigned by the individual psychiatrists responsible for each client's care, and were therefore unstandardised. No statistically significant differences in the clinical categories of the CPNs' and MHSWs' clients were found, but 25% of the CPNs' study clients had been referred to them directly by general practitioners (GPs), whereas none of the MHSWs' study clients had been referred directly from such a source. Studies of the psychological problems of patients treated in general practice (Shepherd *et al*, 1966; Goldberg & Blackwell, 1970; Goldberg & Huxley, 1980) have indicated that many clients treated by GPs are likely to display less severe psychiatric symptoms than clients being treated by the specialist psychiatric services, and it was therefore considered necessary to supplement register data with information on the severity as well as range of clients' symptoms. Furthermore, register clinical data did not provide any information on the clients' psychiatric

symptoms that were present at the time each worker/client interaction took place.

We aimed, firstly, to clarify how far differences in the psychiatric symptoms of the two client groups may have accounted for the differences in working practices found; secondly, to explore the relationships between the organisation and management of the two groups of workers, their interactions within professional networks, and their work with individual clients.

Method

Between June 1984 and July 1985, a researcher (KW) observed and recorded, using semistructured recording schedules, the content and context of CPNs' and MHSWs' work with clients and staff. All CPNs working in general psychiatry with 'full' case-loads were eligible for inclusion in the study. Eleven nurses out of an establishment of 17 fulfilled this criterion. Ten nurses (half of whom had the English Nursing Board 810 CPN Certificate), were randomly selected from each primary-care base. All MHSWs attached to general psychiatric teams ($n = 6$) were included in the study. Each worker studied was observed for a period of one working week. Further details of the method used to record interactions with individual clients appear elsewhere (Wooff *et al*, 1988).

It was originally intended to record all conversation that took place between workers and other professionals. However, some interactions were very rapid, and telephone conversations were difficult to interpret accurately. In these cases, recording was restricted to identification of the professional with whom the interaction took place. Interactions that took place in 'ward rounds' were classified as staff contacts rather than individual patient contacts and are thus included in the staff-contact data presented here.

In order to describe the range and severity of symptoms experienced by clients at the time of contact with each worker in more detail, KW was trained in the use of the Present State Examination (PSE) Interview Schedule (Wing *et al*, 1974), and conducted interviews with one in ten individual clients seen by CPNs, and one in five individual clients seen by MHSWs during the observation period. (Pilot studies had indicated that CPNs saw more individual clients each week than did MHSWs, and the different sampling interval attempted to compensate for this difference). Additionally, all newly referred or re-referred clients seen by CPNs and MHSWs during the observation period were interviewed, but numbers of 'new' MHSW clients were too low to allow the data to be used for comparative purposes. Interviews were conducted as soon as possible following each 'key' observed worker/client interaction, and all took place within 2 weeks of that observation.

Results

Clients' symptoms

Out of a total of 28 CPN clients eligible for interview (a 10% sample of 283 individual contacts), seven were excluded for the following reasons: one because answers were considered to be unreliable; one could not be contacted for interview; one appeared to be demented, had a language difficulty, and could not answer the questions adequately; two contacts were with relatives only; one was for joint marital therapy; and one client had already been interviewed in the MHSW sample some weeks previously. Twenty-one interviews were completed and analysed.

Fourteen out of a total of 15 eligible MHSW client interviews (a 20% sample of 78 individual contacts) are included in the analyses. One client refused to be interviewed, and one interview was conducted by a psychologist, trained in the use of the PSE schedule, following the emergency admission of a client who was eligible for interview by KW.

Clients' CATEGO classes grouped as: schizophrenic and paranoid psychoses (S,O,P); manic psychoses (M); depressive psychoses (D); other depression (R&N); anxiety states (A); and other (X,ON), showed no statistically significant differences as measured by the Mann–Whitney U Test. The borderline nature of the O? class is such that another class is also allocated on the basis of the non-psychotic symptoms present – the single exception to the hierarchical principle which allocates each individual into one class only. When the second CATEGO class was assigned for this group of clients, the two groups of clients became even more similar.

Table I shows the index of definition (ID) scores, arranged hierarchically, to reflect the severity of clients' symptoms. The Mann–Whitney U test found no statistically significant difference between the two groups of clients, and if scores of 5 and over are taken to indicate 'caseness', 71% of both groups could be said to have experienced active clinical symptoms within 1 month of the observed worker/client contact.

The PSE interviews were conducted to try to establish whether the range and severity of the two groups of clients' symptoms were different. However, during the course of the study it became apparent to the interviewer that some of the symptoms recorded as present at PSE interview were revealed as a result of the precise nature of the PSE interview itself, and had not manifested themselves during the observed client/worker interaction.

TABLE I
PSE index of definition scores

ID scores	*CPN*		*MHSW*	
	n	*percentage*	n	*percentage*
8	2	9	4	29
7	4	19	1	7
6	5	24	3	21
5	4	19	2	14
4	1	5	—	—
3	1	5	3	21
2	3	14	1	7
1	1	5	—	—
Total	21	100	14	100

PSE, present state examination; ID, index of definition; CPN, community psychiatric nurses; MHSW, specialist social workers.

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One example of this was a CPN client who was regularly visited at home for the administration of depot injections. The observed visit lasted for 7 min, the client had been known to the worker for over 1 year, and a relative was present at the time of contact. An inquiry concerning the client's symptoms and her husband's physical health was made, some discussion of the need for house repairs took place, and some general conversation ensued. The nurse concerned had found her client's condition 'stable', and intended to continue medication and to discuss the need for repairs with the local-authority housing department. The PSE interview took place 7 days later, at which the client stated "I hear voices. I think I can hear my Mum and Dad and Grandma. I hear them most at night. If I hear them during the day I get up and do my housework. When I'm in bed I can hear them clearly." Her total PSE score was 37 (ID 7), and the CATEGO class assigned was S+.

A second example concerned a MHSW client who had been known to the worker between 6 and 12 months, who lived alone, had family-relationship problems (especially with one daughter whom she felt wouldn't "leave her alone") and an array of physical symptoms. She had referred herself, was being 'treated' by her GP, and her grandchildren were receiving care from a social worker working in a child-guidance clinic. The purpose of the visit was "to check she'd actually gone away for a break as I had suggested". The visit lasted 16 min, enquiries about symptoms were made, and the client's planned private visit to a hypnotist and the mechanisms by which she could obtain such treatment were discussed. Family relationships and financial matters were also discussed. The social worker's view of the outcome of the visit was that she had confirmed that the client had taken her advice and gone away from her family for a break, but that her (the client's) views of her family situation remained unchanged. She intended to check the outcome of the proposed hypnosis treatment. The PSE interview took place 7 days after the observed visit, and an array of 'neurotic' symptoms and physical ailments were catalogued. However, answers to PSE questions revealed that the client thought her daughter was trying to poison her (which was the reason she wanted to stop her daughter visiting so much), and that she tried not to watch space programmes on television because "they attack me with vibrations all in my head", and that a certain television commercial "makes me feel queer as if I'm disintegrating". When questioned further about whether she had volunteered this information to anyone else, she said that nobody had ever asked her such questions, and that she had not mentioned them on her own account because she thought people would think she was silly. Her PSE score was 78 (ID 8), and her CATEGO class S+.

Feedback of the interview results confirmed that neither worker was aware of the full range and severity of their client's symptoms.

Staff contacts

Contacts with other professions

Formal meetings. Table II shows the pattern of staff contacts at 'formal' (i.e. pre-arranged) meetings that took place during the study period. Each consultant 'firm' held at least one multidisciplinary ward round each week. Primary-care multidisciplinary meetings were held with varying frequency throughout the health centres. Both groups of workers attended similar mean numbers of meetings, though the differing emphases of primary-care links for the CPNs and the psychiatric-service links for the MHSWs were evident. The primary-care meetings, which took a mean of 39 min, were far shorter than the 'ward rounds', which took a mean of 163 min for MHSWs and 96 min for CPNs.

TABLE II
Workers' 'clinical' formal meetings with other staff

	Mean per worker/week	
Staff	*CPN*	*MHSW*
Psychiatrist only	0.3	—
Psychiatrist and others	0.1	0.3
Ward-round staff	0.4	1.2
Primary-care staff	0.6	—
Other	0.7	0.8
Total	2.1	2.3

CPN, community psychiatric nurses; MHSW, mental-health social workers.

Four CPNs attended ward rounds regularly; the majority rarely attended. Half the CPNs attended a regular meeting of primary-care staff during the study period. These meetings tended to deal with service delivery arrangements and administrative matters rather than be used for discussion of care plans for individual clients. Only one CPN attended both a ward round and a primary-care meeting. Other regular meetings e.g. a day-hospital administrative meeting and an 'elderly care co-ordination' meeting, were attended in some areas. Each CPN had evolved his/her own particular programme of regular meetings with other staff. There was no consistent overall pattern.

All the MHSWs attended ward rounds during the study period and this was the usual practice. The two MHSWs who belonged to teams where patient/staff ward meetings were held also attended these. Half the social workers attended other regular staff meetings, for example, 'elderly care co-ordination', a 'housing allocation' meeting, and a meeting with day-centre staff. No MHSWs attended any primary-care staff meetings during the study period, and it was not usual for them to do so.

Informal staff contacts. Table III gives details of the less formal contacts that took place over the observation period, which also formed an integral part of overall work patterns. These data do not include the usual social contacts that occurred, but represent contacts with people with whom workers consulted and discussed issues relating to their work. They do not include persons/agencies contacted by letter – an activity in which the MHSWs were more frequently involved than were the CPNs. It can be seen that the mean numbers of MHSW contacts were double those of CPN contacts, and that this excess was mainly attributable to the higher

TABLE III
Staff contacts outside formal meetings

	Mean per worker/week	
Staff	*CPN*	*MHSW*
Psychiatrist	1.8	1.0
CPN	0.9	0.7
Social worker	0.9	1.7
Other mental-health professional	1.2	5.7
Primary-care staff	1.8	0.5
Administrative staff	2.2	2.7
Other	1.0	6.5
Total	9.8	18.7

numbers of social workers' contacts with 'other' and 'other mental health' staff, though they also had more contacts than CPNs with members of their own profession. CPNs had more informal contacts than MHSWs with psychiatrists, with other CPNs, and with primary-care staff.

Contacts with own profession

It was usual for more than one CPN to be attached to each community base. Where this was the case, office accommodation, and often 'injection clinics' and 'group work', were shared. Thus, a great deal of contact occurred within bases. Senior CPNs were responsible for the co-ordination of work within a defined geographical area. All CPNs met for one half-day each month. These meetings were used for various purposes, e.g. to discuss organisational issues, or to update clinical practice. During the course of the study, only one, recently instituted, group supervision session took place.

The MHSWs all shared a common hospital base and therefore informal contacts regularly occurred. Two senior social workers were responsible for conducting regular, usually fortnightly, clinical supervision sessions with each social worker. During the two supervision sessions observed during the course of the study, case-loads were reviewed, objectives clarified, and strategies for continuing care were negotiated and agreed. MHSWs all met for a monthly team meeting at which various matters concerning the organisation and administration of the department were discussed, and a monthly 'professional development' meeting at which matters relating to professional practice were discussed.

Organisation of work

Thirty per cent of the individual clients seen by CPNs during the study period were seen in the CPN primary-care office, and 48% were seen at home. Very few clients were given specific appointment times for either office or home visits. Practices varied somewhat, but it was usual for GPs to send patients to see the CPN directly following a consultation. Clients were also invited to "get in touch" with CPNs at the health centre if they wished for further help. Regular depot-injection clinics were held in health centres, as were patient 'group' sessions. It was usual for the CPNs at each health centre to take 'turns' in running the injection clinics, although they also conducted some sessions jointly. All but one CPN regularly took part in a client group activity, although not all of them met during the 1-week period of observation. The majority of 'groups' (e.g. relaxation groups, and social groups) were attended by all the CPNs working in each health centre (or in one case, a community clinic-based) team.

Hours of work were 0900 h to 1700 h, and there was no centralised emergency or duty system in operation. Very little clerical help was available to CPNs, as one full-time secretary provided the only clerical help for a department of 17 nurses. CPNs kept their own case-notes, which were usually handwritten; current notes were kept in their local offices, and old notes were returned to the central office which was based in the local psychiatric hospital. During the study period, CPNs were piloting the use of a structured method of recording their work, based on the 'nursing process'.

The hospital-based MHSWs saw 17% of their individual clients on wards, 17% in their offices, and 42% in their own homes. They almost always made specific appointments to see their clients, although it was also usual for some social workers to make themselves available at hospital out-patient clinic times for *ad hoc* consultations. Emergency, *ad hoc*, and out-of-hours referrals were dealt with via a 'duty system', which comprised one duty social worker, one back-up duty worker, and one duty senior social worker. Each social worker did duty sessions on a rota basis. Two MHSWs attended weekly client 'drop-in' clubs, but no other regular client group activities outside hospital took place.

MHSWs engaged in more correspondence on behalf of their clients than did CPNs. They had better secretarial/clerical support, with two whole-time equivalents for 11 staff. Their case-notes were generally typewritten, and were filed in the social-work office. Notes and general correspondence were often completed during 'duty' periods if there were few *ad hoc* or emergency referrals. Documentation was generally checked as part of the individual supervision process.

Discussion

Earlier work in Salford (Wooff *et al*, 1988) found that, in their contacts with individual clients, CPNs tended to apply a biomedical model of care for clients in the 'schizophrenia' clinical category and to give 'simple psychotherapeutic' support to their other clients. In contrast, MHSWs were found mainly to apply a psychosocial model of care, and to use counselling techniques extensively. CPNs were over four times more likely than MHSWs to cite 'maintain' as an overall objective, whereas MHSWs were more than three times as likely as CPNs to cite 'change' as an overall objective for their individual clients.

Data on referral sources, contact networks, place of contact, and persons present, suggested that the hospital-based MHSWs worked more closely with members of the specialist psychiatric team than

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CPNs, who were based in primary-care and community settings. The data on the staff contacts observed during the course of the study, presented here, confirmed that MHSWs had greater contact with members of the specialist psychiatric team than did CPNs, and that CPNs had greater contacts with primary-care staff than did MHSWs.

The possibility that these interprofessional differences may have been the result of differences in clients' clinical states, and therefore needs, was not confirmed by an analysis of PSE results. Copeland *et al* (1975) found that non-psychiatrists tended to rate the presence of symptoms more highly than psychiatrists, and the fact that KW was not a psychiatrist may have contributed to the high overall scores found, but any such 'inflation' of scores would apply equally to both groups of clients, and could not therefore be thought to invalidate the finding that there was no statistically significant difference in the clinical states of the two groups of workers' clients.

Because of their involvement with 'acute' psychiatric services, and the fact that the overall objective for 60% of their clients was 'change', it was not surprising that MHSWs' clients had high symptom levels. It was rather more surprising that the clients of CPNs, one-quarter of whom were being 'maintained' by nurses and one-quarter of whom were referred directly by GPs, had such high symptom levels.

Support to primary-care teams

That much mental ill health is dealt with by members of primary-care teams, rather than members of specialist psychiatric teams, is well known, and the attachment of CPNs to primary-care teams may be thought to be an appropriate way of ensuring that primary-care team members receive adequate support from specialist mental-health workers.

There were three reasons for supposing that the criteria GPs used in referring patients to CPNs might not have been wholly appropriate: firstly, the role of CPNs in primary care was not made explicit by their managers; secondly, the majority of patients referred from GPs to CPNs were non-psychotic and only one of the nurses observed had received specific training in the management of non-psychotic psychiatric illness while the others were not observed to use specific treatment skills (Wooff *et al*, 1988); and thirdly, GPs rarely referred patients to MHSWs who were observed to use specific treatment skills in their work with non-psychotic clients, and who therefore might have been expected to be able to offer a more appropriate service than CPNs to a high proportion of GPs' patients.

The multifactorial nature of mental-health problems is such that there can be little doubt that social, biomedical, and behavioural factors should be taken into account when care/treatment plans are being formulated, and the specialist psychiatric team encompassed these distinct perspectives. However, the CPNs did not have close contact with other members of the specialist psychiatric team, and the implication is that adequate primary-care support should be available from the whole psychiatric team, rather than from one professional group only.

Long-term care

Although patients receiving long-term psychiatric care are not confined to those with psychotic illnesses, they constitute a distinct group for whom long-term care is likely to be required. A cause for concern regarding patients with schizophrenia is the possibility that psychiatrists and GPs might assume that the administration of injections by CPNs implies that regular systematic reviews of symptoms take place, and that any difficulties patients may have will present themselves early, thus enabling crisis-prevention strategies to be implemented. Work investigating the operation of CPN services in Salford and elsewhere (Wooff *et al*, 1988; Hunter, 1978; Sladden, 1979) has found that mean CPN contact times for patients with schizophrenia were very short, that the administration of injections in 'clinics' was associated with stopping of conversation with patients, and that the CPNs' collection of information was unsystematic and consequently restricted in content.

There is, therefore, enough evidence to justify the proposition that explicit arrangements for regular, systematic, and detailed reviews of symptoms should be made. Whether these reviews should be carried out by medical or nursing staff is a further issue to be considered. The evidence suggested that the ways in which CPNs are trained, and the ways in which services based upon 'injection clinics' operate, are unlikely on their own to provide either adequate frameworks for systematic and regular review of symptoms experienced by long-term patients, or for the review of psychosocial problems.

The data also indicated that CPN contact alone cannot be thought to provide adequate assessment of, or intervention to ameliorate, the social adjustment of long-term patients and their supporters. The conclusion must be reached that systematic regular reviews should not be confined to the discussion of clinical symptoms, but should also incorporate a social component.

Management styles

Case-register data showed that the mean number of clients in MHSW care per worker on point-prevalence days between 31 December 1976 and 31 December 1984 remained stable around a mean of 53, with those in continuous MHSW care for at least 1 year numbering around 20. In contrast, the equivalent mean numbers in CPN care rose from 30 in 1975 to 59 in 1977 and to 78 between 1982 and 1984, with mean numbers in CPN care for at least 1 year of 12 in 1975, 23 in 1977, and 44 between 1982 and 1984. Between 1976 and 1984, each CPN staffing increase brought about an accumulation of 'long-term' patients (i.e. those with length of care of 1 year and over), as the numbers of established long-term patients did not decrease at the same rate as new patients joined the long-term group. A decreasing proportion of long-term CPN patients (78% in 1975, and 36% in 1984) had a diagnosis of schizophrenia (Wooff, 1987).

Thus, there is evidence that while increases in MHSW staffing did not result in any significant change in long-term case-load sizes, increases in CPN staffing levels did. In the CPN service, as the pressures of carrying larger long-term case-loads built up, less time was spent with individual long-term patients. How far the contrast between the build-up of 'long-term' CPN cases and the stability of the MHSW long-term cases reflected client need cannot be known, but it is suggested here that differences in the management styles between the two occupational groups were important underlying factors.

Psychiatric and medical social-work training and practice, which preceded that of present-day social work, incorporated supervision of individual practitioners' work with clients by experienced 'senior' staff members. Social-work managers are still required to ensure that social workers are provided with adequate supportive supervision of individual cases and with overall case-load management advice. In contrast, psychiatric-nursing management styles have been based upon 'discipline' (Harries, 1976). When the performance of nursing tasks is based upon 'procedures', and nurses can be readily observed by their managers, as they can be on wards, the need for 'discipline', as distinct from 'enabling support', might be argued. When nurses are expected to make judgements, implement therapeutic change, and generally work unobserved by their managers, their main need is for 'enabling support', and the Community Psychiatric Nurses Association (1983) has argued convincingly for such support to be made available to CPNs. Such supervision is not thought to be generally available (North Western Regional Health Authority, unpublished seminar; Skidmore & Friend, 1984) and was not available to Salford CPNs at the time the present study took place.

Supervision of the management of individual cases is required to maximise benefits to individual clients. When resources are finite, some method of controlling service provision must be made, and 'case-load' supervision is thus required to ensure that service priorities and targets are met. Fisher *et al* (1984) found that 'long-term' and 'intake' area social-work teams applied differing criteria of need for continued social-work contact, and the present study did not investigate how far MHSWs and area social-work team leaders in Salford applied differing criteria of need for social-work involvement. However, MHSW managers did attempt to exercise some control over case-load content and size, whereas each individual CPN was expected to manage his or her case-load independently.

Increasing proportions of long-term CPN clients fell into non-psychotic clinical categories, and individual contact times with 'schizophrenic' clients were significantly shorter than those for other clients. The conclusion must therefore be reached that CPN resources were increasingly being absorbed in the care of non-schizophrenic clients and that, as a consequence, the care given to clients in the 'schizophrenia' clinical category, the majority of whom need lifetime care, was reduced.

It may be that the present relatively small CPN input into the care of individual schizophrenic patients, and the relatively large input into the care of other patients in Salford, is appropriate. However, it is asserted here that such a change in activity should have taken place as a result of planned change within the mental-health services as a whole, on the basis of satisfactory 'outcome' studies, rather than as the unplanned result of individual nurses taking sole responsibility for the management of their case-loads. Without management control of case-loads, such changes are increasingly likely to take place if CPNs are exposed to the demands made by the acceptance of direct GP referrals.

How far CPN managers can be expected to have acquired the skills necessary for them to provide this kind of supportive supervision is open to question, but it is likely that they will first have to acquire enhanced assessment and 'treatment' skills themselves before they will be able to benefit from further management training directed towards changing traditional nurse management styles. It may be that nurses will have to look outside their own profession to acquire such training, and the success of the nurse therapy training described by Marks *et al* (1983) has demonstrated how effective such an approach can be.

The importance of teamwork

There is general acceptance of the view that a multidisciplinary team will provide a better standard of mental-health care than that provided by a single professional working alone. One of the key objectives of the White Paper *Better Services for the Mentally Ill* (Department of Health and Social Security, 1975) was to promote the concept of a co-ordinated and flexible service network. The *Report of a Study on Community Care* (Department of Health and Social Security, 1981) called for "an assessment of the degree of overall co-ordination of the various components of the service". Factors which were found by the Winner Report (Department of Health and Social Security, 1978) to hinder collaboration between health and social services included failures in communication, which led to inadequate information, and ignorance of the roles, skills, and outlooks of other professional groups. One of the specific initiatives recommended was the development of the multiprofessional team. Similar conclusions were reached by the working party set up to investigate the role and tasks of social workers (Barclay Report, 1982).

A recent official report on the organisation and performance of the mental-health services (House of Commons, 1985) recommended a specific role within the psychiatric team for CPNs – a view that was endorsed in the community-nursing review (Cumberlege, 1986). In contrast to these views, the Community Psychiatric Nurses' Association (1983) suggested a wide range of possible roles and functions, many of which appeared to overlap considerably with those of other mental-health professional groups. As there appears to be no consensus of opinion and no central advice regarding the roles and functions of CPNs, there seems little prospect of CPNs and other mental-health professionals reaching the kind of understanding of each others' roles, skills, and outlooks necessary for effective teamwork to take place.

In this study, MHSWs were found to have good links with other members of the specialist psychiatric team, extensive links with non-health services, but poor links with GPs. In contrast, compared with MHSWs, CPNs had fewer links with members of the psychiatric team, and outside the health service, but better links with GPs. The data presented here and elsewhere (Wooff *et al*, 1986) suggest that the move to primary-care bases was implicated in the CPNs' lack of contact with the psychiatric team. The primary-care workers did not receive any MHSW input, the psychiatric team received little CPN input, and there was no CPN input into any treatment plans that may have been formulated for CPN clients who were admitted for in-patient care.

The primary-care bases of CPNs were also associated with their relative isolation – they caused logistical difficulties in retaining contact with the psychiatric teams, and it is important to note that, in Salford, the decision to move to primary-care bases was taken by the nurses themselves, and was not part of any overall negotiated mental-health policy shift. Although the precise scale of CPN service moves to primary-care bases is not known, such moves appear increasingly to take place, and it is important to examine the likely consequences of such moves.

The isolation of CPNs, and the implications for care of patients suffering from schizophrenia, were highlighted by Bennett (1978). In Salford, analyses of worker/client interactions (Wooff *et al*, 1988) and the present paper, have shown that CPNs working from primary-care bases not only had more restricted contact with members of the psychiatric team than did MHSWs, but also had fewer contacts with non-health personnel. This isolation was further increased by the fact that CPNs received little or no case-load supervision/support from within their own profession. It is difficult to see how working in such isolation can benefit either nurses or their patients in the long term.

Concluding comments

This paper has suggested that the practice of community psychiatric nursing and the practice of mental health social work are likely to differ more as a result of differences in perspectives of the two groups of workers than as a result of differences in clients' symptoms/problems. It is argued here that the different perspectives of CPNs and MHSWs are complementary rather than conflicting, as clients, particularly long-term clients, have an array of needs, which vary over time and require different styles of professional intervention. It is also suggested that both CPNs' and MHSWs' clients require the kind of detailed review of symptoms generally expected to be carried out by psychiatrists.

In the past, a feature of hospital-based psychiatric care has been the accumulation of long-stay patients in the 'back wards' of large psychiatric hospitals. Here, as in other medical specialities, long-term care has taken second place to acute care. The data presented here have highlighted the dangers of clients with long-term needs being offered an 'acute' service model, with long-term provision being limited to the maintenance of medication. It is argued here that

such a model of service will ensure that the worst characteristics of life in the 'back wards' will be perpetuated in the era of 'community care'.

Far-reaching changes in the ways in which care is provided for people with mental-health problems are occurring now. Patients with long-term needs should receive long-term co-ordinated care which encompasses biomedical, behavioural, and social perspectives; models for acute care should be reserved for those with acute problems. Clear service objectives, priorities, and plans should be formulated, and systems that ensure that such services are delivered must be developed and implemented. If the dream of high-quality community care is to become a reality, managers must ensure that they and their staff are equipped with the necessary skills and resources to enable them to deliver such care.

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