ORIGINAL PAPERS

# Survey of roles of community psychiatric nurses and occupational therapists

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**The roles of community mental health professionals may overlap and need clarifying. A survey is described of 95 occupational therapists (OT) and 200 community psychiatric nurses (CPN), of their views on their respective roles, and information on current practices. Administering medication and crisis intervention were regarded as specifically CPN roles, yet 28% of CPNs did not regularly administer medication. Half of the CPNs' clients were not chronically mentally ill, and over two-thirds of the nurses regularly carried out counselling and anxiety management. Assessing activities of daily living and work skills were seen specifically as OT tasks, yet 60% of the OTs did not usually assess work skills in practice. Roles overlapped considerably, suggesting that a more efficient approach might be to develop a generic core training for community mental health workers.**

The shift away from institutional care towards more community-based mental health services has necessitated a re-establishment of professional roles outside hospital settings. Community psychiatric nursing began in 1954 when two out-patient nurses were seconded to work with discharged psychiatric patients. The numbers of community psychiatric nurses (CPNs, or mental health nurses) increased rapidly in the 1970s after the reorganisation of local authority services and the introduction of specific post-registration training. Occupational therapists (OTs), however, have been working in community settings for only around 15 years (Busuttil, 1992).

In recent years, attention has been focused on multidisciplinary community mental health teams and the necessary mix of skills they should provide (Patmore & Weaver, 1991; Galvin & McCarthy, 1994). It has been suggested that the roles of different professionals in the teams need clarifying, as they often overlap to a considerable extent (Onyett *et al*, 1994). Although CPNs have featured in many research studies along with social workers and clinical psychologists, research on the specific role of the OT is sparse by comparison.

This paper describes a postal questionnaire survey of CPNs and OTs aimed at obtaining information about these professionals' perceptions of their own and each other's roles in community mental health care, and about current practices.

## The study

The questionnaire was devised with reference to published surveys (Parnell, 1977; White, 1991) and piloted among CPNs and OTs in Croydon.

The 30 questions covered years since qualification; years spent in the community; team or individual working practices; location of base; size of caseload and case-mix, and time spent with clients. An inventory of possible tasks and roles was presented three times, to determine the professionals' perceptions of (i) what the role of the OT should be, (ii) what the role of the CPN should be, and (iii) what the professionals themselves were actually doing in practice. Subjects were asked to indicate the appropriateness of possible roles using one of five responses, namely 'rarely/never', 'sometimes', 'often', 'almost always' and 'don't know'. Subjects were also asked to list roles they were expected to undertake which they felt were inappropriate. Lastly, they were asked about their training and qualifications.

The questionnaire was sent to 95 OTs and 200 CPNs together with an explanatory letter and a pre-paid reply envelope, in January 1995. Non-responders were mailed one reminder after four weeks. The sample OTs was obtained via the College of Occupational Therapists' specialist section on mental health, and the sample of CPNs via the Mental Health Directory. Both samples were drawn nationwide.

## Findings

Of the 95 OTs, four were subsequently excluded (three had left the field of mental health and one was still in basic training). Of the 200 CPNs, five who had moved away were also excluded.



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Response rates were 78/91 (85.7%) for OTs and 144/195 (73.8%) for CPNs.

The mean number of years since qualifying was similar (12.4 years for OTs and 13.9 years for CPNs), but on average OTs had spent significantly less time in the community (3.5 years compared to 7.7 years among the CPNs, unpaired t-test, $P<0.05$). The large majority of respondents (96% of OTs and 86% of CPNs) described themselves as part of a multidisciplinary team, and 55% of OTs and 50% of CPNs indicated their main base was a community mental health centre. The mean size of current caseload was 26.3 clients for OTs and 42.3 for CPNs, of which on average 11.6 were categorised as chronically mentally ill by the OTs, a significantly smaller proportion than the mean of 21.5 for the CPNs ($\chi^2$, $P<0.05$). The mean reported length of individual client contacts was similar (57 minutes for OTs and 51 minutes for CPNs).

### *Task inventories*

Responses to the task inventories are given in Table 1. The response 'don't know' was rarely used. The responses 'sometimes' and 'don't know' are omitted from the table and 'often', and 'almost always' are combined which means that the percentages do not add to 100%. (NB: acting as a client's key worker did not necessarily mean that the client was in receipt of the Care Programme Approach.)

*Administering medication.* The large majority of both groups agreed that administering medication was rarely or never the role of the OT. However, only one-third of the responding CPNs agreed that this should 'almost always' be the role of the CPN, and only 44% 'almost always' administered medication in practice. More than one in four CPNs were not carrying out this task regularly:

*Mental state assessment.* Both groups agreed that this should almost always or often be a CPN role. More than twice as many OTs than CPNs regarded this as also part of the OT's role. In practice, the two groups differed significantly ($\chi^2$, $P<0.05$), in that the large majority of CPNs but only around a third of OTs 'almost always' carried out mental state assessment.

*Assessing activities of daily living.* The large majority of both groups agreed that this was the role of the OT.

*Assessing the home environment.* The majority of OTs and CPNs agreed that this too was 'almost always' the role of the OT, with few OTs agreeing that it was also part of the CPNs role. However, similar proportions, around three-quarters, of both OTs and CPNs usually carried out this task in practice.

*Assessing workskills.* Most OTs and many CPNs regarded the assessment of workskills as part of the role of the OT. In practice, however, only 13.2% of the OTs 'almost always' carried out this task, compared to 13.3% among the CPNs.

*Counselling.* Most CPNs and many OTs agreed that this was often the role of the CPN. In practice three-quarters of CPNs and more than a third of OTs stated that they carried out counselling regularly.

*Anxiety management training.* Almost all the OTs indicated that this was part of their role, and relatively few agreed that it was part of the role of the CPN. Among the CPNs, however, more stated that it was part of their role than considered it was the role of the OT. In current practice three-quarters of the OTs and two-thirds of the CPNs reported that they carried out anxiety management training.

*Crisis intervention.* Most OTs and CPNs took the view that this was not the role of the OT, and in practice the groups differed significantly, with a majority of CPNs and only one in six OTs actually carrying out this task ($\chi^2$ test, $P<0.05$).

*Other tasks.* A number of other tasks were felt in general to be the role of both groups, including educating carers, planning treatment and care after discharge from hospital, and communicating with other staff, although OTs were significantly less likely to communicate with GPs than CPNs. Tasks which were demanded of both groups and were felt to be inappropriate included transporting patients, giving advice about welfare benefits, care management, and clerical and administrative work.

### *Training*

Both groups reported a wide range of post-registration training and qualifications, but in general the respondents' replies indicated that the English National Board of nursing offered a professional structure to post-basic nursing training which was much more extensive than the corresponding body for occupational therapy.

## Comments

Some obvious differences in roles between the two groups are suggested by these results, most notably in relation to administering medication and crisis intervention (CPN roles) on the one



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Table 1. Responses of OTs and CPNs to statements about possible roles and tasks in community mental health care.

| Task/role | Response | Occupational Therapists' responses ($n$=78) | | | Community Psychiatric Nurses' responses ($n$=144) | | |
|---|---|---|---|---|---|---|---|
| | | Should be the role of the OT (%) | Should be the role of the CPN (%) | Doing this in current practice (%) | Should be the role of the OT (%) | Should be the role of the CPN (%) | Doing this in current practice (%) |
| Administering medication | rarely/never | 94.9 | 0 | 93.6 | 93.1 | 1.4 | 4.2 |
| | often/almost always | 2.6 | 97.5 | 2.6 | 2.3 | 65.8 | 72.2 |
| Mental state assessment | rarely/never | 1.3 | 0 | 2.6 | 14.5 | 0 | 0 |
| | often/almost always | 77.0 | 97.4 | 68.9 | 36.7 | 97.9 | 98.3 |
| Assessing activities of daily living | rarely/never | 0 | 64.1 | 2.6 | 1.4 | 7.7 | 14.1 |
| | often/almost always | 97.4 | 2.6 | 82.1 | 88.5 | 55.7 | 47.2 |
| Assessing the home environment | rarely/never | 1.3 | 9.3 | 3.8 | 0 | 2.1 | 4.2 |
| | often/almost always | 92.3 | 33.3 | 73.1 | 95.7 | 71.7 | 75.7 |
| Assessing workskills | rarely/never | 0 | 72.4 | 14.5 | 0.7 | 34.3 | 44.8 |
| | often/almost always | 85.5 | 2.6 | 40.8 | 86.1 | 18.6 | 20.3 |
| Counselling | rarely/never | 13.2 | 6.4 | 17.1 | 21.5 | 4.9 | 6.3 |
| | often/almost always | 31.6 | 48.7 | 39.5 | 31.1 | 86.3 | 78.2 |
| Anxiety management training | rarely/never | 1.3 | 14.1 | 6.4 | 10.9 | 2.1 | 5.6 |
| | often/almost always | 91.0 | 23.0 | 78.2 | 55.5 | 66.2 | 63.4 |
| Crisis intervention | rarely/never | 22.1 | 1.3 | 27.3 | 39.4 | 3.6 | 8.5 |
| | often/almost always | 24.7 | 87.2 | 15.6 | 13.7 | 72.2 | 63.1 |
| Acting as a client's keyworker | rarely/never | 1.3 | 0 | 18.7 | 13.2 | 1.4 | 2.2 |
| | often/almost always | 59.2 | 85.3 | 49.3 | 35.7 | 87.2 | 84.1 |
| Educating relatives and carers | rarely/never | 0 | 0 | 5.3 | 3.7 | 0 | 0 |
| | often/almost always | 74.6 | 77.0 | 48.8 | 63.3 | 88.7 | 80.3 |

NB. The responses 'often' and 'almost always' are combined; 'sometimes' and 'don't know' are omitted, therefore the percentages do not add to 100%.





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hand and assessing activities of daily living (an OT role) on the other.

However, fewer than half the CPNs surveyed were 'almost always' administering medication in practice, which is a lower figure than in previous studies (Hunter, 1978). Only half of the CPNs' clients on average were suffering from chronic mental illness, while most CPNs reported frequent involvement in counselling and anxiety management. These findings echo others which suggest that CPNs are spending much of their time seeing clients with lesser degrees of anxiety and depression, possibly at the expense of the chronically mentally ill (White, 1991). The Review of Mental Health Nursing recommended that the focus of their work should be those with serious and enduring mental illness (Butterworth, 1994). The nurses surveyed in this study would have been trained under the traditional Registered Mental Nurse syllabus. Those nurses currently on largely university-based Project 2000 courses may have different priorities when they move out to work in community mental health teams – this remains to be seen.

Given the traditional links between occupational therapy and work, it was surprising to find that only 13% of OTs 'almost always' assessed work skills in practice. Even taking into account the current high unemployment levels among the mentally ill, this would seem to be a low percentage, which was identical to that among the CPNs.

The most striking finding is that the roles overlapped to a considerable extent, in the areas of mental state assessment, assessing the home environment, counselling, anxiety management training, and education of carers. This suggests that many of the tasks of a community mental health team worker may be regarded as not specific to any one discipline, and raises the question of whether a more generic worker should be trained to cover all the possible tasks required. The results of this survey seem to indicate that if CPNs received more training in assessing activities of daily living there might even be no need for OTs in community mental health teams at all, although the relative costs of training different professionals should be taken into account before reaching such a conclusion. On the other hand, OTs could provide much of the support required by clients with mental health problems, which might be sufficient if, for example, general practice nurses could be recruited to administer psychotropic medication. However, practice nurses are at present not trained to detect relapses nor the need for changes in a person's drug treatment, they do not usually have opportunities to communicate regularly with other community mental health team members, and they may not have the appropriate attitudes for community mental health care. The Butterworth review of mental health nursing (1994) strongly recommended that the speciality should be preserved, to offer those in need a skilled workforce.

There is debate over whether community mental health teams should include members with different strengths through which clients' needs can be met in a joint approach, or whether all members should possess the total range of skills likely to be necessary in a particular person's care. It seems clear from this survey that the roles of professionals with quite different qualifications and experience converge to a considerable degree in the day-to-day provision of care. This may be experienced by patients as unnecessary, or confusing, duplication. A more rational approach for the future might be to define the main tasks of community mental health workers and then to design from scratch a more generic, tailor-made core training. Even were this to be done, however, it seems likely that there would still be scope for further training and specialisation.

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