A PATHWAY TO PROFESSIONALISM: THE DEVELOPMENT OF COMMUNITY PSYCHIATRIC NURSING IN BRITAIN AND ITALY

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ABSTRACT

This thesis focuses on a comparative analysis of Community Psychiatric Nursing in Britain and Italy. The nursing role is examined cross-nationally in relation to the development of community care in the two countries. The central role acquired by nurses in developing and implementing deinstitutionalisation is the starting point for the investigation of professional attitudes and experiences in relation to institutional changes. The purpose of the study is threefold:

a) to investigate similarities and differences between community psychiatric nursing practices in the two countries in relation to organisational models, ideological approaches to care, and professional cultures;

b) to analyse whether there are universal elements in the nursing profession which are central to the process of change in both countries;

c) to identify contextual factors which can constrain or facilitate the professionalisation of psychiatric nursing in Britain and in Italy.

The methodology is based on case study research methods. Two samples of nurses have been interviewed, in Britain and Italy, by means of two sets of questionnaires.

The thesis is organized into two main parts. First, the theoretical chapters provide an historical account of community care and psychiatric nursing developments in the two countries. A conceptual framework for the empirical study is built through the discussion of contributions from the sociology of professions, the

sociology of knowledge, and organizational analysis. Secondly, the empirical chapters describe and analyse results obtained from fieldwork. Whilst the empirical investigation has been limited to England, the literature review includes the whole of Britain.

The results suggest that both British and Italian community psychiatric nurses are professionally at a turning point. The advent of community care significantly changed nursing practices and models of intervention, influencing also the self-perceived professional role and identity.

The findings also indicate that the different organization of labour, of nursing training, and of ideological approaches to psychiatric care are explanatory variables for the diversity in nurses' practices and experiences in the two countries. Despite these differences, both British and Italian nurses seem to enjoy a considerable degree of professional autonomy, which makes psychiatric nursing into a particular case within the overall nursing field.

Finally, the prospects for the professionalisation of community psychiatric nursing are discussed by comparing the national situations with indications from the literature on professions.

TABLE OF CONTENTS

APPENDICES

LIST OF TABLES

LIST OF FIGURES

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INTRODUCTION

Both in Britain and in Italy the conversion of hospital care into community facilities have produced many important changes in the organization of psychiatric care, as well as the development of new care models and professional approaches to mental illness. Community psychiatric nursing represents one of the most important innovations in the community care field. The transition from the hospital to the community role has prompted a transformation of the professional practices and of the organization of nursing work in the community. An understanding of professional issues related to the experience of major institutional transformation is crucial to the development of successful community psychiatric care. This thesis attempts to analyse the professional experience of British and Italian community psychiatric nurses. Far from being exhaustive, it is an initial contribution to the development of social research towards understanding professional needs and problems in mental health.

This study is aimed at : 1) investigating community psychiatric nursing practices, professional cultures, identities, and ideologies of care within the different organizational and historical context of Britain and Italy; 2) at finding out those universal professional features that made of community psychiatric nursing a central role in the development of community care both in Britain and in Italy; 3) at analysing the structural and professional factors which can promote or impinge upon the professionalisation of CPN cross-nationally.

The thesis is in seven chapters. Chapters I and II place community psychiatric nursing into a context by providing a brief history of psychiatric community care in Britain and Italy (chapter I), and comparing nursing developments in the two countries (chapter II). Chapter III focuses on the analysis of the literature review relevant to the study, and presents the theoretical

framework and the research design for the empirical investigation. The issue of professionalisation in psychiatric nursing is discussed by examining contributions from the sociology of professions. Organizational analysis and the sociology of knowledge instead provide a theoretical background for the investigation of community psychiatric nursing organization of work and ideologies of care. Chapter IV illustrates the methodology of the study. The analysis of findings is provided in Chapters V and VI. In particular, chapter V examines nursing educational backgrounds in Britain and Italy, their patterns of work, organizational practices, professional cultures and identities. Chapter VI focuses on the analysis of nursing ideologies of psychiatric care. The conclusive comments are presented in Chapter VII, where the opportunity for community psychiatric nursing to achieve a new professionalism is discussed in the light of the research results.

CHAPTER 1. MENTAL HEALTH CARE AND NATIONAL STRATEGIES: AN INSIGHT INTO THE BRITISH AND ITALIAN EXPERIENCES.

1.1 Introduction

At the moment of writing, Europe is undergoing a period of complex economic, political, and social change. The goal of unifying Europe under economic and legislative aspects is bringing to the surface historical differences between countries which reflect diverse social situations. The wave of political change that took place after the fall of Communist regimes, associated with a generalised economic crisis are such relevant factors as to produce significant modifications within the international scenario. Britain and especially Italy are enduring a period of deep economic recession which is likely to have consequences for welfare provision, and with it for mental health services. Cuts in public expenditure, and particularly in the health sector have already been announced by the Italian government. It is not difficult to forsee that pychiatry will shortly become a 'deprived' sector, even more deprived than it is now. It is therefore with some uneasiness that I approach the task of describing the birth and growth of the movement for deinstitutionalisation in Italy, at times in which -despite the unsettled political period- the future of mental health services looked much brighter than now.

It is nevertheless important to go through the history of community care in Italy and Britain, as it lays out differences and similarities between the two societies and their ways of tackling the issue of mental health, as well as the implications for present and future mental health care in the two countries. The fact that they do not represent two isolated cases in the European scene is also significant. Throughout Europe community care is developing, although nationally at different stages and at a different pace (Tomlinson, 1991). The widespread character of the phenomenon indicates that a change has occured in the view of mental distress. That Spain,

Greece, Portugal (listed as deprived countries by the EEC), or Sweden, the Netherlands, and Britain advance reforms in mental health, hence listing it among their policy priorities, means that universally the view of mental illness can no longer be of esclusion and marginalization[1] . Even if this was a mere government strategy to gain political and social consensus, it would convey that there is a major part of society demanding it. This is an important point to be stressed, as it highlights that changes in health policy are not detatched from society's needs.

The development of community care in Britain and Italy is an example of this. The analysis of such developments has to tackle the complex interplay between structural and individual elements which has significantly changed the psychiatric systems in the two countries. At the structural level, macro factors such as politics, economics, and society's structure play an important role. At the individual level, the role of mental health professionals, and more importantly of users, comes to interact with the former.

From a European-wide perspective there has not been only a single approach to the issue. Organizational factors, like the centralized (Britain) or decentralised (Italy, Spain, USA) state administration determined differences in implementing community care strategies. Furthermore, significant disparities between regions or administrative districts are also evident within a same country, and Italy is a striking example of this [2]. Changes which have taken place since the community care prelude (1950s for Britain and 1960s for Italy) are structurally part of European political and social history. Yet national responses to these varied according to the negotiation between the political and professional parties. The fiscal crisis during the '70s motivated the expansion of profit-making and voluntary sectors in health care (Tomlinson, 1991), thus reducing the state's ability to lead and control its care

[1]For a comprehensive account of developments in Europe see Tomlinson Dylan, *Utopia, Community Care, and the Retreat from the Asylum* Open University Press 1991, Chapter 1.
[2]See: Tognoni G., Saraceno B. Regional analysis of implementation, *The International Journal of Social Psychiatry* (1989), Vol.35 No.1, 38-45.

strategies. In Britain the 1989 white paper proposed arrangements to shift a part of mental health care to private and voluntary agencies. Whereas the 1990 NHS and Community Care Act introduced some new elements which can be regarded as a compromise between a profit-making policy -typical of the private sector- and a welfare-state orientation. Such elements are 1)the division between purchaser and provider, which together with the introduction of care management establish a cost-benefit policy closer to private than to state orientation; 2) the mental health specific grant and users and carers consultations, which reflect a welfare state approach.

Although having a shorter history than its British counterpart (the NHS was established in Italy in 1978 and in 1948 in Britain), the Italian welfare crisis endured more difficult conditions, coupled with lack of planning both at the central and local level, and with political corruption that diverted funds from public to private sectors. Although both stemming from poor government funding, Italian and British professional responses to the crisis diverged. In the first case a greater use of private resources (families) has been functional to both replacing political inadequacy and to restoring sociability towards mental health issues. However, perhaps as a consequence of the welfare crisis, the notion that government and its policies are responsible for the citizens' health has partially lost its power so that few expectations seem to be put on the state role in this sector (Hall P, Brockington I.F , 1991), and acknowledgment of private sector efficiency emerges.

Politically, the end of Communist regimes in eastern Europe, echoed by the spectacular and sometimes manipulative voice of media, gave strength to conservative parties. As a consequence, left-wing parties (traditionally promoters and supporter to social reforms) lost power all over Europe. It is not yet possible to forsee the repercussions of this in Italy, where the left-wing -and particularly the communist and radical parties- have always been supporters of psychiatric community care. However, the current political crisis experienced by the Italian government and the consequent

social demand for change are such as to increase the likelihood of a radical reorganisation of social policy whose outcome is difficult to predict.

The psychiatric sector is equally affected by this wave of change both at the political and the economic level. The current situation for Britain as well as for Italy is that of a transitional period in which new elements and progress coexist with traditional and conservative practices. An example of the ideology behind this conservative tendency, is the recent attempt to amend legislation in Italy aimed at re-directing psychiatric practice towards institutionalization (a draft law-project elaborated during the middle '80s by the socialist party awaits Parliament's approval). Similarly in Britain conservative forces (The Royal College of Psychiatrists and the National Schizophrenia Fellowship) joined to promote compulsory treatment orders in the community for users discharged from the hospital and refusing medication (Ramon, 1991). These are both serious attempts to limit consumers' freedom and the re-acquisition of civil rights which previous legislations had granted. Although in Britain the NSF campaign made people aware of gaps in services, and of the need to plan discharges much more carefully, as well as to take into account carers needs.

At the same time, single sectors within the psychiatric framework pursue innovative practices which confirm the positive results of deinstitutionalization, whenever this is implemented with adequate funding, planning, and committment. The user movement is growing and gaining increasing strength both in Italy and in Britain[3]. Work cooperatives have expanded in Italy, thus providing users with a centre for socialisation, a job, and the ownership of the same enterprise which gives them employment, rather than exploiting them through the practice of ergotherapy used in the asylums.

[3]For an account on user groups' perspective see Davis A., 'Users' Perspectives.' in *Psychiatry in Transition*, S. Ramon (ed), 1991, Pluto Press.

Both in Britain and in Italy innovation does not take place on a national scale. That is why the psychiatric sector is polarised in the coexistence between change-promoting and change-blocking factors (Ramon, 1991). Whilst in the British case there are positive signals for change, and the situation appears an on-going one, in Italy the position of the psychiatric sector seems more static. The author's view on the matter is unfortunately pessimistic, as attempts to boycott progressive initiatives or positive on-going experiences are far too visible. From a political point of view, parties which have always supported such successful examples of good practice have now lost their contractual power. Financial cuts also look easier to propose in relation to people whose voice is not yet strong enough to protest. The Italian psychiatric reform is therefore seriously endangered by this wave of conservative change.

A re-distribution of power has also occured among mental health professions, with social workers, psychologists, and psychiatric nurses gaining more power within psychiatry, while psychiatrists have lost something of their dominant position. Again, this varied nationally as in Italy psychology is a relatively new field, and social work only recently acquired a university status (Ramon 1991). Nonetheless, the relevance of these changes has been such as to prompt interprofessional rivalries (Hall, Brockington, 1991), which may occasionally be the basis for opposing significant changes in mental health.

In particular, community psychiatric nursing increasingly gained importance both in Britain and in Italy. In order to understand the whys and hows of this professional growth, it is necessary to analyse the process of hospital closure and community care implementation which have largely paralleled this professional development.

The implementation of psychiatric community care is the departure point for an historical understanding of the current nursing role in psychiatry. Before

community care, psychiatric nursing was exclusively a hospital profession whose birth and growth took place under medical hegemony. Significantly, the advent of community care brought important changes to the profession both in Britain and in Italy, the most relevant being the acquisition of a relevant degree of autonomy from the medical field. The aim of the next sections is to point out the conditions which made this possible, and the rationale behind this development.

1.2 Britain.

The Second World War represents the threshold for psychiatric community care in Britain. A number of events occured which contributed to a significant change in the view of mental illness. Psychologists and psychiatrists were employed by the Army and sent to the front line to screen soldiers suffering from war neurosis. Whilst deserters during the First World War were court martialled and shot, the pattern changed to provide soldiers with the psychological help necessary to face the brutality of the war. Several therapeutic communities were established for this purpose. Evacuation of children and their mothers also required psychological support, and a new emphasis was put on the role of motherhood in promoting the child psychological well-being. For the first time it was acknowledged that outside reality can lead to psychological unhappiness and breakdown. Explanations about war-neurosis were all focused on psychological causes. Psychoanalysis had also gained more ground since its early development during the 1920s. The psychological trend was not reflected within the hospital, although there was the introduction of the open door policy, and of industrial and therapy wards.

In 1948 the National Health Service was established, and psychiatric services were included in its provision. Between the 1940s and the 1950s there was a great expansion in the out-patient sector. During the early 1950s the introduction of psychotropic drugs contributed to emphasising this trend. Currently the sector of out-

patient clinics for adults and children is still greatly influenced by the psychological approach, particularly behaviourism and psychoanalysis (Ramon, 1991).

The origins of British community care are significant to the understanding of its developments over the last twenty years. Psychological rather than strictly psychiatric explanations of mental distress associated with the occurance of a significant need for social adjustment due to the war, constituted the ground from which community care could be launched. There was therefore a change in the epistemological basis of psychiatric care to allow a shift - still partial and on experimental scale - in the locus of care. It has been observed (Ramon, 1987) that the introduction of drugs in psychiatric treatment has been functional to re-affirm the medical dominance in the field, during a period in which psychological developments were gaining importance in the care of mental distress. It is also significant that according to a general opinion community care has only been possible because of the introduction of psychotropic drugs which allowed control of patients even outside the hospital environment. As has been outlined above, this is not historically correct as community care started before the discovery of such medications. More precisely, it can be said that the advent of psychotropic drugs helped in developing community care. Nevertheless since the drug revolution, the expansion of community care took place under the control of the psychiatric establishment, emphasising that any change had to occur within the medical framework.

Community care has been supported throughout the past forty years by government policies which have gradually directed its expansion. However, such support has been more directed towards the production of policy papers than towards real action. The 1959 Mental Health Act supported the development of community care, at least in principle if not with consistent financial provision. A White Paper in 1962 mentioned for the first time the introduction of psychiatric wards in district general hospitals. In 1963 the publication 'Health and welfare: the development of

community care' specified this approach with regards to the local authorities' role. In 1971 the DHSS published a document entitled ' Hospital services for the mentally ill', which proposed the abolition of large mental hospitals and the development of community care. This proposal was restated in 1975 with 'Better services for the mentally ill' (Brooker, 1985).

Government committment to community care, although stable over the years, has never gone beyond generic indications of purpose. Section 117 in the 1983 Mental Health Act states that people under compulsory admission who are discharged to the community are entitled to local authority support. But the law does not specify what is meant by such support, or its standards. Meanwhile the closure of large psychiatric hospitals has been massively promoted, but with very little attention given to the planning of closures, often delegating such organization to local teams. The most dominant comment against government mental health policies focuses on the contradiction between statments of purpose and insufficient financial provision. Community care has been chosen by successive governments because it was considered to be a cheaper option to that of running large and expensive psychiatric hospitals, and not on the grounds of therapeutic considerations. Ramon writes in 1985 'Until now the White Paper 'Better services for the mentally ill" in 1975 is the only one to concern itself with the rationale and organization of community-based services. Significantly it was not seen as a basis for legislation.' (Ramon, 1985)

There is therefore a need to ask why, given the abundance in policy papers, the development of community care has been slowed down by lack of financial and organizational indications. The author agrees with the analysis developed by Ramon (1985), according to which 'politicians follow the initiatives of professionals in psychiatry and not vice versa'. Although an interplay between politicians, lay people, and professionals is acknowledged as the basis for change, it is to professionals that the power to lead the game is granted on the grounds of the expertise they hold .

Although changes have occured within the psychiatric professions (Psychologists, Social Workers, Psychiatric nurses, and Psychiatrists), the psychiatric establishment has not been threatened enough, the disease model rather than the social or psychological is still more dominant. Whilst psychiatrists possess the basis of expertise which makes of them a powerful professional lobby, paramedical professions hold the power of number as their category consistently outnumbers that of psychiatrists. Community care potentially threatens both groups. Psychiatrists are challenged as to the basis of their professional knowledge. The philosophy behind community care disregards the disease model in favour of the social and psychological ones. Paramedical professions on the other hand, react against the threat to their posts, as no guarantee of re-employment in community care places has been given to them by the government. Furthermore, they may feel challenged by the uncertainty that a radical change usually brings about in terms of practice of work. The stronger opposition still comes from those (mainly hospital psychiatrists and nurses) who believe in the disease model which attributes impairments to patients' mental health exclusively to biological causes rather than social and psychological ones.

British psychiatry is currently in a transitional phase, where new progressive practices and out-dated hospital regimes coexist. It has been estimated that 30 psychiatric hospitals have closed between 1980 and 1990, and that 38 are due to close by 1995 (Hill, 1993). Two psychiatric hospitals were closed in 1987, following two different organizational patterns. In the first case, hospital population and staff were transferred to other in-patient units. In the second case, out-patient clinics were created for patients, and the staff employed in community health centres. Generally, little effort has been made to change the hospital regime from the inside, before projecting it to the outside reality. Rehabilitation programmes, where practiced, took place on an individual basis, hence devaluing the collective dimension of hospital life.

On the other hand, the power of professions such as social work and community psychiatric nursing increased due to developments in the legal and educational framework (guardianship for SWs according to the 1983 Act, and ENB training for community nurses). The new generation of psychiatrists seems to be more open to change than their predecessors. Finally, the growth of users' organization is a signal for an assertive wave of change which seems bound to happen.

This is the background where British community psychiatric nurses grew and consistently developed from the establishment of the two first units during the fifties. Nurses interviewed for this research have been protagonists of many of the changes described above. As professionals and as lay people they are part of the British system, therefore both subjected to its mainstream psychiatric ideology and promoters of change. As community psychiatric nurses they are supposed to be in the front line of innovation, as professionals who have been trained by the psychiatric system they reproduce some of its contradictions. For a closer analysis, such elements of incongruity are the starting point for change.

1.3. Italy

The official hallmark for community care in Italy is Law 180, enacted in 1978, few months before the establishment of the national health service. Law 180 came to radically change psychiatric care in Italy. It replaced the old legislation of 1904, whose amendament in 1968 had only partially modified the hospital-based care system by introducing voluntary admissions and paralleling hospital care with sectorized community services on the model of France (Psychiatrie de Secteur), (Mosher & Burti, 1989).

Law 180 planned the phasing out of psychiatric hospitals and their replacement with community services: no re-admission was possible after December 1981, and new admissions were immediately stopped. Compulsory admission could take place only under the agreement on treatment of two doctors and the local mayor. Psychiatric wards were attached to district general hospitals, with a provision of 15 beds for every 200.000 population. Compulsory treatment could take place only within those premises, and last for a maximum of 7 days, renewed under particular conditions for an other seven days. Community mental health centres were to be the backbone of psychiatric care in Italy, equipped with multi-disciplinary staff either newly-employed or transferred from mental hospitals. The law guaranteed that staff were not to be made redundant.

The psychiatric reform followed social and political pressures activated by a movement for deinstitutionalisation, which found its original promoter in Dr. Franco Basaglia. During the early '60s, Dr. Basaglia started to change the hospital in Gorizia, of which he was director. The project first aimed at converting the hospital into a therapeutic community according to the English model proposed by Maxwell Jones, which Basaglia had analysed and liked. Yet, shortly after the first experiments Basaglia and his team realized that it was the institution itself which was the primary source of alienation and mental impairment. Asylums represented the negation and exclusion of deviance from ordinary life, the non-acceptance of weaker members of society whose voices had been silenced through the violence of institutionalisation. In fact, mental hospitals symbolized the contradictions of a capitalist society whose unproductive members had to be marginalised and forgotten.

In the light of this analysis, the group started to run down the psychiatric hospital in Gorizia. The process was slow and required the full participation of in-patients together with staff. There were day-long meetings where patients, nurses and doctors were asked to formulate proposals about dismantling the hospital. The whole

experience was in fact a counsciousness-raising process to which patients, whose individual rights and needs had not been voiced for years, slowly but progressively adhered. The staff had to be re-integrated too, as they were subjected to the same institutionalisation as patients.

Basaglia was boycotted by the local government before the dismantling process had come to an end. The whole team resigned when they thought they could not influence the situation as they should. A resignation letter was sent to the patients as well. The group then moved to Trieste where the state hospital was actually closed in 1977, and replaced with a community care network. From then on, the experience spread to several parts of Italy (Arezzo, Perugia, Torino, Ferrara, Parma, Reggio Emilia). Meanwhile, the Society for Democratic Psychiatry (Psichiatria Democratica) was founded (1973) by professionals and supporters to the movement. The aim of the association are clearly indicated by its manifesto in which the mental health worker's tasks are listed.

> 1. Identify and fight one's own power role in relation to the user.
> 2. Identify, in the individual, unmet social needs that confinement wipes out by concealing them under the diagnosis of illness.
> 3. Identify therapeutic interventions that are implicit in one's specific role performance, after having freed oneself from the instrumentalization that social system exerts by delegating control and power.
> 4. Identify and recognize individuals and social forces already involved, and those to be involved, in the fight. (From Mosher & Burti, 1989, 198)

Psichiatria Democratica actively started to look for political support, finding it among left-wing parties which made the Psychiatric Reform a target on their political

agenda. Left-wing parties were in fact also supporters of the establishment of the National Health Service, of which the psychiatric reform was the vanguard. However, nothing happened until the Radical Party succeeded in collecting the 500,000 signatures required to call for a referendum on the 1904 legislation. The Government of the day, a coalition between Christian Democracy and centre-oriented parties, decided to enact Law 180 in order to avoid the political defeat which a possible success of the referendum would have brought.

At the same time, other pressure groups promoted several social reforms. The abortion law, the divorce law, the introduction of handicapped children into main-stream schools, the youth and the women movements all took place and developed from the middle '60s to the mid '70s. The movement for deinstitutionalisation or non-institutionalisation[4] was therefore part of a broad wave of social change which characterised the country during that decade.

Shortly after the enactment of Law 180, the National Health Service was established and mental health was incorporated within its administrative framework. Regions were granted wide degree of administrative and legislative autonomy. This is one of the reasons why the picture of psychiatric care in Italy is so heterogeneous. From north to south there are great variations in type of psychiatric services and organization of work.

The fate of the psychiatric reform has in fact been inexorablely linked with that of the Italian NHS. Both of the innovations came into being when the crisis of welfare state was deepening, so that taxation increased and local funds have often been diverted to the central government. Regional authorities found themselves with legislative and administrative autonomy but with shortage of budgetary power to

[4] Burti (1989) suggests the use of the term 'non-institutionalisation' as a better reflection of the character of Italian psychiatric reform, whose focus is on the system rather than on patients. The path of institutionalisation is in fact interrupted by forbidding admissions to the hospital, at the same time the process of phasing out hospitals is a gradual one, so that rehabiliation programmes can be set up.

practically implement reforms (Mangen, 1989). Problems of coordination between local and central authority clouded the picture even more. Financially, the community sector has always been under-resourced as compared to the hospital one, as is the case for Britain. It has been estimated that in Britain only the 0,5 billion of the 2,00 billion budget for mental health goes to community structures. In Italy, in 1982, 82,000 milion lire out of 1,245 went to community care. (Ramon, 1991)

From a political view point, the enactment of Law 180 overlapped with the beginning of a difficult period in Italian history, whose events contributed to weakining the implementation of social reforms. The 1980s saw the experience of black and red terrorism. Burti (1989) observed that the assassination of Moro, who was pursuing a coalition between Christian Democracy and the Communist Party (so called 'Compromesso Storico'), was a threshold for the beginning of a critical period in the Italian political and social life. Italians' reaction to Moro's death have been compared to those of Americans to Kennedy's assassination. It was believed that the very basis of democracy was threatened. Special laws were passed to limit political actions and public gatherings, social reforms promoted by leftists were looked at with suspicion. Nowadays, it can be hypothised that the terrorists' actions have been suspiciously functional in maintaining the status quo, to move away from the Compromesso Storico project, and to hold back the revolutionary potential of the social reforms achieved by them.

Similar to the British case, a transformation of the psychiatric care system has been possible in Italy only subsequent to a change in the epistemological basis of psychiatry which reflected a wider social and political reorganization. However, the Italian way of community care differs from the British in one important point. The block of hospital admissions prescribed by the Law meant that from then on psychiatric care had to be carried out only within community structures. Institutionalisation as such was therefore immediately stopped. Instead the British

choice has been that of paralleling community services to hospital structure, hence avoiding a radical rupture with the old system. This is in fact a significant difference with Italy, since in Britain for over 40 years two organizational models of psychiatric care have been cohexisting, both regarded as adequate, although different, answers to mental health needs. In Italy the psychiatric reform meant an epistemological chasm, in the sense that Khun accords to the word, in the philosophy of psychiatric care. The difference is also mirrored in national legislations. The nature of Law 180 is of radical change with respect of the psychiatric order as it had been legally defined up to 1978. In Britain the 1959 and 1983 Mental Health Acts modified the legal status of patients (the introduction of voluntary admissions and informal admissions respectively) and shifted the care and treatment of mental illness from a legal to a medical and social framework (Whitehead, 1983). Law 180, in the Italian case, established the phasing down of psychiatric hospitals paralleled with the implementation of community care, and most important, the right of patients to treatment.

The Psychiatric Reform has been extensively analysed by national and international literature, although evaluation and monitoring have not been carried out on a national scale [5]. It has been observed (Ongaro-Basaglia, 1989) that delays in investigating the outcomes of Law 180 are useful to those who oppose it. Up to 1985 no national study had been published on the implementation of Law 180, despite the fact that criticism developed immediately after its enactment. The picture that emerges from the 1985 CENSIS survey is of fragmentation in the strategies of implementation. Frisanco (1989) describes four main areas outlined by the survey's results. These are a) heteregeneous experiences with wide variations on national and regional scales; b) insufficient degree of personnel mobility from hospital to community structures, coupled with lack of training for community work; c) lack of codification of organizational standards; d) inadequate information systems to

[5] For a comprehensive review article of published literature about the Psychiatric Reform see: Bollini P. and Mollica R., Surviving without the Asylum. An Overview of the Studies on the Italian Reform Movement. *The Journal of Nervous and Mental Disease*, Vol.177, No.10, 607-615.

monitor efficacy and efficiency of services. Frisanco's research also shows that places which followed Psichiatria Democratica and the reform spirit were offering a much better service, and were more in demand. Despite the research's indications, little financial or organizational provision has been set up since then. Up to now the majority of the mental health budget is still directed to psychiatric hospitals and private clinics, still existing to take care of the so called 'residual' population. It has been estimated that only about 3% of the national budget for health care goes to the psychiatric sector, and that 2% is directed to the in-patient sector and 1% to the community sector (Rotelli, 1988).

Since 1985, no other research has been promoted by government on a national scale, although criticism and sensational tales about the malfunction of community services have been largely used by political opponents to support new, institutionalising proposals. The current debate on the 'Italian experience' sees the opposition of two groups: those who consider Law 180's principles as unsound therefore subject to modification, and those who regard the implementation of the Law as defective. In fact, whenever there has been the combination of workers who strongly believed in the potential of the reform, charismatic leaders, and sympathetic local authorities Law 180 has produced the most efficient and effective community services, of which Triest is the most documented one. The root of the problem is that charisma and committment, as well as sympathy, cannot be guaranteed by any Law. It follows that organizational indications, as well as local authorities' statutory duties should be specified, hence avoiding political boycotting and methodological indeterminacy. Yet it may be important to look once again at the role of professionals in the matter. And particularly, to those who hold the culturally acknowledged expertise which provides them with a stronger voice to indicate, evaluate, and change.

The author agrees with the view that:

> 'The story of the Italian Reform is neither a success, nor a failure. It says that a hypothesis grounded on the liberation of the poor is not easily acceptable and creatively managed by the professional community of psychiatrists who share with medicine the bias of having an excess of alternative answers to seriously consider the possibility of their irrelevance for the solution of the real needs.' (Tognoni and Saraceno, 1989, 107)

Psychiatric nurses have been central to the development of Italian community care (Zani et al., 1984, Battaglia, 1987, Ramon 1985, Brooker, 1985, Savio 1991). The majority of nurses interviewed work in areas of Italian good practice (Friuli Venezia Giulia) and they have witnessed the change and experienced it personally. Like their British colleagues, they endure the contradictions of community care on a daily basis, as well as its successes. The 'Italian experience' is unfolded through their testimonials, from the view-point of workers whose unskilled professional status has partly freed them from the bias of science.

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CHAPTER 2: PSYCHIATRIC NURSING IN THE COMMUNITY: HISTORY AND DEVELOPMENTS IN BRITAIN AND IN ITALY.

2.1. Introduction

Community psychiatric nursing has developed during recent years in Britain and in Italy as a result of de-hospitalisation programmes. The role of CPNs first emerged in the care and follow-up of patients discharged from psychiatric hospitals. Nurses were withdrawn from hospital duties and employed in community schemes. Community nurses therefore originated from mental hospital nurses, who were temporarily or permanently allocated to community programmes.

An understanding of the growth and evolution of community psychiatric nursing needs to investigate the nursing profession within hospital psychiatry. As a matter of fact, psychiatric nursing did not grow out of general nursing, and it cannot be considered a specialist branch of this. Both in Britain and in Italy the professional evolution of psychiatric nursing finds its roots in the history of psychiatry. To trace back the history of psychiatric nursing means to analyse the emergence and growth of psychiatry as an independent science, acknowledged and accepted in the realm of medicine.

The analysis of CPN history in Britain and in Italy will outline differences and similarities between the two countries which are linked to the national developments in psychiatry.

2.2. Community Psychiatric Nursing in Britain.

The origins of psychiatric nursing in GB show that the occupation emerged as such only when psychiatry could assert itself within the field of medicine. This took place between the end of the 19th century and the beginning of the 20th century. The following is a brief historical account of these developments, as described by Dingwall et al. (1988).

Prior to 1830 , mental disorder was treated informally, as no clear institutional provision was made for its attendance. The situation significantly changed in 1834, when the Poor Law Amendament Act prescribed the implementation of a workhouse system. Initially, such institutions absorbed any kind of destitute paupers. With the development of theories which placed the care of mental illness within a medical framework, new asylums were created separately. However, workhouses, prisons, and asylums shared a common status in that they dealt with economically un-productive people.

Originally, asylum staff was indistinctly called 'keepers', 'attendants', or 'superintendents' for those in the role of directors. Such denominations always referred to male personnel, as women were called 'nurses'. However, asylums had a prevailingly male personnel who filled the occupational requirement of physical strength. Within the asylums for the poor, attendants shared the same condition as the in-patients.

By the end of the century, the search for organic causes of mental illness was re-emphasised, in the hope of finding successful remedies as in the case of physical illness. This produced a new demand for assistants. In order to satisfy this need, medical superintendents started to introduce the medical nursing model into the

asylum. The most interesting change came in 1891, when examination was introduced by the Medical Psychological Association to nationally certify hospital personnel. Attempts to modify attendants' training began in 1845. In 1885 a group of superintendents produced a paper entitled 'Handbook for the instruction of Attendants on the insane'. Modified with some changes, this became the text-book required for training and examination by the Medical Psychological Association. In 1923 the title was changed in 'Handbook for mental nurses', mirroring the acceptance of the word 'nurse' for staff of both sexes. This edition was the standard work on the subject until 1954. Attendants became the first segment among nurses to acquire a relatively uniform training and a register for certified practitioners.

The discovery that siphilis could be a cause of mental illness, contributed to place the latter within a stable, medical, and organic framework. Following the logic of these developments, mental nursing was assimilated to general nursing as a separate branch of a common occupation. The Nurses Registration Act of 1919 allowed the creation of a supplementary psychiatric nursing register.

From then on, changes in mental nursing training paralleled those in psychiatry. The events which took place during and after the Second World War contributed to modify the view of mental illness, and with it the patterns of care. In 1962 psychiatric nurses were provided with a three year training course that led to the qualification of Registred Mental Nurse. The second and third years of the training programme focused on psychiatric specialisation. A new syllabus was introduced which put more emphasis on the study of psychological developments, which mirrored the evolution taking place in the field. In 1971 the General Nursing Council underlined the need for including community experience in training syllabus. In 1974 the RMN syllabus was modified in this direction.(White, in Brooker ed., 1991)

Meanwhile, the first nursing community experiences had already taken place. The two first community psychiatric nursing units were established in 1954 and 1957 respectively. The service established at Warlingham Park Hospital in 1954 responded to the call to fill the shortage of psychiatric social workers, and to the acknowledgement of a need for supervision of patients following discharge. Nurses spent time in the community but were hospital based. Such hospital links were valued as important to the continuity of care:

> 'Because of his/her training the qualified nurse is well fitted to assess the mental state of a patient, especially if s/he already knows the patient. It is in this nurse-patient relationship that the value of the out-patient nurse is most clearly shown.' (From May and Moore, 1963, in Carr, Butterworth, and Hodges, 1980, 22)

The second CPN unit was established at Moorhaven hospital in 1957. There again nurses had a dual hospital-community role. Differently from the pattern in Warlingham hospital, nurses at Moorhaven acted similarly to social workers, and their role as 'therapeutic agents' was stressed, (Brooker and Simmons, 1986).

In 1970 the reorganisation of social service departments caused a vacuum in follow-up care which CPNs filled. Since then the number of CPNs consistently grew, and such development is well documented by the following figures. In 1954 there were four CPNs, 266 in 1966, 1667 in 1980, and 2758 in 1985. From the last CPNA survey in 1990, the total CPN workforce is estimated to be 4490. The rate of growth has been of 54% between 1985 and 1990, and of 65% between 1980 and 1985.(White, 1990)

Many changes occured over the years both at the organisational and professional levels. The last CPNA survey highlights a distinction between CPNs'

main basis and operational basis. For the most of community psychiatric nurses the operational basis is the community, only 22,6% of nurses in the UK have their operational basis within the hospital. This points out a trend towards following clients in the community rather than referring them to the hospital for community follow-up. The closure of large mental hospitals must have been influencial in this, but above all the understanding, at the managerial level, that the future is in the community. Specialisation also developed among community nurses very quickly. About 42% of nurses reported to specialise with a particular client group, and among these 59,5% specialised in the care of the elderly. 14% of nurses in the UK also specialised in a particular therapeutic approach of which the most developed are family and behaviour therapy. Referrals to CPNs come in large part from psychiatrists and general practitioners (White, 1990).

At the educational level, specific training for CPNs began during the early '70s promoted by the Joint Board of Clinical Nursing Studies. Still, only a minority of CPNs has undertaken this post qualifying course while there are pressures for making it mandatory. The Registered Mental Nursing syllabus was significantly modified in 1982, with the introduction of the 'nursig process' which included elements of social policy, psychology, and sociology. It has been argued that the modified RMN training would have allowed psychiatric nursing provision to be more flexibly allocated amongst all settings of care, including the community. This would have left unanswered the need for a development of specialised CPN education at the mandatory level. A call for specific CPN training is currently an issue, due to the further developments of community care in replacement of hospital-based treatment. That only a minority of nurses undertook the 36 weeks CPN specialised training, seems to be connected to lack of financial resources and the persistence of material interests against educational considerations. (White, 1991, 292)

The dramatic growth in CPN prompts a question: why nurses and not, for example, social workers? What is special about community nursing that a social worker could not do? An answer to these questions leads the debate within the field of professionalisation. Before entering into the details of the matter by discussing the literature on nursing professionalisation and the documented comparison between nursing and social work, let us lay out a thought-provoking consideration. It has been seen that the origins of nursing and its expansion in the community field followed parallel developments in psychiatry. Nursing was created as an occupation because psychiatry needed it, first in its mere custodial aspects, and successively in its caring performances. In both cases nurses have always been an appendix to the medical practice, dependant on it for the execution of tasks which only the diagnostic power of doctors could indicate and evaluate. When psychiatry could no longer be practiced within the protection of hospital walls because an ashamed society demanded the re-inclusion of their deviants and un-productive members, medicine needed to find ways to extend its control outside the hospital too. Who better than nurses, traditional extension of physicians' will, to undertake this task?

2.3. CPNs and Professionalisation

The issue of professionalisation has been differently addressed in the nursing literature. This points out that a move towards a more qualified professional standard emerges from within the profession as an answer to the developments which have characterised psychiatric nursing from an educational, organisational, and managerial point of view.

There are two types of publications available on CPN's professionalisation: sociological and interprofessional comparative articles. Those which analyse the issue of professionalisation from a sociological perspective, discuss whether CPNs have already achieved those standards of autonomy, responsibility, and exclusively

professional knowledge-base which, according to the literature, make an occupation into a profession (Simpson, 1988; Morrall, 1989). Articles which focus on inter-professional comparison tend to concentrate on the analysis of differences and analogies between CPNs and social workers (Morgan, 1991; Manning, 1988; Drodz and Gabell, 1991; Barry, 1987; Sheppard, 1990). Both of these approaches stem from the consideration that community psychiatric nursing is professionally at a turning point.

Together with these contributions, it is also interesting to notice the production of articles on the professionalisation of nursing as a whole (Salvage J.,1988; Dingwall R.,1986; Clarke J., 1986). These papers underline the growth of nursing and the changes which took place within the occupation, based on both training advancement and specialisation. In particular, Salvage observes two main changes in the profession of nursing which could be considered as a starting point for professionalisation. The nursing practitioner role challenges the traditional nurse's subordination to doctors, while patient-centred care approaches modify the routinized character of the nursing job. At the same time, the proliferation of tasks within nursing is looked at with suspicion as being a possible threat to specialisation: 'For example, is serving meals a necessary aspect of the nurse's concern for her patient's nutrition, or a task perfomed because of domestic staff shortages? No clear consensus has emerged.' (Salvage, 1988, 519).

The evolution of community psychiatric nursing particularly fits this description. CPNs are increasingly working as independent practitioners, and they are specialising with specific client groups. As for the proliferation of tasks, the analysis becomes more complex. There is a need to ask whether assisting patients in their daily needs, like eating, is a skilled or unskilled activity. It may be that in psychiatry things appear more straightforward, but it is certain that helping clients to restore their ability in carrying out personal activities (like preparing their meals, dressing, combing their hair, etc.) is central to the process of normalisation in community living. It remains

the question whether the execution of these tasks require particular professional skills or can they be performed by anybody. It is also a disturbing thought that, should the activity be regarded an unskilled one, nurses would need to avoid carrying it out. There is therefore also a issue parallel to that of specialisation which is of relevance for community nursing: is specialisation favourable or detrimental to patients' well-being?

In another article on nursing professionalisation the following comment appears of interest. '...it is not the managerial changes which seem important, but the changes in the way nurses see nursing, and the way they see themselves.'(Clarke, 1986, 29) The quotation highlights a further aspect of professionalisation, that is the self-perceived professional image and role. A reason for doctors being regarded professionally powerful and in possession of a unique knowledge, is to be found in their holding the expertise to restore patients to their original well-being. This remains true as far as society and doctors themselves believe it true. The social imagery attributes to doctors the same functions which in the past were identified in magicians. Medicine is something magic and mysterious because nobody-apart from doctors- knows its rules/secrets, and because such knowledge is applied to the most valuable thing: human life. This is re-inforced in training for medical students, where the issue of professional responsibility is stressed by reminding students of their irreplaceable contribution to human life and death (Becker, 1964).

Doctors are advantaged by performing an activity which in most cases should produce tangible results: an infected appendicitis is physically removed and the patient is immediately restored to health. In those cases where medicine has not yet found ways to overcome an illness, like cancer, the blame has been shifted from doctors to the disease itself, so that in people's imagery cancer is perceived as an obscure threat. In Italy, for example,the expression 'il male oscuro'(the unknown badness) is often used, which reminds one of something uncontrollable, beyond human understanding,

evil, magic. Recent research has demonstrated that physicians tend to avoid diagnosis communication in the case of cancer. Apart from their possibly inadequate psychological training in dealing with it, I wonder if this could hide the embarassment of implicitly admitting a failure in the immense power of medicine.

A science introduced into the realm of medicine like psychiatry, has constantly tried to reduce mental distress to the level of an appendicitis. Who can forget the sad attempts to surgically remove the disease by means of devastating lobotomies ? The trouble is that mental illness is not as easily controllable in its symptoms as physical disease is (let us leave apart also the original causes of this latter, which are frequently neglected by medicine). This may be one of the reasons for psychiatry having always been the Cinderella of medicine, because it was unable to achieve as brilliant and manifest results as other branches of the science. It is within this framework that the attempts of community psychiatric nurses to professionalise their occupation would need to be considered.

The comparison between community psychiatric nursing and social work draws out further, interesting elements in the analysis of the matter. The first data which emerges from the literature is that both CPNs and SWs are increasingly becoming predominant figures in community care. One of the consequences of this is the search for specific areas of intervention in order to avoid overlapping in care provision and delivery. Sheppard (1990) observes that whereas in social work the Seebom Report, the Ottan Report in the early '70s and the Barclay Report in 1982 provided descriptions and prescriptions about the professional role, nothing of the kind is available in the case of community psychiatric nursing. Pollock (1989) in the attempt to define CPN, found out that there is no clear consensus about what CPNs are and should do. The analysis of task-centred definitions of CPN shows that there are diverging opinions about the community psychiatric nursing role. The activity of giving injections is for example considered a vital component of CPNs' work by some

authors, as an 'informed contribution' by others, and rejected as inadequate by still other contributions. It is possible that home visiting is considered as typical of CPNs, but it is also acknowledged that other professions practice such intervention. Organisational differences make the task of defining CPNs even more complex. It is possible that hospital based CPNs, primary health care centred CPNs, and CPNs with district general hospital attachment will have different caring priorities.

Areas offered for social work intervention are more carefully defined in the Barclay Report, which together with social assessment, consultancy work and social treatment methods, identifies a role for social workers in providing networks of support in the community (Sheppard, 1990).

A difference between CPNs' and SWs' role has been indirectly identified in the 1983 Mental Health Act which confers different power on the professions. Such differences seem to be mirrored in training. In another contribution Sheppard (1991) argues that the main distinction between social work and psychiatric nursing lies in their different model-approach to mental health work. Social work training is based on a holistic approach focused on social science and the use of psychodynamic models. The three years psychiatric nursing training (RMN) would be more medically oriented. Furthermore, according to Sheppard, CPNs' and SWs' approach to practice would be substantially different. Social work broadly looks at the social problems which define the context where distress arises, whereas community psychiatric nursing focuses on the individual as the primary area of intervention. Sheppard's research also demonstrated diversity in the length of intervention which reflects the diverse theoretical basis of the two professional groups. SWs' practice tends to be lengthy, thus allowing enough room for psycho-social analysis, whereas CPNs have shorter tasks, also due to their larger case-load.

In conclusion, it seems reasonable to affirm that, although SWs' and CPNs' areas of intervention often overlap, the main difference between the two is identifiable in a diverse professional culture which is visible in intervention style. Individualist and holistic are the most used adjectives to define respectively community psychiatric nurses' and social workers' practice. This should not be surprising, if it is considered that CPNs come from a clinically based training, and they have been traditionally dependant on medical practice. It is also possible to detect interprofessional rivarly between social work and community psychiatric nursing. The impression is that social workers feel exploited out of their original professional role by nurses, who do not possess the necessary knowledge base to act in this direction. This actually confirms the community psychiatric nursing search for a new professional identity, possibly detached from medical practice and certainly different from that experienced in the hospital executive and routinised roles.

The analysis of publications available on CPNs corroborates this hypothesis. The literature production on CPN has constantly increased since 1965, when about one contribution per year was published in comparison with the current trend which is of some 30 articles or papers published every year (Bowers, 1992). The attempt to identify a specific role for community psychiatric nursing becomes evident also in the literature. Interestingly, the publications concentrate on three main areas: descriptive articles about community psychiatric nursing, clinical articles, and papers about descriptive research. The proliferation of publications about CPNs specialist roles, particularly in the care of the elderly, and of long-term clients like those diagnosed with schizophrenia is intriguing. Those papers tend to stress the flexibility of community psychiatric nursing, and the opportunity of addressing training to specialised areas, almost as if aiming to produce sub-professional groups within the same occupation.

It is evident from this analysis, that community psychiatric nurses need to elaborate an occupational strategy adequate to their call for a new professional identity and status. It remains to see whether it is wise to undertake the path of interprofessional struggle with social workers, or to identify a specific nursing contribution to community care. The literature also tackles the issue whether to create a new profession, a mental health worker, that would unify CPNs and SWs competences. Interestingly, such a proposal was quite popular in Italy during the early '80s, when a large number of people were employed in mental health without any professional qualification, and trained in ad-hoc programmes in the field. Currently, such workers are commonly called 'nurses', their modalities of work being just the same as those of other qualified nurses in psychiatry, but their salary is indeed lower. In this case, the creation of a multi-function mental health worker has been detrimental to professional identity, status, and economic reward.

CPNs appear to have two options in pursuit of their goal. A) To follow doctors by trying to define a specific area of knowledge which is still un-shared by other occupations, find a market for it, take full responsibility for carrying it out as well as decisional autonomy, and code of practice. B) To take the opportunity that community care has offered them, that is to proceed with the process of dismantling the very basis of bio-organic psychiatry, and demonstrate that mental illness can be healed by other approaches than the medical one. This second option does not need to totally reject, for example, the use of drugs, but to make it secondary to other psycho-social intervention approaches. Should CPNs choose this second option, they would need to first acknowledge the value of such an approach for clients. In other words, they would need to realise that to assist and re-socialise clients in cooking, shopping, and dressing nicely, as well as counselling, are as important activities as operating an appendicitis. CPNs need to be aware that their contribution is essential to restore clients' health. It is only from this consciousness that they could transmit

the value of their job to society, to render it socially acknowledged, and so acquire a new professional status.

2.4. Community Psychiatric Nursing in Italy.

Similar to the British case, nursing began to acquire an occupational status in Italy only when psychiatry could assert its domain in the care of the 'insane'. This process began to acquire a more definite shape with the unification of Italy in 1861. Prior to this period some institutions for the care of the insane had already been established in several Italian states. During the 19th century admissions of 'deviants' to such institutions occured on a smaller scale than in Britain, where the number of people with mental health problems increased as a consequence of industrialization and urbanisation. Between the end of the 19th century and the beginning of the 20th century the rate of admission in Italy dramatically increased, possibly as a reflection of social and economic changes brought in by the unification process.

Law 36 in 1904 'Provisions on Public and Private Mental Hospitals' can be considered the starting point for the official recognition of psychiatry in Italy. The law 'actually ratified Italian psychiatry as a defined scientific discipline and as a function of the state' (Mosher & Burti, 1989, 189 see ref. Chapter I). Prior to this law, there were no legal provisions regulating psychiatric practice on a national scale. It is in the 1904 law that the word nurse appeared for the first time in official documents: 'local regulations in each asylum will need to indicate parameters in order to allocate nurses proportionally according to the number of inmates.'(Art.5)

Law n.36 answered the need for controlling a phenomenon which was potentially a cause of social disturbance. It was therefore informed by the principles of dangerousness and public scandal associated to the mentally distressed. Accordingly,

psychiatric care acquired a mainly custodial and assisting form. Within this framework, the nursing role was predominantly custodial. As a consequence, little emphasis was put on training and qualifications. The task of establishing professional courses for nursing was delegated by the law to the hospital director. Requirements for admission to nursing roles were the following: 'to have a healthly physical frame,[...], to have demonstrated a good ethic and civil behaviour, to be able to read and write...' (art.23/R.D.n.615).

Since the responsibility of training was delegated to hospital directors, nursing education developed in as many ways and forms as the number of hospitals in the country. An attempt to regulate the heterogeneity of nursing training took place in 1971, following an initiative of the Ministry of Health. A document was circulated which emphasised the need to overcome custodial forms of care, in light of the partial shift of mental health care to district general hospitals envisaged by an amendament to the 1904 law in 1968. The circular from the Ministry of Health required that professional courses had to conform to several criteria. Among these, candidates were required to possess a secondary school diploma. The length of courses was also established at two years. The introduction of psycho-social studies in nursing curricula was also recommended, in order to better take into account recent developments in the field.

In everyday reality, nurses learned their job from senior colleagues while working. In order to meet the new requirements, many of them gained the secondary school diploma at night schools. New courses were organised within hospitals, but always under the control and indications of hospital directors, who were, of course, doctors. One of the most used handbooks for psychiatric nursing reported the following recommendations: ' When the doctor visits patients, either newly admitted or long-stay patients, the nurses have to follow him without inappropriately speaking ,

and especially avoiding questioning patients unless at the doctor's indication (i.e: to interpret patients' words or speak with him in the local dialect).'(De Giacomo, 1962)

While psychiatric nursing education was persistently delegated to doctors, legislation regulating registered nursing training had already been approved, but with no mention of psychiatric nursing. It was only following the objectives indicated by Law 833, establishing the Italian national health service, that the issue of psychiatric nursing training was fully addressed. Law 243 in 1980 decreed the 'extra-ordinary professional re-qualification of generic and psychiatric nurses'. Such measures replaced indications contained in the 1904 law, and established that psychiatric nurses were residual professionals, to be replaced by registered general nurses.

As a consequence of this policy, nurses currently employed in the Italian community psychiatric services belong to three different professional groups. 1. There are still psychiatric nurses, now close to retirement, who were transferred from mental hospitals to the community following indications from law 180. 2. There are registered nurses who do not have a psychiatric specialisation. Training for registered nursing only provides a generic psychiatric knowledge which has in fact no relation to psychiatric community work. 3. There are psychiatric workers, 'operatori' in Italian, who do not have a nursing training but an ad-hoc training undertaken while already working in the community. It was deliberate that the latter were employed by community services during the first years of the psychiatric reform. Their lack of professional qualification was considered a good starting point for organising training according to local needs and the policy of community mental health centres.

There are few economic differences between the three groups, and if any, differences can be more striking in terms of professional culture. Psychiatric nurses (group 1) are in fact representative of the old mental hospital nursing culture, which has been progressively transformed thorough the services culture pertaining to

community values and significantly deinstitutionalising. It should not be forgotten that this professional group was a determining factor in the process of hospital closure and community care implementation. Massive evacuation of patients from mental hospitals could not have been promoted without the cooperation and support of nurses, who represented a significant care linkage between hospital and community. For many nurses this was not an easy transition. It meant a radical shift of practices and place of work. The safe hospital environment was left for the uncertainty of the community. Consolidated practices abandonend for new and not yet tested nursing experiences. Not everywhere were nurses supported with in-service community training, which was sometimes locally provided for by community services. There was indeed resistance to the change, and refering back to the hospital culture was often the only defence nurses could choose.

The experience of mental hospital nurses is now part of the psychiatric reform history, as the majority of them has now retired. Their contribution to the reform has been essential to a change in the nursing role in psychiatry. Despite the many problems encountered, most of these nurses were able to take on the professional challenge which the community post offered them. Starting with their experience, the nursing role in psychiatry changed from custodial to therapeutic. Although they lacked formal training, their hospital experience was certainly useful to the community job. It is not by chance that registered nurses are often negatively compared with psychiatric nurses by community mental health centres workers. The most common comment is that psychiatric nurses knew how to deal with mentally ill people, while registered nurses, although formally trained, do not. Unfortunately, the experience of psychiatric nurses has not been studied, therefore it is not documented. This is a common regret among nurses, who feel that oral history is not enough to describe their experience and to value their professional identity.

Psychiatric workers (group 3) were employed immediately after the psychiatric reform. Several community mental health centres, especially in Northern Italy, chose to hire people who did not have any clinical training. The assumption was that lack of formal training could guarantee absence of professional bias, i.e lack of bio-organic psychiatric orientations. These people received training from community mental health centres, which organised ad-hoc training packages according to their needs and therapeutic approaches. As a consequence, the professional knowledge and competence of psychiatric workers vary greatly all over Italy. The majority of them was professionally equated to the qualification of nurse, according to the law 243 in 1980 quoted above. Their salary is slightly lower than that of registered nurses or those psychiatric nurses still working.

Registered nurses (group 2) have been employed all over Italy, and following legal indications they are due to be the majority of nursing personnel in community psychiatric services in the future. They have a three year training in general nursing in which different aspects of medicine are analysed, including psychiatry. However, practical experience in community psychiatry is not included in training. They usually approach the community job with little or no experience and knowledge in mental health care. Again, some community mental health centres established training programmes for these nurses, but this is not widespread all over Italy, and generally left to local teams'initiatives.

As for psychiatric care provision, type and content of psychiatric nursing care vary greatly over Italy. There is no homogeneity in defining methods of intervention or work style because they both depend on the organization chosen locally by community mental health centres or by psychiatric wards in district general hospitals (repartino). By and large doctors still have a significant influence in deciding the intervention style of the team work, therefore also of nursing. However, there is a general effort towards adopting a democratic leadership, according to which

therapeutic philosophies and associated practices are commonly aimed at by the team-work.

It was part of the psychiatric reform ideology to reject traditional working roles , and to consider every professional contribution equally relevant to the care process. Partly, this concurred in re-shaping psychiatric nursing identity. It certainly helped nurses to give up their custodial role and build a new professional identity. Unfortunately, this was not backed up by adequate and institutionalised training, so that nowadays nurses cannot claim a specific professional knowledge nor status. A clear example, is that in Italy the specialisation or the definition of community psychiatric nursing does not exist as for its English counterpart. Nurses working in community mental health centres, the most widespread organisational form of community psychiatry, are usually called nurses-and not psychiatric nurses- or better 'operatori'. This latter is a neutral term, like worker, which on purpose does not reveal a specific professional competence. If this intended to free mental hospital nurses from the chains of custodialism, it also contributes to formally rendering the nursing job not specialised nor specifically defined. Significantly, there are no career opportunities for Italian community psychiatric nurses, as there is no internal hierarchy in the job. Nurses in psychiatry are disadvantaged in comparison to nurses in other branches of medicine who have access to career development.

In comparison with the English situation, little has been written about psychiatric nursing in Italy, and the few articles available were published by social scientists rather than by nurses themselves. Generally speaking, it is not possible to draw a comparison between social workers and psychiatric nurses in Italy. The areas of professional intervention remain considerably separated, in that social workers are more often assigned to administrative and bureaucratic tasks rather than specifically therapeutic ones. This does not mean that nurses, too, sometimes undertake administrative procedures on behalf of their patients. Social workers have a longer

training, in which sociology as well as psychology are dealt with quite extensively. Recently the social work diploma has been included among (short) univerisity courses, thus providing social work with a better professional status. However, there does not seem to be inter-professional rivalry between the two groups, rather a sort of communion of interests in that they both feel themselves to be neglected professions.

There are claims by both psychiatric nurses and social workers which attempt to assert a specific professional domain (Coordinamento Inferm.psichiatrici CGIL Lazio, 1988; Madia, Pani, 1988; Samory, 1988). However, there does not seem to be enough cohesion in proposing professional changes. Regionalism contributes to weakening the professional unity which would be necessary to become a pressure group. Psychiatric nursing culture and perceived identity in fact vary according to local contexts, and the organization adopted by community mental health centres.

Paradoxically, the ideology of the psychiatric reform by aiming at abolishing professional boundaries among mental health workers, succeeded in weakening the occupational power of the most neglected professions, in particular nursing. It is strange enough to consider that the whole system was promoted and implemented by enlightened psychiatrists, who believed in the therapeutic potential of mental hospital nurses and in equally valuing any professional contribution. This meant a significant change in the division of labour within psychiatry. The medical hegemony was really eradicated by the care process, and each professional- nurses included-was asked to take full responsibility at the decisional and executive level. As a consequence, nurses were not allowed to be subordinated to doctors's directives, but encouraged to fully take part in creating the therapeutic programmes. In those areas of good practice where this system succeeded, nurses do have an important contractual power in team-work. The paradox is that these nurses do not feel they are nurses any more, because their job has no relation to tasks and skills which are listed among the professional nursing requirements. They lost their traditional professional identity, but they do not

know how to define the new one. Legally, they are still nurses with no career chances and with a nursing salary.

Doctors, on the other hand, are not in any sense traditional psychiatrists, but they had the professional power to modify the epistemological basis of their job and still retain their professional identity. They do have career opportunities and a very good salary. They also have many more tools than nurses to communicate their experience. They publish, and they have a stronger voice in asserting their revolutionary ideas because they are doctors. What did not change, in fact, is that society still confers a higher status and importance on doctors than on nurses. The difference is that doctors still feel doctors, even if innovative doctors, whereas nurses do not feel they are nurses any more.

The comparison with the English situation is particularly interesting. British CPNs have a specific training in mental health, the RMN training, which contributes to a higher recognition of the occupation. They also have the opportunity to specialise in community psychiatric nursing, thus better defining their community role. Most important, they are organised into work-teams which are exclusively composed of nurses. They potentially represent a threat for psychiatrists, who run the risk of loosing control of that clientele which is directly referred to CPN teams by GPs. The longer and better structured training they received reinforces their professional identity, so that they feel they are nurses (see Table A, B). Finally in Britain there are fewer differences according to local contexts and organisations.

On the other hand, it might be that the British better shaped professional identity and culture produces more resistance towards change, and also to interprofessional cooperation. Culturally, there is in Britain a stronger belief in specialisation than in Italy. If on the one hand, the process of deinstitutionalisation is promoting the emergence of new community specialisations, on the other hand it is

also likely to threaten those specilisations which had an established role within hospital psychiatry. The co-existence between hospital and community care in Britain might therefore be detrimental to the CPN development towards professionalisation, as role conflict could arise between hospital and community nursing. At a time in which new community occupations acquire increasing importance as a consequence of dehospitalisation, community psychiatric nurses appear to be the link between the old hospital regime and community care. Because the occupation was generated within hospital psychiatry, it seems reasonable to suppose that some of the hospital culture has been inherited by CPNs. Whether this legacy will generate role-conflict or help in the community development of the profession is something to be considered when tackling the issue of professionalisation.

Table A: Comparison between British and Italian CPNs training.

COUNTRY	TRAINING	ORIENTATION	QUALIFICATION	MANDATORY
Britain	3 Years RMN	Predominantly clinical, specific on mental health	Registered Mental Nurse	Yes
	36 weeks CPN	Community oriented	Community Psychiatric Nurse	No
	ENB courses	Different subjects: social/psychological/ clinical	No specific qualification	No: considered post-qualif. courses
Italy	3 years nursing training	Medical, loose and generic on mental health	Infermiere professionale: registred nurse	Yes, only recently as a requirement to work in community psychiatry
	No training requirement, in-service training	Social, community oriented	Operatore psichiatrico: mental health worker	Not formally: training is organised by the team according to local needs
	No training requirement, in hospital training	Medical, mental hospital based	Psychiatric nurses:qualification available during the asylum years, no longer existing	No, training courses were left to hospital directors' discretion
	Post qualifying courses equivalent to ENB	Different subject: social, psychological, medical	No qualification	Not formally

Table B: CPNs organization in Britain and Italy.

COUNTRY	BASIS	TEAM	CAREER
Britain	Community/hospital	CPNs teams	Up-grading system
Italy	Community	Multidisciplinary teams	No career opportunities

In comparing community psychiatric nursing in Britain and Italy, there is a need to carefully take into account the cultural and historical differences described in this chapter. By and large such diversities become factors determinant of the professional experience in the two countries. However, an analysis of differences should also help in isolating those universal professional elements which in both countries made of CPN a key occupation in the development of community care.

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CHAPTER 3: A FRAMEWORK FOR THE INVESTIGATION: THE THEORETICAL IMPLICATIONS OF IDEOLOGY, ORGANIZATION, AND PROFESSIONALISATION.

3.1. Introduction

The present chapter will review the literature relevant to this thesis. Three main topics have been identified as meaningful to an understanding of community psychiatric nursing on a comparative basis. These are: a) the ideology of mental illness, b) the organizational structure of community care, and c) the issue of professionalisation.

a) The acknowledgement of an ideological perspective which characterizes an historical view of mental illness, by providing meanings, explanations, and patterns of care to the phenomenon is essential to understanding differences and similarities between British and Italian professional practices. The literature review on ideology will analyse the emergence of theories on ideologies, and link it with the experience of mental illness in our society. The issue of professional ideological committment to historically determined philosophies of care is tackled, as well as the interaction between society, politicians and professionals which gives rise to a dominant perspective on mental illness.

The analysis of ideology is both necessary to the contextualisation of CPN in the two countries, and as a tool for the empirical investigation. One of the two questionnaires used for this thesis aims at analysing nurses ideological positions in relation to mental illness and its models of care. Such analysis proves to be useful in highlighting nurses individual perception of the phenomenon as a reflection of their professional practice and experience.

b) The organizational structure of psychiatric community care is fundamental to comparing CPN in Britain and Italy. Differences between the organization of mental health services in the two countries are indicative of diverse political and professional strategies to the implementation of community care. The professional experience is supposed to vary according to the organizational context which, on a national basis, is provided for the development of community psychiatric services. The process of hospital closure generated many significant organizational changes which have directly involved professional cooperation. The development and growth of community psychiatric nursing is one of the expressions of the new organization of mental health services.

The literature review on organization is focused on the analysis of the interaction between professionals and their organizational environment. An attempt is also made towards understanding the universal principles which lie behind the philosophy of community care, and the ways through which these have been organizationally implemented on a national scale. The organizational variable is taken into account throughout the empirical analysis. The investigation of CPNs practices, interprofessional relationships, hierarchical structures, professional identities and cultures is constantly referred, on a comparative basis, to the organization of mental health services.

c) The issue of professionalisation represents the core argument of this thesis. It stems from the consideration that community developments in psychiatric nursing are likely to produce significant changes at the level of professional identity and content of work. Not only does CPN represent one of the major organizational innovations produced by deinstitutionalisation, but the present role of CPNs actually evokes a potential for an epistemological chasm in psychiatric care. The opportunity for community psychiatric nursing to become an independent profession is linked to the likelihood of this occurance.

The analysis of the literature on professionalisation aims at providing those elements of judgment which are necessary for a thorough understanding of the phenomenon. Different contributions on the emergence of professionalism are analysed, and the role of the medical class in establishing its dominance among the healing professions is widely discussed. The analysis of the emergence of professions in the modern world is developed both at the macro and micro structural levels, medicine being the most powerful and documented example.

3.2 The framework

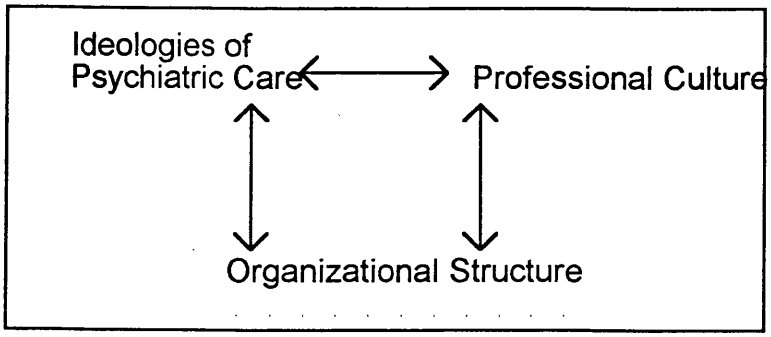
Mental illness is an individual and social phenomenon which demands to be given meaning, which cannot be left without meaning because of its threatening and ambiguous nature. The review of the historical conditions in which psychiatric care developed in Italy and in Britain highlighted the importance of structural and cultural factors in defining national strategies for the care of mental illness. At various points in time, mental illness has been regarded as the result of biological impairments, as the outcome of social problems, or as the manifestation of psychological incapabilities at the individual level. It has also been the case that the three ways of looking at mental illness have been used together, and been conferred higher or lower priority in particular historical conditions. Different philosophies of care have also been dominant in different historical periods, and linked with the various definitions of mental illness.

The interactive nature between the process of social construction of mental illness, and the therapeutic approaches is therefore fundamental to an understanding of community psychiatric nursing professional identity and culture. An interplay between politicians, lay people , and professionals produces an historical perspective and/or a definition of the phenomena at the collective level. The outcome of this process is defined as the "ideology of mental illness". The ideology of mental illness

results from the social construction which historically defined a public view of the problem. Professionals are the bearers of therapeutic ideologies which are closely related to this construction. Professionals are given the social mandate to create and implement a dominant ideology of mental illness. This mandate is performed through the use of specific therapeutic approaches originating from professional disciplines and professional backgrounds.

A dominant therapeutic ideology reflects the approach of a dominant professional group. In psychiatry this group is represented by psychiatrists, whose professional background gives them the status and the power to define a therapeutic trend. Psychiatric workers adapt to a specific philosophy of care on the basis of their different professional cultures . Therefore, variations in a dominant ideology of care take place because of the professional mediation activated during its implementation, and because of the interaction with other stakeholders involved in the process.

Dominant ideologies of care and nursing professional culture interact within an organizational environment. To each ideology of psychiatric care is attatched an organizational perspective which has the function of providing the structural conditions suitable to its implementation. Psychiatric nurses implement an ideology of care within an organizational framework. Ultimately, professional culture and organizational structure also give feed back producing inter-field changes.
A representation of this interactive process is described below.



Applied to the proposed research project, this approach requires an investigation of the dominant therapeutic ideology attatched to the implementation of psychiatric community care in Italy and in Britain, as well as an analysis of the organizational structures of community care in the two countries. The professional cultures and identities of psychiatric nurses assume centrality in this analysis. The review of the literature on professionalisation is aimed at providing those cross-national contextual factors which can enhance an understanding of the current trends in community psychiatric nursing.

Ideology of care and professional culture tend to be abstract concepts whose empirical investigation is difficult if their components are not broken down analytically. In order to conceptualise the above variables the following review of the literature on the subjects has been undertaken.

3.3 Notes on ideology

Psychiatry appears to be a fruitful arena for the application of ideological analysis. The history of psychiatric care illustrates how historical meanings associated with mental illness produced different systems of care. Historically according to the prevalence of one or the other interpretation of mental illness, one therapeutic approach or the other has been dominant.

During the asylum times, therapeutic approaches were mainly based on the assumption that mental illness was due to biological impairments. The advent of community care promted the adoption and testing of several methods of interventions which often combine different clinical perspectives with socially and psychologically oriented practices. As a consequence the identification of a dominant therapeutic approach becomes more difficult. From an ontological viewpoint, it may be affirmed that mental illness is now a multi-dimensional phenomenon whose origins imply a search for many and different variables. This is why, for example, British psychiatric care makes use of counselling, behaviour therapy, drug treatment or ECT. Similarly, in Italy-although there is a prevalence of non-biological approaches- there is indeed coexistence between psycho-dynamic, psychoanalysis, psychotherapy, drug treatment and several contrasting theories on rehabilitation.

The complexity of the phenomenon is such that the analysis of the emergence of a particular psychiatric ideology within a given historical period would need a whole theoretical dimension to itself. I do not wish, therefore, to undertake this task in depth. An understanding of the concept of ideology is necessary here as both an investigative and relational research tool. In analysing psychiatric nursing practices in Britain and Italy it is necessary to tackle the issue of their conceptual development within the mainstream psychiatry in the two countries. Chapters on data analysis will show that it is often impossible to understand national differences between nursing

practices without placing them within the ideological framework from which they have been generated. Similarly, acknowledging the existence of different perspectives in psychiatric care has been necessary in relating to nurses at the stage of interviews. It therefore becomes a priority for comparative analysis, where the researcher needs to be aware of cultural diversities in order to understand the interviewees properly. According to the research perspective I have chosen to adopt, the different British and Italian philophies of care are historically determined. They are the products of social, economic, and political conditions: they are ideologies.

The acknowledgement of ideology in psychiatric care is simply the acknowledgement of a perpetual coexistence, at times in conflict or at peace, of different explanations of mental illness from which means and methods of care are derived. Ideology provides both professionals and lay people with a belief system in which a meaning is attached to mental illness, and which can only with difficulty be proven or disproven. Ideologies are not just methods for the care of mental distress, they are actually the expression of the ways mental illness is experienced in our society as an historical product.

The theoretical review that follows is not aimed at being a comprehensive analysis of the literature on the subject. The review deliberately provides the reader only with a general conceptual framework on ideology, which however well represents the author's view on the issue.

An analysis of the interaction between therapeutic ideologies and the professional cultures which are used as a means of putting them into practice, implies to focus on the relationship between theory and practice. Theoretically, a study of this relationship has been developed by the sociology of knowledge. The following section will analyse some of the more significant contributions of the sociology of knowledge to the purpose of this study.

The sociology of knowledge emerged in Germany during the 1920's. The title of the discipline derived from Scheller's essay "Wissensoziologie". The first major sociological espression given to this discipline was K. Mannheim's "Ideology and Utopia". The objective of the sociology of knowledge is an analysis of thought in its social expressions. The analysis of thought - intended as both a product of the intellectual elite and as a lay pre-theoretical construction - is investigated in its relationships with social reality.

From an historical and philosophical point of view, the sociology of knowledge finds its roots in the experience of relativism and inter-subjectivity. Relativism states that the world is not as it appears, and that assumptions about the world cannot be taken as un-related to social reality. Relativism identifies external forces acting upon individuals, of which individuals are not always aware. There are norms, perceptions, and behaviours taken for granted by society because they pre-exist the birth of individuals. These factors are instead localized in terms of space and time.

Historically, the theory of the social conditioning of ideas has developed at a stage in which truth becomes less defined in terms of the absolute, due to a gradual disintegration of an order of certainty. Mannheim links this experience to the end of religious despotism. In post-medieval Europe, the monopoly of knowledge was no longer linked to the Church, hence other interpretations about the world became possible. The process of secularization marked the end of religious supremacy over the symbolic organization of society. In modern society, the function of religion to act as a meeting ground, by ordering individual values hierarchically, diminished. The disappearence of a supposedly objective reality, defined mainly by religion, produced the experience of relativism.

From an epistemological perspective, the sociology of knowledge deals with the problem outlined by relativism: if any knowledge is distorted by its social origins, is it possible to achieve independent standards of truth? Philosophically, this problem

has been connected with Plato and Bacon whose approaches focused on the ideal world. Bacon (16th century) identified in "idola" the elements which mask reality. He distinguished among different idola in relation to the source they come from. The social character of "idola fori" and "idola teatri" threatens the achievement of an objective knowledge of reality. Bacon was interested in purifying intellect from the distortions coming from reality.

Mannheim connects his concept of "particular ideology" with Bacon's theory on idola. According to Mannheim, the phenomenon of a 'particular ideology' occurs when in a debate an opponent's view is based upon his/her personal interests, whether or not the individual is aware that such interests are guiding his position. A 'total ideology' is instead what entirely defines the dominant thought of an historical period. The spirit of an era affects the structure of thought. The objective of the sociology of knowledge as a discipline is the analysis of total ideologies. Contrary to Bacon's theory, the sociology of knowledge does not attempt to purify the intellect, it instead acknowledges the existence of ideology as a phenomenon permeating reality.

Mannheim also refers to Marx's theory on ideology. In Marx's theory it is actually possible to follow the basic principle of the sociology of knowledge, which is that human consciousness is determined by its social existence. Marx did not conceive of hypothetical world of ideas, he rather considered social consciousness as rooted in human existence. Two concepts of ideology are present in Marx's theory. 1. Ideology is conceived as a general phenomenon pervading mankind. It exemplifies the modern human being's alienation, whose world is subjected to reification. This concept refers to the anthropological condition of mankind since the presence of the division of labour. This latter has originated the reification process which annihilated the relationship between thought and its social roots. The shaping of an ideological consciousness took place on the assumption that human consciousness is a

phenomenon independent from the human being, that however produces it. An example of ideological consciousness is religious ideology.

According to Marx, mankind can avoid being estranged from its products and its consciousness only within the communist society. An ideological consciousness has existed since human prehistory, and it cannot be used to produce social change because it is 'false consciousness'. The shift from prehistory to history represents a move from fragmentation to unity:to communism.

2. Ideology is the result of the ruling class' values, ideas, and knowledge, because the ruling class owns both the means of economic production, and the means of intellectual production. Hegemonic ideas have the function to mask class dominion.

In Marx's view only working class thought is not ideological. According to the marxist's pragmatic concept of truth, truth is not an interpretation of the world. It instead consists of acknowledging the need for changing the world. Working class practice is a true practice because it aims at transforming society.

According to Mannheim, Marx neglected to shift from critique to self-critique, therefore to the sociology of knowledge. Mannheim objects that working class thought is also ideologically biased. Any class or position is ideologically permeated , because in any situation historical conditions act upon the thought. Whilst in Marx's approach ideology is negatively characterized, in Mannheim's perspective ideology is regarded as the un-avoidable historical and social condition of thought. The sociology of knowledge includes in its framework Marx's theory on ideology, but it does not accept the negative value attatched to it.

Three main sociological approaches have dealt with the relationship between social reality and thought, whose influence is visible in the sociology of knowledge. These are: a) the theory of casual determinism; b) functionalism; c) the theory of affinity (through elective choice).

a) According to the theory of casual determinism, ideas are pure reflections of their social conditions. There is no spontaneity in human thought; ideas are internal effects of external causes. The sociology of knowledge detatches from this approach by focusing on the conditioning of ideas rather than on determinism.

b) Ideas are regarded by functionalism as analogous to institutions. Institutions exist in order to perform a social function, similarly ideas are functional to society. Society is conceived as an organism, so that a mutual relationship between thought and society is outlined. In order to understand the functions of ideas there is a need to focus on social reality to which ideas are related. In this sense both Durkheim and Althusser embrace a functionalist approach. They consider ideology as having a cohesive function in supplying an imaginary or symbolic representation of the structure of social relationships. By providing symbols which have the function of increasing individual committment and identification with society, ideology also provides social order, and offers a defined place for individuals.

Partially derived from this approach, structuralism has instead developed an analysis of the symbolic codes which structure social rules, and some attempts at decodification are also to be found in semiotics and semantics. Berger and Luckman (1966) can also be placed within this framework. Their studies contributed to widening the objective of the sociology of knowledge by identifying it with the whole realm of human knowledge. Berger and Luckman argue against Mannheim that it is not an objective of sociology to deal with epistemological problems, such as the achievement of scientific knowledge. Sociology is instead meant to deal with the relationship between knowledge and reality. Berger and Luckman analysed the processes of knowledge which characterize everyday life, and pointed out the stereotypes commonly used in social interaction. Further developments of their theory assumed a psycho-social character by focusing on the genesis of mind and self.

c) Within the framework of the theory of affinity, ideas are regarded as belonging to the platonic world. Ideas are distinct entities from social world, but they need to find a social group by which they can be sustained and implemented. There must be affinity between a set of ideas and the social group which decides to embrace them.

This perspective is well represented by M. Weber in "The Protestant Ethic and the Spirit of Capitalism." Boudon (1970) proposed a comparison between Weber's concept of affinity and Mannheim's theory on ideology. In Boudon's view a structural homology ('omologie structurale') links the two theories. Weber's analysis of the capitalism is based on a parallelism between two events: the modern enterpreneur's behaviour and the puritan ethic. The relationship between protestantism and capitalism is based on their structural identity. Accordingly, Mannheim's sociology of knowledge is based on a correspondence between the ideal products of society , and its non-ideal aspects.

Concerning this research project, the concept of ideology of care does not necessarily need to bear the negative marxist view on ideology, although it is assumed to be socially constructed. However, it is fundamental to consider the moral element embedded in every ideology of care, for which professionals claim to know what is right for their patients. In this respect, an ideological committment is not effectively neutral or purely instrumental , but is likely to be morally charged. 'Ideologies also define at least implicitly, improper practice and provide the framework within which to judge specific treatments practised by oneself or others.' (A. Strauss, 1964, 365).

Treatment ideologies are always characterised by two elements: a moral prescription, and the societal mandate to help patients. Ideology therefore provides a framework for judging what is best or what is harmful for patients. In agreement with the sociology of knowledge, there is a need to recognize ideology as permeating social action, including professional action or practice. In itself, this recognition does

not attatch a negative value to any therapeutic approach. Instead it accounts for the existence of an ideology and for its importance to the analysis of professional practices. The concept of structural homology suggests that the different ideologies of psychiatric care in Italy and in Britain can be analysed in terms of their structural identities to the social structures which define the national contexts.

Finally, interesting suggestions come from Thompson (1984) whose original contribution focuses on an attempt to unify phenomenological and structuralist approaches to the analysis of ideology. Thompson assumes that ideology is not just the expression of the dominant class's ideas and values, nor the base for a community of shared values where conflict hardly arises. Ideology results from a dialectical process. By addressing Gramsci's theory, Thompson describes the process of negotiation which precedes the emergence of a dominant ideology. Cultural spheres of society become partners of a particular ideology. Yet, in order to become dominant, an ideology needs to be negotiated with society as a whole. The intellectual leadership (both traditional intellectuals like academics, and the organic intellectuals like managers and technicians) need to relate to the popular culture of subordinated classes. 'These sediments of common sense or popular culture constitute the stratum of ideology.' (Thompson 1984) In Gramsci's view, a hegemonic principle is not such by virtue of its intrinsic logic, but because it manages to become a 'popular religion'. In this respect, popular culture becomes the terrain where a particular ideology is negotiated. In Gramsci's meaning, culture contains the inheritance of the past which helps in constituting social collectivities or classes. The culture of popular classes brings in itself an historical inheritance which may be a barrier to its assimilation of an emerging dominant ideology.

This concept is fundamental to a modern interpretation of Gramsci's thesis. It implies that the very ways in which knowledge manifests itself in a given society, prevent that knowledge from being assimilated to the hegemonic ideology. Popular

cultures constitute what Gramsci calls 'Epistemic Communities'. The base of knowledge of the epistemic communities can present barriers of assimilitaion into an hegemonic ideology. 'The problem of penetration and assimilation of those epistemic communities presents a challenge to any group which seeks to recruit them to its cause, whether it is a revolutionary movement or a dominant bloc...' (in Thompson, 1984, 114).

Concerning this research, the latter approach to the analysis of ideology suggests a new interpretation of the relationships between the ideology of a dominant professional group, and other professional sub-cultures. Epistemic communities are those professional groups that in psychiatry have been particular resistent to change. In Italy the movement for deinstitutionalization was promoted by a group of professionals who were able to recruit to their cause the epistemic community of psychiatric nursing, which could ' present a challenge to (or could feel threatened by) any group which seeks to recruit them to its cause'. In England the process of deinstitutionalization appears to be at the initial stage of negotiating a recruitment of professional groups.

The proposed comparative analysis should account for different ideological positions among Italian and British psychiatric nurses .

3.4 Notes on organization

> 'The most dramatic change in the mental health arena in recent decades has been the deinstitutionalization movement. More than anything else, this movement involves fundamental changes in the *organizational* arrangements by which our society dispenses mental health.'(Scott and Black Ed., 1986, 8)

If ideology on mental illness represents an historically dominant view, philosophy, method, or therepeutic approach on mental illness, organization is the means by which this is put into practice. In the past, the asylum was the organizational answer to the prevalence of an organicistic ideology of mental illness. The asylum, whose location isolated its inmates from collective life, expressed in itself a specific therapeutic approach, a precise organization used to define rhythms, hierarchies, and procedures through which the organicistic ideology of care was implemented.

At the moment, psychiatric community care represents an ideology of mental illness which places the origins of distress within a multicausal terrain, where social, psychological and biological factors meet. Community mental health centres, CPN teams, primary health care teams, and day hospitals are the organizational structures arranged for the care of this multidimensional phenomenon. In a period in which the transition from hospital care to commmunity-based structures is fully developing, particular consideration needs to be placed on organizational issues.
This applies in particular to Italy and Britain.

Organizations represent the relational tools through which everyday life is carried out. Schools are organizations, the church is supported by a complex organizational structure, public services are a collection of sub-organizations; so it is

for hospitals. Social and institutional meanings are attached to such organizations, which express both the reasons for their existence and the multitude of contradictory social, political, and economic interests that led to their establishment. As any other organizational structure, mental health agencies serve the interests of many, sometimes conflicting, groups of which professionals and users are the most important. Without a clientele, mental health agencies would loose their raison-d'etre', without a staff they would not be able to satisfy users' needs.

This thesis is concerned with the study of professionals, particularly community psychiatric nurses, whose everyday practice is carried out within relatively new organizational structures. Many of the nurses interviewed have had a dual hospital-community work experience, others come from a hospital-based training, although their practice is established in the community. Professional reluctance to shift from a hospital to a community post, often arises as an expression of resistance towards new organizational modalities which require professional adaptation. Values and procedures learned during hospital training need to be changed according to the new community care requirements. Moreover, the considerable differences between the British and Italian psychiatric community care organizations are explanatory variables for an understanding of professional disparities among nurses in the two countries. The analysis of these latter will be tackled in chapters on findings. The following section will instead provide the theoretical framework relevant to this analysis.

A relevant contribution to the study of mental health organizations has been given by Scott and Black (1986). Although their analysis focuses on the American situation, many theoretical observations can be extended to Britain and Italy.

The area of mental health care is characterised by indeterminateness at different levels. Meyer (in Scott and Black Ed., 1986) observes that there is a general

lack of consensus on the distinction between mental health and mental illness. There are no rules which incontrovertibly define who is mentally ill. I will add that, even when a person has been consensually diagnosed mentally ill, different opinions may be advanced by different professionals on the type of diagnosis. Such lack of consensus is likely to impinge upon the establishment of stable and clearly operating organizations. Similarly, loosely defined professional boundaries about who is appointed to do what, and who is professional or who is not, contribute to rendering the organization less clear about how to achieve its goals.

The Italian and the British situations are quite illustrative of the case. Community mental health care in Italy finds its major expression in Community Mental Health Centres. Such organizations are multidiscplinary, and in view of the principle of the psychiatric reform, professional boundaries are loosely defined. Accordingly, it is difficult to identify who is doing what. Professional interventions and competences often overlap, so that it is sometimes difficult to understand what differentiates a consultant from a nurse or from a psychologist (apart from salary). This has important consequences on sharing responsibility and degree of autonomy among psychiatric staff, and of course on hierarchy.

In the British case, psychiatric community care is spread among different organizational forms which range from community mental health centres, to CPN teams, primary health care teams, day hospitals, and crisis intervention centres. No one of these organization can be considered the fulcrum of the network, but they are supposed to interact independently in the care process. On the one hand, it can be noticed that it must be difficult to handle this complexity efficiently. On the other hand, organization within each unit is certainly more clearly defined than in Italy. CPN teams, to which all nurses interviewed belong, are organized according to a hierarchical system that regulates nurses professional competences, responsibility, and autonomy. However, recent debates about CPNs' and SWs' overlapping practices, as

well as lack of consensus about CPNs role and care-aim are likely to produce organizational confusion at the professional level.

According to Manoukian (in Kaneklin and Orsenigo Eds. 1992), the philosophy which lies behind community care implicity produces organizational uncertainty. The author refers to the distinction proposed by Tonnies between community and society. The former is the place where values like solidarity, interpersonal relationships, consensus, and common objectives are at the basis of collective life. Society is instead characterised by individualism, economic transactions, private and individual interests. Whereas community is value-oriented, society is goal-oriented. It is not by chance that community care has made use of the term 'community' and not 'society'. Community recalls in our social imaginary a type of collective life where solidarity replaces individualism, health of people has priority against individual interests. In Manoukian's view, the philosophies of care attached to the development of community care and therapeutic communities have imlicitly or explicity made use of this model. Society, within this framework, is the origin of distress. It is the place from which suffering people have been marginalised and stigmatised. Communities which are value-laden should therefore create the necessary conditions for the re-integration of people, and their rehabilitation.

The first organizational dilemma is that community care is an organization that, although operating within society, by definition opposes some of the dominant values and goals of society. Moreover, the philosophy attached to community care by being value-oriented finds it more difficult to identify goals which can be empirically monitored and evaluated. I suggest that the situation may be even more complex that what Manoukian indicates. The relationship between society and community is often characterised by ambiguity and by the wish to achieve co-existence between the community care values and goals and those embedded in the capitalist system. Professionals who operate within this contradictory condition, may experience

uncertainty as a result of the mixture between ambiguity and incompatibility of values and objectives that the co-existence of the two models produces.

Lack of clarity about task and aim of the organization produces complexity, uncertainty, and interdependence. In the case of community care agencies, task and aim are often confused, so that the aim of rehabilitating or re-integrating people becomes predominant over the task. According to Manoukian, a characteristic of community care organizations is that of having a particularly high level of indeterminateness of task. Idealization is an answer to the uncertainty which this situation produces. This consists of stressing the positive elements of community care ('what we do produce is good for people') and neglecting the negative aspects, or problem areas.

Similarly, Hasenfeld (in Scott and Black Eds, 1986) proposes an analysis of community mental health centres which may be useful to better understanding organizational issues in mental health care.
People served by CMHCs are heterogeneous and volatile, therefore an unstable and unpredictable group. Dealing with what the author defines 'raw material', organizations are directly involved in a system of values so that CMHCs' technologies are value-laden. Secondly, CMHCs function in a turbolent environment characterised by conflicting interest groups and resource uncertainty. Moreover, the goals of these organizations are often ambiguous and contradictory. They operate within an environment characterised by a lack of recognised and shared technological knowledge, and have an internal structure in which different interests of power among professional groups are present. Given this condition:

> 'Symbolic cohesion is provided through a mental health ideology which serves to mobilize institutional legitimation yet permits various interest

groups to pursue their own interests in the conglomerate.' (Hasenfeld in Scott and Black Eds, 1986, 134)

Let us analyse in detail the characteristics described by Hasenfeld. A high level of heterogeneity in clientele makes it more difficult to define a stable care system. This becomes complex when there is a constant shift of funding that leads to the search for the forms of treatment which are easiest to finance. As a consequence, it is problematic to standardise patterns of care in a single delivery system. An answer to this has been the establishment of highly differentiated systems of care, each of which deals with a specific clientele. This appears to be the case of Britain, where CPNs specialise with different client groups. Other strategies include what the author defines as 'creaming or cooling off', that is taking only those clients who have desiderable attributes, or shifting clients to other organizations. Both in Italy and Britain this seems to happen not between different organizations, but among professionals. In Italy, I often found nurses complaining about their chronic clientele, with little or no chances of improvement, as opposed to consultants' clientele, suffering from various forms of neurosis and certainly more professionally rewarding in terms of short term care results. In Britain interprofessional rivarly among different CPNs teams was evident in the sharing of category A and B clients. The former are again continued-care clients, the latter are 'acute' clients. It is evident that with chronically mentally ill patients the predictable rate of success is low, with the consequence that it becomes more difficult to sustain staff morale.

Human service organizations dependence on a turbolent environment arises because of the difficulty of establishing a stable domain consensus. They do not base themselves or do not depend on economic mechanisms, but rather on political bargaining which involves external interest groups. Changes in mental health policy impinge upon continuity in organizational strategies, as well as the emergence of pressure groups like users' organizations or family associations.

In the British case, it is reasonable to suppose that the accelerating rate of deinstitutionalization places mental health agencies in the fore-front of new developments, never before experienced. In Italy, lack of a stable political consensus upon Law 180, coupled with perseverance of critiques and proposals of amendments to the reform have certainly contributed to endangering the institutional basis of community care.

Community mental health agencies are publicly funded organizations, whose goals are ascribed through specific legislative and funding bodies.

> 'The political economy of an organization is closely affected by its ability to generate outputs in accordance with its ascribed goals.'(Hasenfeld in Scott and Black, 1986, 139)

Hasenfeld observes that these goals are usually abstract, therefore subjected to different interpretations. Lack of clarity at the legislative level contributes to rendering goal-identification more difficult at the organizational level. In the case of Italy, where a certain range of autonomy is delegated to regional governments, community care is supposed to target different local needs so that the organizational structure greatly varies across the country.

In agreement with Manoukian, Hasenfeld stresses the richness of ideology as opposed to shortage of technology within community care structures. The risk is that of widening the gap between theory and practice, hence increasing the advent of crisis of legitimacy and the lack of professional identification with institutional goals.

> 'Because mental health ideologies cannot provide CMHC practitioners with workable technologies, they resort to several strategies in order to reduce uncertainty and formulate manageable work procedures.

> First, there is a drift toward more established and routine technologies, particularly the use of medication. Second, practitioners lower their expectations regarding desired outcomes. Third, they develop, through trial and error and shared experiences, satisfying work procedures for client management which are shaped by the legal, political, and economic constraints they encounter.'(Hasenfeld in Black and Scott Eds, 1986, 142-143)

To summarise, the unstable character of community care principles impinges upon the establishment of a strong and generalisable organizational structure. At the macro structural level, I agree with Hasenfeld in explaining indeterminateness through the presence of multiple interest groups within the mental health arena. Users, who should be the strongest interest power in the negotiation, see their ability to represent themselves impaired by their condition of sufferers. As happens in general medicine, patients are not given the social and political mandate to decide upon the conditions of their care. Such power is instead delegated to doctors, whose technological knowledge in the field legitimises their position. More evidently than in other branches of medicine, in psychiatry indeterminateness arises because of its lack of stable legitimation among medical sciences. The Cinderella of medicine, psychiatry has struggled over the past two centuries to acquire a peer position within medical specialties. But the irreducible character of mental illness to be analysed according to a causal-effect model, typical of medicine, endangers the position of psychiatry. It is the objective itself of psychiatry, mental illness, to impinge upon the legitimation of the discipline.

With the advent of community care, the psychiatric establishment has become seriously threatened. Lack of legitimation comes now not only from medicine, but from alternative ideologies of care within psychiatry. The number of interest groups

competing for the sharing of funds, as well as for status and public acknowledgement, has increased dramatically. In the struggle for survival, the emerging trend of community care needed a strong ideological basis to oppose dominant psychiatry. This was particularly evident in Italy, where the ideological involvement of community care professionals has been the powerful spring-board to bring about change. Whereas this assumed different connotations according to historical differences among European countries, one trend now seems predominant within the community care sphere. This is that of relying on ideology without sufficiently supporting such theory with practice. Organizational indeterminateness is therefore produced both by the presence of multiple and opposed interests in psychiatric care, and by a degeneration of the ideology which has supported community care. In this latter case, the analysis by Manoukian appears to be appropriate.

In order to survive, community care, more than other disciplines within medicine, needs to be rigorous in terms of goal-planning, achievement, and evaluation. Only by so proceeding, will it be possible for community care to prove that ideals are well supported by practice, and to prevent persistent attacks from the conservative psychiatric establishment.

At the micro-level, the persistence of conflicting interests within psychiatry, fed by different ideologies, produces important effects on the professional establishment. Interprofessional relationships also change, with the advent of community care. The emergence of a new and large labour market among para-medical professions may threaten psychiatrists, as well as generate professional rivarly among the new competing occupations. It is reasonable to suppose that this has consequences upon the organization of mental health care.

With regard to Britain and Italy, it seems possible to delineate two different organizational strategies which have been useful to the re-organization of mental

health care according to community priorities. Whereas in Italy nurses have been co-opted by psychiatrists in the organization of multidisciplinary teams, in Britain the process has been of differentiation among professional specialties. The main organizational consequence is that in the former case there is homogeneity of practices, in the latter there is heterogeneity. Again, this sends us back to the way in which community care developed historically in the two countries. In Italy a cohesive ideology of deinsititutionalization sprang out from professionals and crossed all professional groups, thus producing a collective organizational model. In Britain, community care was mainly promoted by government and opposed by professionals. As a consequence, an individualistic approach to care developed, producing professional segmentation.

Faced with these two different situations, it may be supposed that professional responses to organizational changes, as well as to organizational indeterminateness will be diverse. For example, in Italy the practice adopted towards inter-team conflicts is to openly face them and act upon the issue. Anxiety is elaborated at the team level and interprofessionally. Although professional boundaries may still be perceived by single professional groups, it is certainly more difficult, for example for nurses, to act as a compact professional pressure group. This is because nurses do not operate in nursing teams but in multidisciplinary teams. Professional power is thus fragmented, whereas uniformity of practices is pursued at the team level. British CPNs, however, have in principle more professional strength to bargain their power position within the psychiatric arena. They may more easily act as a group against a common enemy by being mono-professionally organised. As compared to their Italian colleagues, they may also have more clearly defined delegating practices whereby professional boundaries of intervention are identified. At the same time, because of the individualistic organization or work, the elaboration of anxiety takes place in Britain not at the team level but through individual superivision.

There is finally a need to mention the new organizational formulae which are presently developing both in Britain and in Italy. In Britain, Sir Roy Griffith's indications in 1988 identified in the case manager role a key component for the development of individual care packages which could comprehensively answer users' needs. Such developments had to take place according to a mixed economy approach in which all the resources available, from private to public and voluntary sectors, could be effectively employed. 'Caring for People' in 1989, and the 1990 NHS and Community Care Act envisaged the use of case management within a framework of joint collaboration between Social and Health services (Thornicroft, 1992). The introduction of the managerial culture within community services in Britain currently appears to generate confusion and uncertainty among mental health professionals (Evaluation of Short Course Diploma, LSE, 1993). The lack of clarity about the role of case manager, his/her professional qualifications along with the budgetary issue not throughly defined in the Act, represent a source of ambiguity for community care. Professionals are understandably puzzled and concerned about their different types of clients. On the other hand, case management appears to be a tentative answer to the fragmentation of care which emerged as a consequence of specialism in Britain. In this sense, case management might be an opportunity to develop a holistic care approach which can overcome the individualistically-oriented British care style. That professionals should be accountable for financial and coordination issues, however, seems to be a government strategy aimed at delegating functions which otherwise are a State responsibility.

In Italy, on the other hand, the lack of central government indications on community care gave rise to innovative practices among which cooperatives for mentally distressed people are the most interesting. Cooperatives emerged during the late seventies as an answer to the need to provide ex-hospital patients with the opportunity for a job. There are now several cooperatives all over Italy, whose size and structures greatly vary between and within regions. Generally they consist of a

joint administration between users, professionals, and clerical staff. They are non-profit-making organizations supported by a national law (N.381, 1991) which prescribes the employment of at least 30% of so called 'disadvantaged people' (handicapped, drug-addicted, mentally distressed, general forms of marginalisation) in exchange of specific tax exemptions. By becoming members of the cooperative, users also become owners of the enterprise giving them a job. Along with employment, solidarity, social and recreational activities, and job training are at the basis of the cooperatives' life. Mental health services support their users in facing the difficulties which often arise when undertaking a job. The job itself is regarded as a priviledged channel for rehabilitation and social integration.

It is important to underline that cooperatives are separate financial and administrative bodies from community mental health centres. Although they have often been established following the initiative of mental health services, their autonomy is considered an important condition for the development of normalisation. This sometimes generates inter-organizational conflicts between services and cooperatives in that the therapeutic aims and the economic needs can not always be easily met.

These are only some of the differences produced by the diverse organizational patterns of Italian and British psychiatric community care. However, they should highlight the importance of organization in shaping the professional experience of nurses in the two countries. Further insights will be provided in the section on data analysis.

3.5 Notes on understanding professionalisation

The important role assumed by psychiatric nursing in the implementation of psychiatric community care, and its status as a new nursing category raises the issue of a likely change in nursing professional identity. The acquisition of a new professional identity, one that is more relevant to current trends in psychiatric care, places psychiatric nursing within the terrain of professionalisation. Attaining a new role in psychiatric community care also implies a more autonomous and independent position for nursing than in the past. Psychiatric nursing is challenged by the possibility of becoming an independent profession. In other words, there is the potential for nursing to undertake a process of further professionalisation.

The analysis developed in chapter 2 has demonstrated that developments in community psychiatric nursing differ from an historical and professional viewpoint in Britain and Italy. The pathway to professionalisation is also different according to the national contexts. Theoretical contributions taken into account in this section will therefore need to be contextualised in relation to nursing's occupational position, and developments in Italy and Britain. The final part of this chapter will address this theme.

An understanding of nursing professionalisation is linked to an analysis of medical dominance for two reasons. A) It has been previously outlined that both in Britain and in Italy psychiatric nursing developments largely depended on parallel developments in psychiatry, which -like any other branch of medicine- is characterised by medical hegemony at the decisional and legislative level. B) In the literature on professionalisation, the medical profession is repeatedly proposed as the typical example of professionalisation in modern society. The control of the market against possible competitors is indicated as a feature of medical dominance within the healing profession. Any process of professionalisation undertaken by para-medical

professions has therefore to take into account the dominance of the medical profession.

The analysis of the literature will show that this dominance is also pursued through training. It is during the training process that a professional culture is shaped in the form of 'the values , preferences and style of professional life adopted by a group of professionals.' (Ramon, 1986) An understanding of the concept of professional culture is subordinated to an analysis of the concept of profession as it developed in modern society.

3.5.1 The development of professionalisation.

Two main approaches are identifiable in the literature on professionalisation. a) A focus on the macro-structural conditions which have been necessary to the development of professionalism. b) A complementary approach which focuses on micro-social factors which have contributed to the creation of professions. These factors consist of claim to unique knowledge and skills, training schemes, strategies of control over entry, the creation of a cohesive group and the emergence of professional associations.

Among the structural studies on professionalisation, the Weberian and Parsonians analyses are often debated. Berlant (1975) compares Weber's and Parsons' theories on the emergence of professionalism. Parsons' explanation of the establishment of the medical profession is in accordance with the functionalist paradigm. According to this perspective the condition of illness incapacitates people from meeting their social responsibility. This produces psychological tensions which are handled through the creation of norms. Norms allow individuals to experience the illness condition within a role framework by adopting the sick role. They are oriented towards the maximization of socially useful tasks which have the function of

compensating the temporary failure caused by illness. The medical profession has the role of preventing the social incapacity caused by illness, or the reduction of its consequences by means of legitimising the sick role.

The patient who is ill, and the doctor who is supposed to be competent in restoring the patient's health, need norms in order to interact. Parsons describes three conditions that the patient is likely to experience which are: technical incompetence, physical helplessness, emotional involvement. 'They combine to make the patient more vulnerable i.e. more exploitable, and more or less incapable of rational judgements.' (Parry and Parry, 1976, 8)
The physician too, may be stressed by the confrontation with the suffering by not possessing required skills and by being emotionally involved.

The adoption of problem solving roles is the solution to the patient's and physician's problems. The patient must assume the sick role that entitles her/him to help; and the physician must offer help to the patient in acceptable forms. Socially institutionalized practices increase the acceptability of the service and legitimize the physician's authority.

Parsons also includes other functional attributes in this relationship. They are: the application of scientific knowledge to clinical practice, the penetration of the patient's private affairs or particular nexus, the prevention of counter-transference, and the building of trust in the patient. Scientific knowledge is ensured by universal criteria of professional recruitment and of identification within the profession. At the same time, functional specificity is pursued by evoking specialization towards narrow goals. Intrusion into the patient's private life is ensured through the combination of the normative pattern variables of universalism, functional specificity, and affective neutrality. On the other hand, the presence of an institutionalized setting protects the physician's interests by providing witnesses (nurses, para-medical attendants) to

her/his practice. Parsons also recognizes the physician's temptation to pursue her/his own interest: partly for this reason practices of control are set up within the profession, but not formalized in order to preserve the physician's self-confidence and autonomy.

Berlant suggests that by focusing on the normative structure of the relationship between patient and doctor, Parsons neglects the analysis of the physician's behaviour. Parsons sustains that, in order to be functional to society, medical practice has to follow certain norms. He offers a normative picture of how the profession should be. Berlant also highlights a contradiction between Parsons's definition of medicine as functional to the social system, and the stated goal of medicine (namely restoring the patient's health) which is an end in itself. The author suggests that a certain degree of neurosis and of incapacity of the individual psychological and biological systems are likely to be functional and necessary for the maintenance of the social system.

The Parsonian attempt to separate the medical profession from business is compared by Berlant with Weber's theory. Weber distinguished between economic groups, and groups with secondary economic interests. Yet, he demonstrated that differences between the two groups decrease when confronted by economic and political determinants. In Weber's view, virtually every group engages in economic actions in order to face scarcities of goods. The medical profession is thus classified as a commercial class: 'Professionals constitute a class in so far as they share common economic interests on the basis of their market situation, which in this case is determined by the marketability of the service.' (Berlant, 1975, 50)

Among commercial classes there is a latent competition, resulting in the development of class organization and of the need for monopoly. According to Berlant, Weber's theory on monopolization is well demonstrated by the history of the

medical profession 'particularly with regard to monopolization as a form of both domination and rational conduct.' (Berlant, 1975, 50)

The stages that characterize the Weberian process of monopolization are analyzed by Berlant with the purpose of describing the emergence of medical dominance among the healing professions. Professionals sell services which are not tangible items and therefore need to be presented with a certain amount of persuasion in order to be converted into commodities. The manufacturing of commodity items is the pre-requisite for professional domination over the market. The task consists of convincing a buyer that the service is a commodity and that s/he has to pay in order to have it. 'The American Medical Association, one of the guild type organizations of the medical profession, has frequently preferred patients to pay for service whenever possible as a matter of moral principle, and has tended to reject alternative payments methods.' (Berlant, 1975, 51)

A separation of the service from the results it can guarantee is also fundamental. Hence , a service needs to be presented as a performance of appropriate skills applied to a specific problem. Weber describes this requisite of the process of monopolization as the separation of the service from the satisfaction of the client. In other words, to provide a medical service does not always imply the restoration of patient to health. The current focus in the UK on a need-led service which aims at achieving consumers involvement and satisfaction in planning, providing and using services seems to represent a clear example of Weber's observations.

A further step consists in the creation of scarcity of service. This can be reached either through a decrease in the supply by reducing the availability of commodities, or with an increase in demand by means of up-grading the quality of commodities and their marginal utility. In the case of the medical profession both of these criteria have been adopted by using the institutional mechanism of licensing. 'By

setting high standards for license, higher quality service increased, and the proportion of qualified suppliers reduced through strict licensing requirements. (Berlant , 1975, 52).

The monopolization of supply can be pursued through three methods. a) By bringing the suppliers together; b) by driving competitors out of the market; c) by resorting to legal action (namely persuading the state that the competitors need to be eliminated). This last method has been the most useful for the medical profession. In contrast, the other two methods are commonly used in the marketing of tangible items but are less suitable in the case of intangible commodities. In fact, the unification of individual suppliers does not create scarcity, because of limitations on the quantity of the services that the individual practitioner can afford to withhold from the market. Driving competitors out of the market is also difficult because it is unlikely to guarantee the ownership of the in-put of production, as happens in the case of tangible items. The device used by the medical profession has been that of monopolizing education, which is the in-put factor. In order to monopolize education in a field where it is difficult to demonstrate who has better competence, a measure of legal action has been necessary at the points of both supply and production.

The restriction of group membership is another strategy useful in monopolizing the market. It contributes to making the service scarce, it increases members' loyalty and per-capita incomes in the market, and independently it raises prices by decreasing supply relative to demand. This strategy is linked with the attempt at eliminating external competitors by claiming the authenticity of service. The two ways of realizing this are legal licenses, and the ethical claims used for raising the marginal utility of the group's service. According to Berlant, the American Medical Association has made use of both of these.

A further requirement is 'to fix prices above theoretical competitive market value.' (Berlant, 1975, 54) When price fixing is not legally permitted, there is always a way to informally agree about a standard price. The unification of suppliers is also important to this. The members are economically rational if they act as a single supplier, because the control over the sale of service is not in the hands of every single person. In order to unify, members need co-ordination, which in turn increases the sense of mutual interest and of group identification. Internal competitors need to be eliminated as well. In Berlant's view, the usual mechanism used for the achievement of this goal is medical ethics. Through medical ethics, economic practices such as bargaining and advertising have been condemned.

The dominating character of the medical profession is also expressed in its empirical practice. Berlant underlines how physicians always expect patients to adhere to their technical advices and judgements. Medical ethics are indicated by Berlant as an important element in the process of institutionalisation of the medical profession. Historically they changed according to the political goals pursued by the profession, and to the organizational developments which occurred within the discipline. These changes may have an innovative character whenever they bring to the creation of new ethical provision. They may instead assume a revisionary perspective when leading to the elaboration of specific exceptions to pre-existing ethical rules. The latter occurs when it seems more convenient to yield to political exigencies than to confront them. By contrast, confrontational strategies consist of using pre-existing ethical rules against political interference.

Ethics are not mere superstructure, but contribute to achieve certain positions and are therefore part of the organizational structure. Some ethics increase group solidarity, some others build cordial relationships with the political authorities or contribute to eliminating external competition. They can 'appeal to men with self-identities of being highly principled... they are a means for achieving political

effectiveness as a group without requiring real political awareness among most professionals by confounding consequences with morals, thereby cutting off contemplation and discussion.' (Berlant, 1976, 67)

Analyses which provide an explanation of the interaction between politics, economic forces and occupations have also been developed by Parry and Parry (1976) and by Friedson (1970). This latter defines the difference between occupation and profession as he affirms that profession is an occupation that has gained power and a dominant position within the division of labour that allows control over the substance of its work. Virtually each occupation ascribes itself to the status of profession, but in relation to the definition of profession, the occupations have nothing in common except the hunger for prestige. Profession is thus a social symbol that people attribute to some occupations and not to others. But how does this happen?

Parry and Parry (1976) analyze the social institutionalisation of professions in relation to the social structure. They maintain that issues of social mobility, class boundary and state mediation are the core of our understanding of the relationship between professions and social structure. The authors provide a critique of the traditional sociological studies of professionalisation. Johnson (1973), quoted by Parry, distinguishes between the 'trait model' and the 'functionalist model'. The first puts forward a list of core attributes representing the common characteristics of professional occupations. The functionalist approach considers instead those elements which have a functional contribution to the maintenance of society.

The main weakness of both these perspectives is in the overlapping of the occupational characteristics with the features of a specific institutionalised form of their control. In fact, in looking for specific sequences of events through which each profession should pass in identical stages in order to achieve professionalisation, these

approaches do not examine the dialectical process which characterizes the negotiation of its standards of professionalism for each profession.

Parsons' functionalistic approach is proposed as an example. It regards the policies of change engaged in by professions in terms of 'temporal constraints upon the unfolding process of differentiation'. On the other hand Weber's analysis is criticized for not being contextualized to the history of continental Europe, thereby not extendable to the English-speaking countries. Weber's association of the rise of professions with the bureaucratic phenomenon does not take into account the differences between professionalisation and bureaucracy.

Berlant affirms that between the Weberian ideal type of bureaucracy and the institutionalisation of medical profession there are many differences. In the professionalisation of practitioners there is a general absence of juridical areas , because authority is obtained by the medical profession on the basis of license to practice. There is also a general absence of formal hierarchy, and 'there is a fraternal egalitarian quality to the relationship of practitioners to one another.' (Berlant, 1976, 60). Professionals own their personal means of production thus avoiding dependency on others, whereas the Weberian bureaucrats are supposed to be separated from the tools of their work.

With reference to similarities, Berlant sustains that both bureaucracy and professionalisation preserve written records and 'demand full working capacity and see work as a full time vocation rather than as an advocation.' (Berlant , 1976, 61). Yet, the bureaucrat is less likely to participate in policy making due to the hierarchical nature of his job, while the medical professional contributes in determining social and political goals, in other words in shaping policies.

Differing slightly from Berlant's position, Parry and Parry highlight the potential conflict between professionalism and bureaucracy. Weber saw professionals overlapping with bureaucrats because professionals were supposed to serve the bureaucratic machine, rather than become an independent group which might act as a constraint on the system itself. In this sense Weber ignored the analysis of the dialectical process which characterizes the emergence of professions.

In general, Parry and Parry are critical of those theories on professionalisation which do not value the interdependence that has historically characterized the relationship between the professions, the state and the economy. The sociological studies of the 70s brought changes in this direction. Johnson (1972) is acknowledged by Parry and Parry as partly representing this new perspective.

Johnson sustains that when specialized occupational skills develop, relationships of social and economic dependence are created, and paradoxically relationships of social distance develop too. The emergence of specialisation produces dependence on new skills, the area of social shared knowledge is reduced, and as a consequence social distance develops, creating uncertainty. Professionals may also use mystification in order to increase uncertainty and therefore to reach a higher degree of autonomy. 'Uncertainty therefore, is not entirely cognitive in origin, but it may be deliberately increased to serve manipulative or managerial ends.' (Parry and Parry. , 1976, 41)

Johnson regards professionalism as a form of institutionalised control in the occupational context. Thus professionalism is not something inherent to the development or to the nature of particular occupations. In order to prove this assumption, he elaborates a typology of professions focused on the 'core of uncertainty existing in the producer-consumer relationship.'

There are three main models of producer-consumer relationship. The first type is the 'collegiate control'. It is based upon the control of the producer over the consumer through the producer's definition of the consumer's needs and ways in which these needs can be satisfied. Professionalism and guild-control are sub-types of collegiate control. 'Professionalism is seen as a product of social conditions in the 19th century in Britain, and guild-control as one of the phenomena associated with urbanization in Medieval Europe.' (Parry and Parry, 1976, 41)

In the second model accounting for uncertainty, needs and ways of the consumer are defined by the consumers themselves. This type includes both oligarchy and corporate forms of patronage as well as type of communal control' (Parry and Parry , 1976, 43). The third category of producer-consumer relationship is the 'medieval type'. Capitalism is an example of it. The capitalist intervenes in the relationship between producer and consumer in order to rationalise and regulate the production of the market. A second example is that of state mediation as illustrated in the case of British welfare state policies.

According to Parry and Parry, a main advantage of Johnson's analysis is to reject the concept of an unfolding process of specialisation, dividing types of occupations on the basis of a rational principle. On the other hand, Parry and Parry consider Johnson to have overemphasised the relationship between the professional and the client, whereas the relationship between colleagues is neglected. 'Control over clients has in our view been historically less important.' The British Medical association is brought as an example: ' the colleague has always been a group of peers organized to pursue some collective ends. It was certainly not primarily concerned with controlling clients.' (Parry and Parry , 1976, 44)

Parry's structural perspective seems to me to neglect the consideration of the micro-social level of interaction. The fact that a professional association does not list

among its aims an improvement or an analysis of the professional-client relationship, does not necessarily mean that this is not a strategy. It can either be a conscious strategy, or a direct result of a traditional neglect of the client's perspective.

A connection between profession and social mobility is indicated by Parry and Parry in the concept of 'security at work'. Differences existing in the social mobility of professional groups are assumed to depend on means available to the groups in order to reach security at work. In the case of doctors, standards of education and legislation were employed to control entry. The structural position of an occupational group accounts for the tactics and strategies undertaken by the group to control its situation. Autonomy in medicine is reached through the dominance of its expertise in the division of labour . 'It is true that some of the occupations it dominates-nursing for example- claim to be professions...in essence the difference reflects the existence of a hierarchy of institutionalized expertise.' (Parry and Parry 1976, 49)

The ways through which occupations achieve different standards of social mobility and the status of professionalism find their origin in the relationship between the state and the economic system. Durkheim conceived the state as secondary to society, and power as a form of control stemming from society. He considered the doctrine of economic liberalism as a source for the production of individualism, and therefore of anomie. Marx and Weber, on the contrary, did not conceive social disorganization in terms of a potential consequence of capitalism. Yet, they shared with Durkheim the notion that capitalism is defined by a separation between state and economy. 'It is from the existence of this separation which itself is derived from economic liberalism, that two alternative theories of power and control in capitalist society have been developed.' (Parry and Parry , 1976, 63)

According to Marx, power derives from the ownership of property, and lack of power relates to non-ownership. Whereas in Weber's concept of market the notion

of 'life chances' is put forward. Both Weber and Marx consider the horizontal class division a typical capitalistic phenomenon, and they regard power as a form of control over particular markets.

Parry and Parry sustain that if the relationship between state and economy is a typical feature of capitalist society, the relationship between them has varied from the continental European to the Anglo-Saxon worlds, particularly in the US and in Britain. Yet in England where the philosophy of 'laissez faire' was widespread, state intervention in the economy developed rapidly. ' In the mid-twentieth century it is usual to speak of mixed economy, meaning that the intervention of the state in a number of important economic activities has become at least equal to that of private enterprise.' (Parry and Parry , 1976, 67)

Whilst in England industrialisation expanded first by enterpreneurs, in France and in Germany industrialisation was an objective of state policies. This made a great difference to the relationship between state and economy in continental Europe compared to Britain, state intervention being more stressed in the first case than in the second.

Market capacity is part of a political process and power struggle where the principal form has been the free occupational association. Professional associations, trade union, and business associations are rooted in the market. According to Giddens, these three main forms of occupational association differ in the use of resources found available in the market. Associations of businessmen use capital as a resource for the manipulation of the market. Professional associations manipulate education and skills in order to control the market and specific forms of service. Trade unions are concerned with the manipulation of labour power aiming to regulate areas of the labour market. In practice, the last two types overlap and often compete with particular occupational groups. This situation is illustrated by the emergence of

different associations within a same occupational area. 'The effort of occupational associations is directed towards the creation of identity between 'likeness' of interests (class) and 'likeness' of kind (status).' (Parry and Parry, 1976, 77)

There is a direct link between status and occupation. Some forms of occupational control can produce increased income and allow the possibility of increasing the status of the occupation within society. When an occupational association controls the entrance onto its labour market, standards of selective recruitment are established. A selective recruitment based on high status background reinforces the status of the occupation and confirms its position in the class structure. 'The barriers erected by high status occupations are in themselves an important element in the establishment and continuation of class division.' (Parry and Parry , 1976, 77) Homogeneity is created behind these barriers by a shared style of life which includes similarity in family and educational background, shared normative assumptions and expectations, and similar relational patterns.

Social mobility can be developed only thorough collective action. Collective action is based upon occupation, because occupation is in itself rooted in the market relationships. A threat to occupational stability usually evokes awareness and the consequent formation of occupational associations directed towards the closure of occupational opportunities. The process of social mobility therefore requires the presence of three conditions. Firstly there has to be a similarity of market capacity, secondly an assimilation to the normative sphere in terms of values, and thirdly it is necessary to develop identity of relational patterns, specifically familial and friendship networks.

Occupational associations perform a key role in class formation and maintenance. 'Unionism and professionalism can be considered as alternative occupational strategies which typify the approaches to the market and status control

of numerous occupational associations based on a particular type of market capacity.'(Parry and Parry, 1976, 79)

Professionalism and trade unionism differ in their strategic orientation. The first is directed towards the achievement of social mobility, and once this has been reached , towards its maintenance through mechanisms of closure. Unionism is instead centred on the mechanism of collective bargaining, but it has not usually been associated with the process of social mobility across class boundaries. The mobilization of class solidarity in working class occupations tends, on the contrary, to prevent from the assimilation to middle class aspirations.

The division of labour, understood as the division between those who have skills to sell and those who have money to buy them, is regarded by Parry and Parry as the basis for the development of associations of employers and trade unions. At the beginning of their existence trade unions and professional associations adopted similar patterns of bargaining. The difference between them then developed through the different uses of education as a 'key resource for the manipulation of the market and control over its entry.'

Specialisation in education, the qualification of the association and the presence of a membership provide means of control over recruitment, and ensure a certain degree of monopolisation towards closure to entry. An increase in the price of services will then improve professional remuneration, and this is a means to reach an enhanced standard of living and a higher status. State support, when obtained, reinforces this situation: 'a legal monopoly backed by legal sanctions.' When state support is not possible, at least an acquiescence of the state is important.

This concept of professionalism has been particularly important in America and Britain where free professional associations have flourished. In contrast, in

Germany and in Italy a distinction has developed between the self-employed professionals and the professionals in a secure bureaucratic position.

Any change in the relationship between state and professions is crucial because professionalism 'as an occupational strategy should be understood in relation to the development and maintenance of class structure.' (Parry and Parry , 1976, 86) Occupational associations represent the institutional answer given by professions to the uncertainty characterizing the capitalist market. They have historically engaged in practices of exclusion in order to protect their job security: 'The relationship between the relative success of exclusion practices and the reaction of the excluded, is fundamental to an understanding of collective social mobility.' (Parry and Parry 1976, 87)

The theoretical framework thus developed by Parry and Parry is then tested through the analysis of the emergence of the medical profession.

Parry's analysis is fruitful to the purpose of this study because it indicates the importance of the structural level of investigation in the study of professions. The issues of social mobility, class boundaries and state mediation stand as a core component in the relationship between profession and social structure. Yet, the level of micro-social analysis which accounts for cultural, social and subjective experiences in the process of professionalisation has been partially neglected by Parry and Parry.

A link between macro and micro levels of analysis is provided by Friedson's study on medicine which presents a more holistic approach (1970). Medical dominance and status among healing professions is explained in relation to structural conditions and social-cultural needs. Medicine defines itself as a profession by interacting with different levels of the society.

According to Friedson, medicine's dominant character is demonstrated by its social prestige. Medicine has displaced law and the ministry:today's goods and other forms of property are less important than the welfare of citizens. The profession of medicine has thus become the prototype for people who want to reach a privileged status in society.

The prevalence of medicine is not only due to its prestige but also to its authoritative competence. The development of universities and medical schools has been central to the establishment of medical dominance, together with state support and acknowledgement from the public. In fact, with the establishment of professional associations in Germany and in England, physicians gained more power, but public confidence was not secured until the support of the state and the spreading of public education enabled people to acknowledge the physician's competence.

The foundation of medicine is therefore political in character because it involves state aid in establishing and maintaining its prominence. As an occupation, medicine has got its own representatives who manage to direct state policies in the occupation direction. Once the profession's status and prominence have been established on a political level, other mechanisms ensure its dominance at the micro-relational level.

The division of labour among healing professions is structured by the politically-supported dominant profession. The activities of the physician are in many aspects similar to and overlap with those of other professionals in the field. What really distinguishes the physician is the control he holds over the division of labour. Those occupations falling under the physician's control are called 'para-medical'.

The control of the physician can be expressed in different ways. Firstly, the knowledge and the technical skills learned by paramedical professionals are replaced

and enlarged by physicians during practice. Secondly, paramedical workers tend to assist rather than replace the physician, to execute orders and to be supervised by the physician. Finally, the prestige generally assigned to paramedical workers is much less than that ascribed to the physician. 'These characteristics are such that the paramedical occupations can be distinguished from established professions by their relative lack of autonomy, responsibility, authority and prestige.' (Friedson, 1970, 49)

Those occupations which have fallen or have been pulled into the division of labour are considered as paramedical. Occupations which instead perform similar tasks (i.e. herbalist compared to pharmacist) are called 'irregular' but not paramedical. In these terms, the sharing of the task does not constitute the basic criteria to fall within the distinction.

In the division of labour, hierarchy is identifiable within paramedical occupations too. For example, nurses are considered to be in a higher occupational bracket than attendants. The degree of autonomy by which work can be carried on independently from the occupation appears to affect the hierarchical position and the power retained by the occupation. The more paramedics gain autonomy, the more they overlap with the physician who is also the source of legitimacy for the occupation.

Paramedical occupations cannot therefore work if not under the direction of the physician. Paramedical workers must either find professional satisfaction within this hierarchical scheme , or look for it outside. In the first case they will remain within the present paramedical division of labour; in the second case they will be parallel to the institutional medical order. Being outsiders means finding autonomous areas which are not dependent on the medical sphere (i.e. homeopathy).

But where does the source of professional status come from?
A profession attains its position by virtue of the social recognition given to it by a group in society which is persuaded to accept the knowledge and the skills brought by the occupation. Its position is then ensured by economic and political influence of the elite which is sponsoring it, and that to some extent discourages other occupations from entering into competition. Once the profession has established its autonomy and the uniqueness of its knowledge, it can develop its own interests which can also differ from those of the elite which has promoted it. Yet it is essential for the profession 's survival that the dominant elite remains persuaded by the values expressed by the profession. If a profession's work is regarded as having little relationship to the knowledge required by society , it may have difficulties in surviving. 'The profession's privileged position is given but not seized by society, and it may be allowed to lapse or may even be taken away.' (Friedson, 1970, 73)

Some occupations have relationships with lay people, and their survival depends upon a certain degree of popularity among lay people. The organizational problems become those of bridging the gap between the profession and lay people. When the public is considered unable to evaluate what the profession produces, the state intervenes. The state evaluates and defines a legal monopoly on the basis of technical and standards requirements attached to the profession, among which formality of training appears to be more important. The state helps in bridging the gap between profession and public 'if only by restricting the lay-man's choice.' (Friedson , 1970, 74)

In order to maintain its dominance, medicine has to be autonomous. Its status is related to the degree of autonomy it can achieve. Autonomy derives from three sources. First, the body of knowledge and skills that constitute the profession has such an unusual character that non-professionals cannot evaluate it. Second, professionals in medicine must be trusted by definition, because they have to be

responsible for their decisions without a need for supervision. Third, the profession itself is considered competent to judge deviant performances, and it has the ethical competence to evaluate and provide corrections to them: 'Its autonomy is justified and tested by its self reputation.' (Friedson , 1970, 137)

Medicine is therefore a self-regulating profession, as nobody but the medical professionals can evaluate or disprove competence. The point is, then, to understand how the criteria of self regulation come about. The answer is indicated by Friedson in the training processes undertaken by aspiring physicians. In this Friedson can be linked to Becker's (1964) and Jackson's (1970) analyses which are focused on the contents and meanings transmitted to students during professional training. This way of tackling the issue takes into account the micro level of analysis, but also allows an understanding of the social imagery about the medical profession, as it is experienced and perceived by lay people.

According to Friedson, the internalisation of particular norms and values which medical students experience during their professional training helps in explaining the autonomous and self-regulative character of the medical profession. In Jackson's view, this accounts for the ethics and ideology which are behind medicine, while in Becker's opinion it explains how students 'learn to play the part of physicians in the drama of medicine', and where professional status comes from. Ultimately, Jackson regards the setting of training within the academic environment as a means to extend the range of legitimation of the profession and of its concern for public rather than individual interest spheres. Thus a direct connection is established between the micro and macro levels of analysis.

A profession is defined by specific training and core knowledge, and by its capacity to involve the private and social sides of the professionals' lives. A code of ethics and ideology define a status and life style of universal relevance. Professional

status and social recognition will be regulated by the extent to which a body of knowledge and techniques are held in ballance with one another.

The observation of the standards of practice related to the self-regulative character of the profession refers to the sense of responsibility that the medical professionals are supposed to internalize during the training process. Yet, practising medicine also implies taking risks. Habitually, judgments cannot be objective because they are often a matter of opinion and 'it would not be wise to create formal codes of rules placing one opinion, theory or school over another.' (Friedson , 1970, 162)

Practitioners are therefore likely to feel a sense of uncertainty and vulnerability. This can be a reflection of the perspective of the worker rather than of the scientific and technological inadequacy of medical knowledge. Medical practice is in fact organized in a way that emphasis is put on personal rather than on general responsibility. This latter refers to the archetypal feature of the medical practice. The physician holds the life of the patient in his hands, s/he is directly and personally responsible for the patient's well-being. Since responsibility is personal, wrong performances do not contaminate medical science and only the physician will eventually be blamed for it. This idea is transmitted to students during training and Friedson also underlines the existence of specific sessions dealing with 'getting into trouble'.

Related to this, there is the physician's commitment to 'action'. Action is always considered better than inaction, even when the results are not completely predictable. The physician must believe in what s/he does in order to practice. S/he must believe that what s/he does is good rather than harmful, that action is preferable to inaction: 'He is himself a placebo reactor who is developing faith in his remedies and so modifying his behaviour towards patients.' (Friedson, 1970, 168).

The physician emphasises the idea of uncertainty so as to provide himself with the psychological ground from which he can justify his concern on pragmatism. In Friedson's view, it is in this that the physician differs from the scientist, because he cannot suspend action in the absence of evidence as the scientist does.

The fact that the physician must rely on his experience makes him resistant to changes. Therefore, another feature of the physician is a kind of ontological individualism. This does not mean that he is not rational, but that his rationality is particularized and technical. These considerations paradoxically contrast with the substance of medicine as it is empirically perceived: an occupational niche defined around problems of universal, or at least widely experienced, social concern.

According to Jackson it is through training that this area of knowledge assumes an aura of mystery, a quality of the sacred and professionals become the priests of that area of knowledge. In this respect training includes the initiation into the mystery of knowledge and practice. Professional authority thus derives from the holding of this particular sphere of competence, acquired through qualification and attested by a professional group of peers.

On the ground of their authority, professionals do not need to justify their decisions and they do not need to reveal their basis in theory. 'The process of professionalisation can then be seen as a process of increasingly protective measures to define the boundaries between the sacred company of those within the walled garden, and those outside.' (Jackson, 1970, 10) In this sense it can be affirmed that the general practitioner and the nursing staff enjoy lower professional status than the specialist in medicine, because they are more in contact with the profane world (patients and not cases). Their professional mystique is thus compromised by the contact they must make with the profane world.

This argument is linked with the self-defensive attitude of those professionals who instead enjoy a high professional status. According to Jackson, they can be assumed to be particularly resistant to change: 'Those appointed to make proposals for change were exactly those whose self-interest inevitably led them to oppose change. And it was demanded of them that they change the very system which was the source of their own authority and privilege, and which had given them power to bring about reform.' (Jackson , 1970, 12)

There is, finally, a moral element embodied in the dominance of medicine. This aspect has been investigated by Friedson and by Kennedy (1981).
During the last few years many problems and issues which have a social, political and ethical nature have been transformed into medical problems, therefore into technical issues whose solution has to come from people holding a particular competence.
In modern society, deviance is related to the concept of illness and this latter is the area of competence of medicine. 'In our days, what have been called crime, lunacy, degeneracy, sin and even poverty in the past, is now being called illness, and social policy has been moving toward adopting a perspective appropriate to the imputation of illness.' (Friedson, 1970, 249) The consequence of this movement is a professionalised institution that has assumed the right to judge and define the behaviour of individuals.

In evaluating this situation it is important to distinguish demonstrable scientific achievements from the status of the occupation. Medicine has gone far wider than 'its demonstrated capacity to cure.' For instance, a person who drinks heavily is re-labelled 'alcoholic', and alcoholism becomes an illness. This judgement is established by medicine despite the fact that knowledge on aetiology and predictability of the treatment is absent in the discipline, as it is in law and religion. 'While medicine is widely independent of the society in which it exists, by becoming a vehicle for

society's values, it comes to play a major role in the forming and shaping of the social meanings imbued with such values.' (Friedson, 1970, 252)

The concern in medicine pertaining to treating illness assumes the character of active intervention which aims at seeking and finding out the illness. Medicine thus creates social meanings or interpretations of illness where they were lacking before. It performs the role of social entrepreneur through the treatment, containment and eradication of something bad: the illness. The conventional claim of medicine that it is more serious to miss a disease than to diagnose one, does not take account of illness as a social construct, not all of which is supplied by medicine. In our society there is in fact a social emphasis on the concept of health that interacts with the medical definition of illness.

Medical knowledge and procedures are themselves a function of the social character of medicine as an enterprise. 'The content of this enterprise is one drawn from and imposed on the experience of the lay-man of the society in which the professional practices.' (Friedson, 1970, 277)

Since medicine interacts with lay-people in establishing its enterprise, it is important to know how people become aware of being ill and of needing professional aid. Depending on the societal culture, the relationship between lay-person and her/his distress varies. Common to every culture is that distress is experienced as a deviation from what is regarded as normal or desiderable. The social structure of the lay community is likely to influence the lay-person's decision whether to seek professional help. Friedson hypotheses the existence of a lay-referral system that implies an organized societal reaction to illness. 'A reaction that is selective in picking up one attribute rather than another, that declares it serious rather than minor, and that exerts patent pressure on the individual to behave accordingly.' (Friedson, 1970, 300)

Medical treatment thus becomes the sort of societal reaction to discomfort/deviance. Because of the need to specifically train people in order to perform medical practice, medicine necessitates institutional organization and legitimation. Medical dominance is ultimately defined by its interaction with macro-structural elements (political and economic agents) and micro-structural factors (interaction society/lay people).

The autonomy gained by medicine once its dominance has been established, assumes characteristics of reification and gives a perverse connotation to the system. This can actually be extended to any professional status in our society. The example of engineering proposed by Friedson clarifies the matter. An engineer, by means of his/her professional competence, is expected to prescribe how to build a road.Yet, his professional autonomy gives him the right/power to evaluate if the road should be built, and where it should be built. The last two aspects are of public rather than of professional interest. 'Where lay-people are excluded from such evaluation, true expertise is not at issue, but rather the social and political power of the expert.' (Friedson , 1970, 336)

There is an analytical distinction between the practice, exercise or application of expert knowledge, from the knowledge itself. The means through which medical knowledge is implemented rely much more on customary usage and personal preferences rather than on systematic knowledge guided by self-conscious theory. In this sense the professionals' claim to autonomy in how to apply their knowledge is not justified 'even though the character of its pure knowledge is acceptable.' (Friedson,1970, 344)

In the course of its application knowledge is transformed into a socially organized practice. Because of the practitioner's commitment to action, intervention takes place even when there is no reliable knowledge. 'As a moral enterprise, medicine

is an instrument of social control which should be scrutinized as such without confusing the 'objectivity' of its basic knowledge with the subjectivity of its application.' (Friedson, 1970, 346) The medical rationale for deciding what is best for the client comes from the fact that most clients are kept ignorant about their condition, or unable to evaluate their choices: 'The autonomy of practice would still not be justified owing to the fact that, apart from what is purely technical and instrumental about practice, there is embodied in it an inexorable moral element. It must be decided that a road is desiderable, that instruction in a given academic subject is needed, that a complaint is a symbol of something bad: these are not technical decisions alone, and cannot be removed from lay debate.' (Friedson, 1970, 357)

3.5.2 Shaping of professional cultures.

The importance of professional training in understanding the process of professionalisation has been pointed out above. Training is also an important area of study for the analysis of professional behaviour as it is experienced by lay-people. The process of education to a profession is supposed to build in the student the expert knowledge needed to practice, and that ensemble of attitudes and professional behaviour which tend to be standardized in professional practice. It is therefore by unravelling the elements and stages which compose the process of training that it should be possible to understand the shaping of professional culture and professional personal and collective identity.

Becker (1964) and Davis (in Cox ed.,1975) respectively have analyzed the training of medical students, and the training of student nurses. The comparison of these studies suggests an interesting similarity between the two educational processes.

Both authors describe the training process in very similar ways. Becker regards training as the educational process by means of which students are ascribed to the medical profession, it is thus a rite of passage from a lay to a professional conception of the medical job. Davis affirms that the passage from the lay philosophy to the identification with the professional culture occurs during the training process.

Therefore, training consists of both learning basic sciences and their application, and of passing through ceremonial rites and ordeals of initiation which altogether make the status of physician. (Becker, 1964, 4)

According to Becker, three main aspects characterize our society: the increase in the number of professions, the increase in the length of training and the trend towards the practice of profession in organization. Because of the increased length of training, aspirants have to choose their professional studies when they are still very young. In comparison with the past, between the student's commitment to the profession and her/his becoming part of the professional world there is a large gap in terms of time. At the time of her/his original commitment, the student may have a confused picture of what her/his professional life could be like. 'This may in turn lead to more and more use of tests of various kinds to predict whether the aspirants will be selected before they have access to substantive knowledge.' (Becker, 1964, 6)

The period between the choice of the profession and its real practice is particularly important to an understanding of professions. Becker does not conceive the process of education as an individual gradual achievement of standardized levels of knowledge. Training is instead regarded as a process that students collectively experience and learn to cope with for the attainment of their professional status. The focus of the analysis is therefore on the patterns of behaviour adopted by the student-group while relating to the educational process.

Group perspectives are 'coordinated views and plans of action people follow in problematic situations.' Students will search for a guiding perspective for their behaviour in situations where academic effort is required. A consistency of the perspective can be found when level and direction of efforts towards academic performance are coherent and consistent. 'To deal with the consistency of perspective with one another and with the relation of the perspectives we studied to the role of student, we use the concept of student culture.' (Becker, 1964, 34)

The students' actions take place within an institutional environment, their perspectives therefore interact with institutional rules. With the concept of 'students' perspective' the author means a set of ideas and actions that persons elaborate in response to a situation. Thoughts and actions are coordinated in the sense that actions flow from the ideas contained in the perspective. According to the authors, their definition of perspective is in fundamental accord with that of Karl Mannheim in his ' Ideology and Utopia' '...the subject's whole made of conceiving things as determined by his historical and social setting.' (Becker, 1964, 34)

A particular perspective develops when individuals or groups have to face dilemmas. Perspectives differ from values by being situational-specific. Values are abstract and generalized, and are not specifically referred to a given situation. Perspectives contain values, but also the evaluation of the situation where values are to be applied.

Actions and ideas contained in one perspective mutually reinforce one another. Actions derive their rationale from ideas, and successful actions reinforce the ideas they come from. Together, they constitute a complex of mutual expectations. The students' culture consists of collective responses given to problems coming from the institutional setting. The fact that responses are collective, means that they cannot be regarded as the product of individual motivation 'while individual motivation plays

a part in the development of the actions, the final activity is one that is carried out jointly with the other members of the student body. (Becker, 1964, 437)

The collective character of ideas and actions implies that students retain a certain degree of legitimacy in what they do. The sharing of the same point of view and engaging in similar activities give a rationale for this. According to the findings from the Becker's research, students make use of this autonomy in directing their academic efforts. In fact, students and educators often have different ideas about how hard and how much effort the students should put on their work. As a consequence, students attempt to convince the faculty that they are doing well, by directing their efforts towards the things they assume to make a good impression on the faculty.

Students' degree of autonomy in directing level and efforts of their academic performances can appear paradoxical in medical school.In this case the power of the faculty is in fact more than in any other school, given the strong commitment that students invest in their medical career. According to Becker, this finding acknowledges the sociological proposition that 'superiors in organization control the behaviour of their subordinate in part because subordinates consent to having their behaviour controlled.'

The transformation of the student nurses' initial idealism into their professional view of nursing is defined by Davis as a process of doctrinal conversion: 'I mean the psychological process whereby students come to exchange their own lay view and imagery of the profession for those the profession ascribes to itself.' (in Cox et al. , 1975, 118)

The lay imagery of the initial student is built on a core of humanitarian values where love and desire to help others is considered a sufficient motivation to ensure the student's commitment to the nursing job. This is the student's lay conception of

nursing. The main concern of the student at this initial stage is to acquire, as quickly as possible, the technical skills necessary to perform her/his social purpose.

An institutional approved imagery is opposed to this lay conception, by means of putting much more emphasis on the relationship between nurse and patient rather than on the administration of technical skills. The nurse-patient relationship is presented as problematic, and thereby the student's humanitarian philosophy is gradually de-constructed. The institutional imagery promotes a move from an interaction between two lay perspectives (student and patient) to one between a professional perspective and the lay perspective of patients.

According to Davis this process of doctrinal conversion takes place in six stages. The first stage is of 'initial innocence'. During this period students who look forward to mastering practices and techniques are instead required to observe patients within the wards, and to try communicating with them. Students at this point experience feelings of frustration and embarrassment. They sense role deprivation while relating to patients because of their lack of technical tools and knowledge.

The second stage is called 'labelled recognition of incongruity'. Students start to react by remarking ' nursing school is not what we expected'. According to Davis, this is probably the most difficult stage of doctrinal conversion because students question their choice by realizing the partial failure of their expectation.

The third phase is 'psyching out'. It is the collective response given by students as a group to the incongruity between their lay imagery and the institutional imagery. 'Not until the values and norms implicit in this imagery are rendered incongruous-the achievement of the second stage- can psyching out assume the status of an institutional adaptive mechanism.' (Davis, in Cox ed. 1975, 124) Generally, students start psyching out the instructor about the gap between their expectations and what

the school is offering to them. In Davis' view, a first internalization of the school perspective occurs during this period and the student's cognitive framework starts to be modified.

'Role simulation' is the fourth stage. It consists of performing those roles perceived by students as rewarded by their instructors:'by this point in time, students have learned that to enact their lay conception of nursing with patient would win them little favour with the instructor.'

'Provisional internalization' and 'stable internalization' are the final stages. This consists of a subjective uneventful transition from provisional to stable internalization. The first is characterized by a recurrent failure at integrating between precepts and role orientation which guide the student towards the significant institutional behaviour. Two phenomena are generally associated with the occurrance of stable internalization:a) the function served by professional rhetoric; b) the emergence within the student group of relatively unambiguous positive and negative reference models of the professional nurse. (Davis, in Cox ed. 1975, 128)

Two observations can be made in relation to these studies on training. Firstly, training appears to be an important element in the process of professionalisation, both because of the knowledge it is supposed to convey, and because of the educational models used for its transmission. The modalities of transmission and not the technical skills in themselves appear to shape professional culture. These modalities are set up through a process of interaction between the students' expectations and the institutional setting of training, with its organizational rules. The result is a compromise between the needs of both parties, and the product is the shaping of a profession.

The second consideration regards the collective element rooted in the training process which has been underlined by both the authors considered. Studying patterns of professional behaviour takes place at a collective rather than at an individual basis. As a group the students engage in group's mechanisms of interaction and collectively decide upon the negotiation of their professional expectations within the institutional setting. What is shaped since the beginning is therefore a specific professional culture which exists as a result of collective choices.

The graduate student who works in organizations as a professional, brings with him/herself the knowledge of technical skills (perhaps learned on the basis of individual capacity) and a specific professional culture. The latter belongs to the specialisation it has been shaped by, and is shared by the people belonging to the same specialisation. It is the professional culture therefore which is likely to be used again in time of negotiating professional performances within the institutional setting.

Concerning this proposed research project, the use of professional culture in the terms defined above is fundamental to an understanding of the interaction between profession and organization :i.e. psychiatric nursing in its interaction with psychiatric community care and with the institutional environment.

3.5.3 How does theory fit into practice? Professionalisation in Britain and Italy.

So far, the theoretical contributions analysed have taken into account the emergence of medical dominance from several perspectives, which generally looked at such developments in the Anglo-Saxon world (Britain, USA). As models of intepretation they are in fact useful to better understand the complex net of relationships which together shape a profession. Nevertheless, research calls for contextualising such analyses within the field of study of British and Italian community psychiatric nursing. In the case of Italy a further theoretical effort needs to

be undertaken. Interesting suggestions in this sense come from Krause, who has extensively analysed the relationship between the Italian state and the medical profession.(Krause, 1988a, 1988b)

Krause views the emergence of professions rooted in the relationship which historically and nationally these have established with the state. This process is not uneven across capitalist countries, because capitalism developed differently both amongst Western European countries and in the States. Italy would be a peculiar case within the European scene, or using Krause's words 'a deviant case'. To begin with, Italy became a state only in 1876, and due to the political system of principalities which had existed previously, the central state was particularly weak. It was only during the facist era that Mussolini tried to reinforce state centrality, but following the war period centralism was nevertheless weakened by bureaucracy and the prevalence of particular interests (church and professions) against public ones. After World War II the party system was established and it immediately split in the contrapposition between Christian Democracy (DC) and Communist Party (PCI). According to Krause it is from this period that, because of state weakeness, parties could begin to control the state and share areas of power within it. The system which emerged is called in Italy 'partitocrazia' which can be translated as 'the governement of parties'. In Krause's view this system permeates the Italian society completly, so that nothing can be undertaken without a party's patronage. An implicit bargain among parties which gravitate around the right-conservative DC or the left progressive PCI (now split between PDS -left democratic party, and Rifondazione - Refoundation) results in the control of the most important areas of social and economic policy. For example in the television area, national channels are implicitly controlled by three parties: channel one is Christian Democrat, channel two is socialist, channel three is left oriented. Krause defines this condition as that of parceling-out or 'lottizzazione' in Italian, which consists of a proportional share of areas pertaining to jobs, education, and information.

In terms of professional growth and evolution, the state role has emerged as that of a nourishing mother which rather than representing public interests, has constantly been pulled between contrasting professional requests. Krause's thesis seems to be that rather than regulating professions, the state has been controlled and regulated by them. Capitalism itself has assumed a peculiar form, in that it developed and is actually sustained by small firms and craft enterprises which are the major source of Italian productivity. This would contrast with the USA model where large capitalist firms act as principal actors on the market.

> 'To sum up, neither the state nor any profession, or even capitalism itself, can function on their own, with solidarity, independent of political party decision making. The evolution of professional group autonomy, such as that of the italian medical profession, cannot be understood apart from this fact of life.' (Krause, 1988, 153)

In Krause's opinion, the main difference between the Italian and English or American medical profession is that in Italy it grew because of the state. Since the Middle Ages training for Italian doctors was university-based, thus contrasting with the English and American non-university professional model. Until 1800 in Anglo-Saxon countries training was developed through apprenticeship, it was only towards the end of the century that a university based training was introduced. A consequence of this difference was that 'while the majority of the poor and peasant class in Italy at mid century (1800's) could and did see the publicly-paid, free community physician who was in almost all cases a university-trained physician, most Americans, poor or otherwise, saw unregulated and often ill-trained practitioners, who frequently charged high fees.'(Krause, 1988b, 231)

Thus, even prior to the unification of Italy, a strong tradition had emerged towards free and publicly sustained medical care. The unification process only

reinforced this trend, which was once again supported with the establishment of the Italian NHS in 1978. The National Health Service was the result of a negotiation between contrasting interests. Centre-oriented parties, especially Christian Democracy, agreed to the establishment of the NHS partly because they thought to buy-off opposition from the left, and partly because the system was believed to rationalise costs, thus reducing national expenditure in the health sector. According to Krause, physicians played a crucial role in the formation of the NHS as it actually stands. They were able to preserve a huge private sector which guaranteed them a permanent choice whether to work in the public or in the private sectors. Krause observes that this approach of the medical profession to the state is typically Italian. In practice, the position of Italian physicians would be that of asking for state financial support, but refusing any control in how the money is allocated.

According to Krause the Italian training model has for long been oriented towards a formal classroom-like pattern, with no or little place for practice. An internship has been introduced only recently. A further difference is that university is virtually free in Italy, taxes are very low and compared to those of Anglo-Saxon countries they can be considered only as a symbolic contribution. Public universities have thus guaranteed a greater access to medical education, often causing over-production of a skilled but un-employable population.

Krause goes further by saying that from a practical viewpoint, the Italian NHS does not exist. Regionalism, in place of it, regulates the national health care, and-but this is well-known- huge differences can be detected between 'red' regions and 'white' regions. Politically the former are promoters of a public health service which involves direct citizens' participation, in a sense advocation is guaranteed by the acknowledgement of citizens'rights to have a say on health care provision. White regions, controlled by DC, have instead chosen to reinforce the church-based care model by combining private and public funds (more public than private).

Krause concludes his observations by observing that finally the Italian state is faced with a deep health care cost-crisis. It is perhaps now time for physicians to face cost-cutting and so to see, for the first time, their hegemony curtailed.

Krause's observations are crucial to this analysis and need to be throroughly commented . In the writer's view Krause seems to distinguish between state and parties, and further between state, parties, and Italian society. I personally disagree in viewing the state as detached from political interests, but share Willis's (1983) opinion about the existence of a degree of insulation of the state apparatus from the dominant class. On the one hand the state indirectly serves the dominant class's interests. On the other hand the state also acts as a mediator between contrasting positions within the domininant class, thus ensuring its own autonomy.

> 'Following Polulantzas (1978:128-129), the state is not a 'thing' but the material condensation of a balance of forces and relations.[...] Rather than being a tool of the dominant class it must integrate all classes within the capitalist mode of production. From this point of view the state is a type of relationship within a material framework of organisation. This framework is constituted by an array of judicial, legislative, military and coercive institutions which together comprise the state bureaucracy of which the health bureaucracy is a part.'(Willis, 1983, 26-27).

In Italy the issue arose when the partytocracy system began to degenerate. The unexpected consequence of politicisation, an overwhelming aspect of Italian life, has been the emergence of political professionalism (Mastropaolo, 1984). By political professionalism is meant the emergence of parties' professionalisation, whose major consequence has been that of neglecting the representation of society's will in favour

of the promotion of the political profession. To be a politician became a profession just as to be a medical doctor. Interestingly, the same contrapposition between particular professional interests and collective interests emerged in the political professional as much as in the medical professional. Lobbies amongst parties are just the same as professional lobbies amongst physicians. There are strategies of control over entry into parties as well as to professions, as there is a membership and a sort of interneship to be undertaken before being fully accepted by the political community. What therefore seems to have happened between parties and medical groups is a negotiation upon the areas of professional hegemonic control. This may be why the Italian NHS ended by being a sort of compromise between a collective service and an arena for the representation of particular political interests. In accordance with Krause, it can be observed that this was possible only by virtue of the endemic weakness of the Italian state. A weakness which has been historically determined as the result of the unification process. Compared to the UK, in fact, Italy is a young country where regionalism becomes a necessity for an equal representation of cultural differences and local needs.

Following Willis'considerations (1983), the medical group has been functional to legitimising the nature of capitalist society by becoming 'organic intellectuals':

> 'Extending the Gramscian analysis then, doctors must be seen as organic intellectuals which emerge in association with a new dominant class in advanced capitalism 'exercising the subaltern functions of social hegemony and political government'. (Willis, 1983, 16)

It becomes interesting to observe what happens when, as in the Italian case, politics degenerates and the medical group is pulled into the process. By participating in the system of parties, the medical class has in a sense endangered its professional position. In Italy, for example, there is not the same belief in expertise as there is in

Britain. I wonder if the psychiatric reform, with the crisis of traditional psychiatry it involved, has been possible because of this.

Perhaps the main difference in terms of professionalisation between a politician and a physician is that the former cannot claim a unique knowledge-base, therefore an expertise, as can the latter. Political corruption may be one of the mechanism adopted by political professional to control the uncertainty deriving from this situation. In commenting on Krause's analysis, I would advance the hypothesis that the relationship between the state and the medical profession in Italy is not peculiar in itself. It rather became a 'deviant' case -using Krauses' words- when the contradictions of the system emerged openly. In a sense, a failure occured in the state role of negotiation between the inter-conflicting hegemonic class interests. Recent events in the country tend to confirm this hypothesis. Connections between Mafia and parties, particularly DC and Socialist Party, have been detected, thus openly showing the system of corruption which is governing the country. Interestingly, the health sector is among the most involved in corruption. There public funds have been diverted for private interests thus under-budgeting health care provision, and seriously endangering the existence of the NHS. It is now quite clear that deficiences within the public health sector are due to the political corruption of those who administrate the system, rather than to the inadequacy of the principles which led to the NHS's establishment. Over the last months, media coverage has constantly denounced cases of malfunction within the health sector, thus putting the blame on both politicians and doctors because they are co-participants in this degenerating system.

A general observation which needs to be made is that, since its emergence as a dominant professional group, the medical profession has lost some of its power in terms of status and societal acknowledgment. If this has been more drastic in Italy, it is also noticeable in Britain. The growth of users' movement both in Italy and in Britain seems to confirm this trend. Furthermore, in British psychiatry the issue of

professional accountability as well as the split between purchaser and provider appears to address the need to better represent consumers' rights against the prevalence of professional hegemony. Finally, the developments in community psychiatric nursing have indeed shifted some of the psychiatric professional expertise from medical to para-medical groups.

The transitional period which is characterising the British and Italian psychiatric systems at the moment is likely to produce modifications in the balance of power between the medical profession (psychiatrists) and the state.

3.5.4. Understanding social change: the theoretical contributions of Parsons and Habermas.

There remain two authors, Parsons and Habermas, to be analysed in the present literature review, whose contributions fit well in this conclusive section. They both tackle the analysis of social change, although from different perspectives. Parsons provides a description of social change and allows the explanation of all the variables analysed in this thesis. The intepretation of Parsons' analysis which is here presented also aims at proposing an alternative perspective to that outlined in the section on professionalisation, concerning Parsons' approach to the development of the medical profession. Whilst in that case the focus has been on the functional aspects of Parsons' theory, here attention will be paid to a dialectic interpretation of the author.

Habermas' study focuses on the content of change, and in so doing explains the reasons for its occurance. The development of community psychiatric nursing has been the primary response to the crisis of hospital-based psychiatric treatment. In tackling the analysis of CPN professional development there is a need to consider

both the institutional transformation of psychiatric hospital care into community-based facilities, and the role of psychiatric nursing in implementing this shift. The research needs therefore to achieve a comprehensive explanation of both macro structural variables and micro variables pertaining to the individual professional experience of the nurses involved. Most importantly, the focus of the analysis has to be on change. Community psychiatric nursing both in Britain and in Italy is a profession in transition whose future development depends upon the evolution of community care strategies in the two countries, and on the profession's ability to establish a new institutional role within this changing context.

In order to link the variables analysed through a coherent framework, I will refer to Parsons'theory on social development, and in particular to an intepretation of such theory proposed by Gilli (1975). Parsons' attempt to bridge the analysis of social action with that of social system accomplishes the need to investigate CPN at the level of individual experience as well as in its interaction with the systems of psychiatric care in Britain and in Italy.

According to Parsons social change occurs in response to the need to further specialise the social system. Change therefore implies development which takes place in the form of functional differentiation (specialisation). Growth and development in pre-industrialised society were a quantitative problem. In the past social units tended to be a re-production of the general system. For instance the family was for nearly all purposes a self-sufficient and self-contained unit. By ensuring a certain amount of resources, a family could grow and become strong enough to achieve control of a whole village. Social development in modern society is, on the other hand, a completely different phenomenon, as each sub-system accomplishes a specific function. Modern society is characterized by high levels of structural integration and by a strict control over resources. Social change therefore becomes a qualitative phenomenon.

Each social structure changes by moving from a condition of relative simplicity to one of further complexity. This process implies a) the loss of functions of the old system, b) the generation of new structures, which have to perform specialised functions in the interest of the general system. For example in the past the family accomplished a range of functions, from the production for outside the family (handicraft products) and within it (agriculture produce), education for its members, socialisation etc. In modern society many of these functions are being performed by separate social structures, each of them specialised in the attainment of one of these goals, or in an homogeneous set of them.

Likewise, the psychiatric hospital may be considered a specialised solution which sees to the separation of the control of mentally distressed people from the rest of marginalised members of society. According to Foucault, in fact, the origins of psychiatry date to the decision to separate the detention of mentally distressed people from that of thieves, paupers and other unproductive social members (Foucault, 1976).

Social development has therefore caused both an increase in the number of sub-systems and the specialisation of these sub-systems. Functional specialisation implies that each sub-system accomplishes only one function (or homogeneous set of functions) and that it does so in a more efficient (specialised) way than before. The process of differentiation is pervasive in character: it can be observed wherever a new phenomenon is developing. As regards this thesis, the phenomenon under investigation is the process of differentiation of psychiatric nursing from a hospital to a community role.

Why does a system need to differentiate ? Differentiation occurs as an answer to internal or external problems, namely to work out a contradiction between the system and its environment (internal or external). External and internal causes operate jointly. More precisely the external causes operate through the internal. In the case of

community psychiatric nursing, is therefore important to investigate which need the development of the profession answered. But first it is necessary to explain the reasons for the development of community care. Within this framework, in fact, CPN represents a specialised function of the sub-system 'community care'. Accordingly, psychiatric nursing within the hospital represented a function of the sub-system 'in-patient' care.

The internal operation of each sub-system is regulated by the four functional needs of each social system, which are themselves the result of functional differentiation. Each sub-system is divided into four functional parts specialised in dealing with the four basic needs:

A) Adaptation: the need of the sub-system to relate to the environment and to draw resources from it;

G) Goal attainment: the purpose for which the system is established by the general system;

I) Integration: the maintenance of the order internal to the sub-system;

L) Latency or pattern maintanance: the creation of sufficient motivation to perform the tasks useful for achieving the goal.

Only the structure dealing with goal attainment performs a task useful to the general system. The remaining three parts operate for the maintenance of the sub-system. When a process of differentiation occurs, a considerable amount of resources has to be available in order to both provide the internal harmonization of the sub-system and ensure the achievement of the specialised goal. Whenever a social change occurs, therefore, there are social costs to be paid.

For this reason the process of differentiation is discontinuous. During stagnation the system directs its energy towards integrating the new function. This is why differentiation is linked with integration, as without this latter the harmonization of the specialised function is not possible.

Parsons also observes that in very small sub-systems differentiation/integration pairing may develop according to the pattern variable affective neutrality/affectivity[6]. Differentiation means undertaking action for the achievement of a goal. In itself it is therefore instrumental. Yet in small sub-systems the individuals are directly involved in the change which also generate role transformation. This produces frustration and anxiety that may threaten the maintenance of the sub-system. The solution is provided by integration under the form of affective activities, like jokes, manifestation of feelings and affection.

CPNs can be considered as a small sub-system. Both in Britain and in Italy the nurses interviewed operate in relatively small teams where possibly the level of inter-subjective relationships plays a role in CPNs' professional experiences. It will therefore be important, during data analysis, to take into account the Parsonian pattern variable of affective neutrality/affectivity as it may bear an heuristic value in understanding the findings.

Finally, it is still important to remember that the process of social differentiation involves social units, and that the smallest of the unit is the role. This implies that the analysis of social development cannot be limited to the individuals who perform a particular role. More precisely, the process of change cannot be influenced by the personality of those who are involved but by the experience of the group of people who perform specific roles.

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[6] From a theoretical point of view social action and social system are linked through the concept of 'pattern variables'. During his/her interaction with the social environment the actor is faced by four dilemmas (pattern variables). Social systems always present a combination of the solution offered by such dilemmas. The pattern variables are:
1) Particularism versus universalism: in the interaction with other people the individual has to decide whether to judge the other according to universal criteria (universalism), or criteria of uniqueness which can be ascribed to subjective characteristics of the person (particularism).
2) Performance versus quality: actors need to decide whether to judge a person for what s/he does (performance) or for what s/he is (quality).
3) Affective neutrality versus affectivity: action can either be undertaken for instrumental reasons (affective neutrality) or for emotional reasons (affectivity).
4) Specificity versus diffuseness: the relationship with the other can take place either across a range of objectives (diffuseness) or according to a specific goal (specificity). (Abercrombie, Hill & Turner, 1988; Rocher, 1975).

As regards this thesis, it has been observed that CPN is at a transitional stage, and that its development followed the crisis of hospital psychiatry. In Parsonian terms CPN is an example of social change, therefore of functional differentiation, hence of specialisation. Because the profession appears to be still in a transitional phase, it can be assumed that the process of differentiation has not yet been completed, and the sub-system is spending some of its resources on internal integration. It is possibly at this stage that the conditions for professionalisation are most visible, and have also most chances of success.

However, it is important to note that the development of psychiatric nursing in the community answered the need of the system 'psychiatric care' to evolve from the in-patient care situation towards a more specialised care provision: i.e. community care. Community psychiatric nursing therefore emerged as a specialised solution to a problem of the system to which it belonged: the psychiatric hospital. Hence its differentiation from the past hospital role does not answer an internal need of the sub-system 'psychiatric nursing' but the need of the general system it depends on. It has to be seen whether the professionalisation of community psychiatric nursing also meets the purpose for which the general system of psychiatric care established it, that is specialised psychiatric nursing care in the community.

According to Gilli (1975), Parsons sees the process of differentiation as a solution to both productive needs and needs pertaining to social control. A limitation in the analysis is that he did not investigate as to whether the productive function and the function of control could be synergic or rather in conflict with each other. This is where the analysis by Habermas serves to clarify the issue.

Habermas (1979) considers social change as an answer to the crisis of legitimation pertaining to the social system or a part of it. The legitimacy of a specific sub-system is linked to the ideological ability of its members to provide explanations,

set of beliefs, norms and values which can adequately explain and justify the existence of the sub-system. A crisis of legitimation is therefore dependant on the ideological crisis. This latter occurs when the very base of ideology are criticized to the extent that it is no longer possible to recollect any foundations of truth in the ideological message. The concept of criticism in Habermas' theory is in accordance with the hegelian view of criticism as a positive means to the achievement of progressive human self-awareness. At the very basis of this theory lies a belief in human history as a constant and progressive process towards self-awareness, which brings society to a continuous evolution and to constantly overcoming social constraints.

The Habermas' concept of the crisis of legitimation applied to the proposed research, logically leads on to an interpretation of community care developments as an answer to a crisis in the scientific paradigm of psychiatry. Lack of legitimacy develops when the ideological basis of psychiatry no longer has reference to the scientific knowledge which is supposed to support it. In Habermas terms, as well as according to the concept of ideology proposed in this thesis, ideology needs to have some relationship with truth in order to accomplish its function of legimitation and therefore to gain a sufficient degree of rational consensus. Truth and knowledge are here considered as historical concepts, they are therefore characterised by a constant development which leads to continuously evolving explanations of the human condition.

According to this view, the development of community care represents a stage of institutional transformation where the paradigm of hospital-based psychiatry is being modified towards a new and more representative paradigm of knowledge. CPN is an answer to these new developments.

If the theory by Parsons helps in understanding the relationships between the different parts involved in the process of change, Habermas provides an explanation

about the content and focus of such change. It also indicates that if community psychiatric nursing aims at establishing a new professionalism, a shift in the ideological basis of the profession is necessary, one that is able to represent the new paradigm of care which psychiatric nursing has come to perform.

3.5.5 Conclusions

This literature review has shown that an analysis of the nursing move towards professionalisation is not an easy and straightforward task. Many variables concur in shaping differences and similarities between the national situations. What seems to be common to both Britain and Italy is the transitional period which characterises the psychiatric system in the two countries. Developments in community care promoted the emergence of new occupations virtually separated from the medical establishment, such as occupational therapists, CPNs, social workers, home visitors, and art therapists. This occurance is likely to modify the relationship between para-medical occupations and psychiatrists but, above all, it may endanger the very epistemological basis of psychiatry, which is medical. Community psychiatric nurses represent the watershed in this situation. Their role is projected towards the future of psychiatric care, the community, whereas their origins belong to the past of hospital psychiatry. CPNs are caught in the middle of change. In contrast with other paramedical occupations, they have traditionally been nurtured by medical training institutions. Hence, in analysing the evolution of this profession towards the community, it is also important to take into account the degree of change which affects the relationship between CPNs and the medical field. There is indeed little doubt that if CPN had to become an independent profession, it would need to revise its relationship with the medical establishment.

The analysis of the emergence of the medical profession indicated the many ways through which hegemony has been achieved and maintained . The growth and

autonomy of community psychiatric nursing represents a challenge to medical dominance, and it is likely to be controlled and channelled through mechanisms which can grant the hegemony of the medical role within the psychiatric arena. Such mechanisms will possibly follow strategies which during the medical history have proved to be successful at defending the market from possible competitors. Amongst these, control over the content and site of nursing training, witholding competence which could create a specific professional niche for CPNs, and fragmentation of the occupation through specialisation or control at the organizational level are all visible components which characterise CPNs practice either in Britain or in Italy.

The section on professionalisation highlighted the relevance of training in providing an occupation with the expert knowledge necessary to a professional status. The equation which resulted from such analysis was in short the following -
the more professional knowledge is specific and unique, the more likely it is that an occupation will become a recognised profession. Furthermore, structured and detailed training programmes contribute to building professional cultures and identities which promote identification with the occupation. It will therefore be interesting to see whether the growth in number and importance of CPNs in Britain and Italy has been paralleled by educational advances so as to produce a change in professional status. Changes in training are therefore regarded as an indicator of the professional power acquired by nurses as a consequence of their new community role. The more training is structured and organized according to the nursing role in the community, the more the professional field becomes specific and the expertise unique. One of the fundamental requirements for an occupation to become a profession is to limit entry to the professional field. In order to achieve such a goal it is necessary to set up training requirements in order to avoid de-qualification. In short, if access to community psychiatric nursing posts was open to generically trained nurses, then community psychiatric nursing would lose in terms of professional status.

A further important point is that changes in education need to be formalised in order to be acknowledged. Any advance in training which is not standardised and rendered official will have an effect on practice but not on status.

The relationship between training and practice is crucial to the process of professionalisation. Changes in the profession may occur both as a consequence of new training programmes, and as a result of new experiences which can eventually produce a whole shift in the professional role. It is important that professional practice and education provide regular feedback to each other. This is particular so in the case of semi-professions like nursing. In fact, if an important change occurs in the medical practice and it is not paralleled in training, it would not affect physicians' professional status because it is universally acknowledged already.

Alongside education and practice, professional identity also plays a role. The stronger nurses feel about their identity as professionals, the more likely they are to achieve changes at the educational level which effectively mirror their practice, and eventually to gain in terms of status. It is therefore fundamental that training is oriented towards developing a collective professional identity which can increase the level of group cohesion and create homogeneity of professional cultures.

The comparative analysis of training, professional identity and culture within the organizational and ideological British and Italian contexts is aimed at identifying the potential attributes which can promote or impinge upon CPNs professionalisation in the two countries.

This thesis will particularly address the analysis of elements of professional nursing culture and identity, organisational structure, and psychiatric ideological approaches which are thought to bear a major influence upon the professionalisation of British and Italian community psychiatric nurses.

Parsons' theory on social change has been used as a means to describe and study the relationship between these different variables. In particular, CPN is seen as an answer to the process of differentiation from hospital-based psychiatry which is visible in the new community care developments. In Parsonian terms, CPN is therefore a sub-system of the general system of psychiatric community care. Each system and sub-system are regulated by four functional needs which pertain to the achievement of the goal for which the system is established, and the internal maintanance of the system itself. It is assumed that professional community psychiatric nursing culture and identity in the Parsonian model pertain to the functional need of integration. Culture provides the set of beliefs, customs, and ways of professional life which support and integrate the professional group and also promote a specific professional identity. The nursing ideologies of care pertain instead to the functional need of latency, that is of providing the system with the sufficient motivation to achieve the goal. The goal is represented by the care of mentally distressed people in the community. Organization possibly fits into any of the four functional parts of the sub-system. More specifically it could have, together with culture and ideology, an integrative function. The adaptive function is represented by training. It is in fact assumed that for the sub-system of psychiatric nursing the priviledged resources to be taken and transformed from the environment are given by information technologies under the form of professional education. The following table illustrates the model.

Adaptation	Goal attainment
Training	Psychiatric nursing care in the community
Nursing ideologies of psychiatric care	Professional culture and identity/organization
Latency	Integration

Habermas' study leads the analysis to the content and focus of the CPN sub-system, interpreted as a model of social change. It says that not only psychiatric nursing culture, identities, organization and ideology interact with each other, but in particular that an epistemological change is in process in the paradigm of the profession. The study of the direction and future developments of the new community psychiatric nursing professional paradigm is ultimately the objective of this thesis.

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CHAPTER 4: METHODOLOGY

4.1 Introduction

This chapter describes the methodology underlying the empirical research components of the thesis. Whilst the historical and the literature reviews provided the theoretical framework for the investigation, the aim here is to outline the research design of the study, and the logic behind it. A model of the overall researh design is provided, and the stages it entails are described .

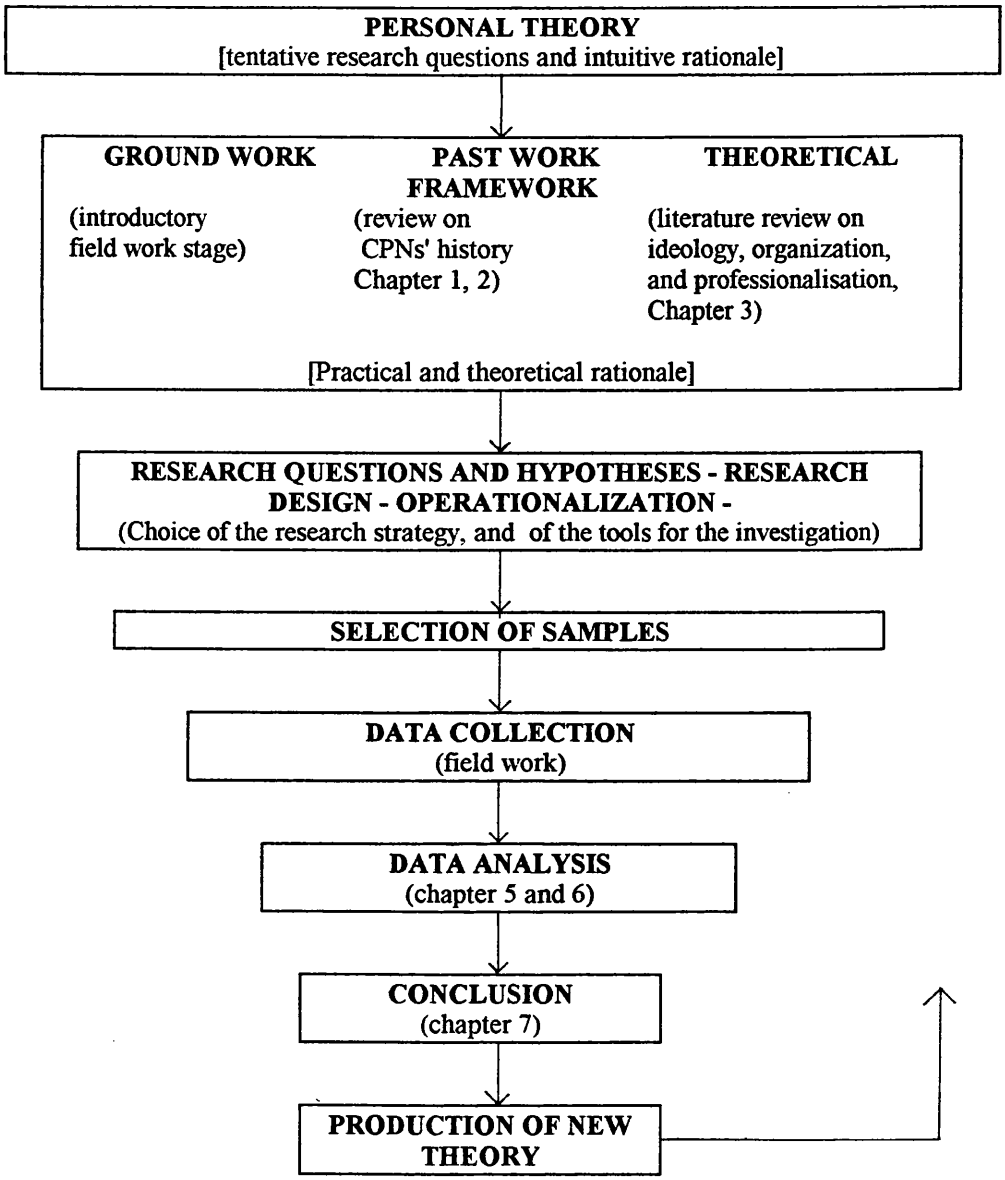
4.2 The Epistemological assumptions

The purpose of any research is to build knowledge, being it descriptive, exploratory, explanatory or predictive. The ways through which the search for further knowledge is pursued may differ according to the researcher's perspective. The theoretical framework has highlighted that the focus of the investigation lies in the process aspects of the social phenomenon under scrutiny here, rather than on its static attributes. The study addresses the process of change which currently characterises the experience of British and Italian community psychiatric nurses. Within this perspective, a unilinear causal-effect model for the understanding of social phenomena is rejected in place of a multicausal-systemic epistemological approach. This implies that the focus of the investigation lies in the interaction between the elements which are thought to best represent the phenomenon. In accordance with this perspective, the design of the enquiry accomplishes the need to support the circularity of the elements processually gathered during the investigation.

Marshall and Rossman (1989) provide an exemplified description of such a research cycle. A personal and still tentative theory is the starting point for setting up a research interest. Formal theory and past work on the research subject helped in defining and shaping models and concepts for the research, which are then formulated

into hypotheses. The operationalization of the theoretical model into indicators, the choice of the setting and of the tools for the investigation lead to the experimentation, testing, and data collection. The analysis of data, their description, generalization, explanation, and prediction eventually produce new theory, from which the circular process might start again to generate new research ouput (Marshall and Rossman, 1989, 23).

Although analytically the stages of the research process may be separated, in practice there is a continuous feedback between the information gathered from any of the sources used. It is in this way that the original and tentative theory gradually comes to be shaped, re-defined, and enlarged. The development of the present research followed a very similar process, whose stages are described in the scheme below.



* This scheme is partially elaborated from Evertson and Green (1985) in Marshall and Rossman, 1989.

4.3 Personal Theory and Ground Work

The antecedents for selecting the research subject originated from previous research carried out by the writer with a team of psychiatric nurses in Italy. The study was a qualitative analysis of nurses' experience of deinstitutionalisation (Savio, 1991). Nurses attached to a CMHC were extensively interviewed by means of repeated and

gradually modified interview schedules. Data collection stopped when all the topics relevant to the experience of nurses were thought to be covered. Methodologically this kind of approach is often considered the starting point for the development of more structured research (Bryman, 1988). The results did in fact generate further research interest. In particular it emerged that 1) the role of professionals is central during stages of significant institutional change, like de-hospitalization and the implementation of community care; 2) the development of a new community role may be perceived by professionals as both a threat to their professional identity and a challenge to the achievement of occupational endevours; 3) professional reaction to change may differ according to the organizational structure and the ideology of care characterising the setting of care.

These observations were generalized from the experience of the Italian nurses interviewed, most of whom considered themselves as pioneers of a new psychiatric nursing professionalism. The rationale for comparing the Italian and the British experience stemmed from the following. Similarly to the Italian case, the British care policy is being progressively oriented towards replacing hospital care with community based structures for the care of people suffering from mental distress. The development and progressive growth of CPN indicates that psychiatric nurses are going to play an important role within the process of deinstititutionalisation in Britain. These common elements contrast with differences in the history of psychiatric care in the two countries, the organization of community care, and the ideology behind the development of deinstitutionalisation. That both British and Italian community psychiatric nurses find themselves undertaking an important professional challenge, despite the difference between the two countries, may indicate attributes of the profession which go beyond national boundaries. The search for universal elements which could link and explain the experience of British and Italian CPNs formed the intuitive rationale of the research project: 'But the search for answers also reaches beyond theoretical fragments and joins the eternal search for basic patterns of human

behaviour which trascends all cultural influences.' (Oyen, 1990, 4).

Kohn (quoted in Oyen, 1990) distinguishes between four kinds of comparative research, each of them differing by the rationale behind the comparative approach. In the first type of cross-national study the researcher's interest lies specifically in the countries which are the object of investigation. This means that the selected countries present some particular features, nationally defined, which may be of heuristic value for the research purposes. The second type of comparative analysis takes place when the countries are the context of study, the research tests the occurance of a phenomenon in two or more countries. In the third kind, countries are the unit of analysis : investigation focuses on the relationship between social phenomenon and characteristics of the countries. The fourth type is trans-national, in which countries become part of an international system of analysis. Concerning the present research, its comparative focus deals with the first and the third level of the typology. As the literature review outlines, there is a specific interest in Britain and Italy due to the presence of similar institutional occurances - de-hospitalisation, community care, and the role of psychiatric nurses within the community. The historical review also indicated that, although sharing the common aim of establishing a community oriented mental health care system, the two countries differ as to the method adopted, and the pace of implementation. England and Italy are also the units of analysis because there is an interest in testing the relationship between the theoretical framework and the national contexts. The aim is to analyse which differences and similarities the interaction between organization, ideology, and professional culture produces, and to which extent the data analysed are the result of the specific context of investigation or features of generalisable (universal) nature (Teune, in Oyen 1990; Miles & Huberman, 1984).

The ground work or pre-piloting stage has taken place contemporarily to the review of the literature, helping in building the theoretical framework described in the

previous chapter. The ground work has consisted of some introductory field work undertaken in order to develop familiarity with the context of investigation. In the case of England, it was important to achieve a better understanding of the changing scenario of psychiatric care in the country, as well as of the different organizations through which community care is being implemented and the ways these are experienced by professionals in the field. In order to accomplish this task, two organizations have been contacted which could offer alternative pictures of community care developments in England. These were a community mental health centre (resource centre in Islington) and a walk-in multidisciplinary centre (Compass Project in Camden). The aims of the research were broadly explained to the staff in both centres, who were asked to collaborate in elucidating their work experience. During the interviews only broad and open-ended questions were put to the interviewees. In some instances this approach follows the assumption of the grounded theory (Schwartz & Jacobs, 1987, Glaser & Strauss, 1968) according to which the researcher does not attempt to build beforehand a strategy of investigation. This approach met the need to avoid as much as possible research bias which could have developed as a result of the researcher's previous work in the Italian psychiatric field. The grounded theory approach partially avoids this occurance by rejecting the use of conventional tools of investigation (like a pre-prepared interview schedule), which might focus on some aspects of the context by excluding others. In principle, the grounded theory also requires the investigator to begin by exploring the field with the least amount of information on the subject as possible, which may also include avoiding any litereature review on the issue. Although not entirely possible for the present study, given the researcher's knowledge on the subject, the foreign identity of the investigator did help in detecting differences and similarities between psychiatric practices and organizations in the two countries. Interviews and a general attempt at 'getting to know the context' have taken place through the use of stereotyped conventions (as in any ordinary conversation between people who do not know each others) which helped develope means of interaction and eventually a better

understanding of the context. This ground work has helped in building a relative familiarity with concepts and behaviours of the psychiatric environment in England. Also, it has provided a first glimpse of the ways through which mental illness is institutionally managed by witnessing the reception of clients, the setting of work, the procedures undertaken in arranging appointments, welcoming clients and and negotiating with other organizations. The experience itself fostered comparison as occurances different from the Italian approach would be easily noticed.

In between the English ground work stage and the full research implementation, the writer had been employed by a cooperative for disadvantaged people in Northern Italy. The job focused on the evaluation of rehabilitative projects jointly set up by the cooperative and local community mental health centres. This opportunity has been used as a means to develop informed knowledge about the context of care, the tools being used, and the psychiatric culture characterising that East side of Northern Italy. Observation has mostly been used in this stage, while carrying out structured interviews for the job side of the visit has however been useful in better understanding professional behaviours. Being relatively experienced in the psychiatric field, and being Italian were also considered as fulfilling requirements of cultural and theoretical awareness for this stage. The same community mental health centres visited during the Italian ground work have became then part of the sample of Italian nurses approached later.

This introductory stage has been useful in increasing the relational tools for carrying out the research, specifying the focus of the study, as well as in developing the background knowledge together with the information gathered from the literature review. The ground work, the analysis of the past work and of the literature review narrowed the focus of the investigation to three main issues which have became the object of data collection. These are: 1)analysing similarities and differences between nurses practices, organization, professional culture and identity, and ideology of care;

2)identifying universal elements which point to the description of CPN cross-nationally; and 3) investigating change-promoting and change-blocking factors in the development of a new psychiatric nursing professionalism.

4.4 Choice of the research strategy

The choice of the research strategy depends upon a) the research questions, b) the aim of the study i.e. which are the conclusions the study aims at reaching as an answer to the research questions, c) the control over behavioural events, and d) the focus on contemporary or past events. According to Yin (1984) the combination of these elements leads to the choice of one of the following strategies: experimental research, survey, archival analysis, history, and case study. Survey and archival analysis (such as economic studies) are suitable strategies to the investigation of research questions which aim at predicting certain outcomes, or explaining the incidence and prevalence of a phenomenon (who, what, where, how many/how much). They ususally focus on contemporary events, although archival analysis may also be applied to the study of past events. Experiment, history, and case study may instead be suitable reserach strategy when how and why research questions are being asked. The focus is not therefore on the incidence and frequency of phenomena, but on the investigation of the elements (links, relations) which have led to the development of the phenomenon. Whereas history does not focus on the analysis of contemporary events, case studies and experiments do. In addition, experimenting is the only method among the quoted research strategies in which it is attempted to hold control over behavioural events. This entails control over the factors which can influence the phenomenon, and their manipulation in order to observe and measure variations. Quasi-experimental research can be used in situations where the investigator has little control over behaviour, provided she has sufficient knowledge of the phenomenon to enable her to measure changes following the repeated occurance of certain events.

Applied to the proposed study, this distinction among research strategies entails the following:

According to the three main issues which form the obejct of data collection (outlined in section 4.3), the research questions are of how and why nature. The identification of universal elements which point to the description of CPN cross-nationally entails asking why English and Italian CPNs came to be central to the implementation of community care, i.e. which are the attributes and functions of the occupation that propmoted its development and growth both in England and in Italy following the advent of community care. The investigation of change-promoting and change-blocking factors to the development of a new type of psychiatric nursing professionalism implies asking how CPNs may achieve a new professional status in both countries. At the same time, however, the study is not aimed at analysing incidence or frequency of CPN on a cross-national basis, which would entail an archival or survey analyses. Although the research attempts at answering how and why research questions, it focuses specifically on contemporary CPN and not on past events. An experimental or quasi-experimental design would apply to both the nature of the research questions, and to the focus on contemporary events. However, the proposed study does not focus on controlling and manipulating behavioural events, as experimental research does. This research methodology would imply previous knowledge of the phenomenon on a cross-national basis, which instead has become part of the empirical enquiry of this study by focusing on the description of differences and similarities between English and Italian organizations, ideologies of care, and professional cultures. An experimental design also entails a background knowledge about these factors, in a way that their influence on CPN can be separately measured. The adoption of a systemic framework of investigation about ideologies of care, organizations, and professional cultures aims at analysing the intereaction between these factors rather than at measuring the weight which each individual factor may have on the phenomenon.

Although none of the above described research strategy is mutually exclusive in the sense that more than one can be used in a same research (Yin, 1984), case study is possibly the most flexible among them (Hakim, 1989). ' A case study is an empirical enquiry that: - investigates a contemporary phenomenon within its real-life context; when - the boundaries between phenomenon and context are not clearly evident; and in which - multiple sources of evidence are used.' (Yin, 1984, 23). Case study strategies have specific advantages when ' an how and why question is being asked about a contemporary set of events, over which the investigator has little or no control'. (Yin, 1984, 20).

In the light of these considerations, the methodology which seems to offer more advantages to the research purposes is that of a multiple case study research design. Differently from other research methods (i.e survey), the case study approach does not aim at achieving statistical generalizations. Instead, it focuses on the development of analytical generalizations aimed at ' generalize a particular set of results to a broaden theory'(Yin, 1984).

Case studies apply to the analysis of groups with a shared identity, common interest or activities like occupational groups and their focus can be on 'relatively stable patterns of relationships and activities in social groups selected as typical or deviant, or strategically different on some criteria, or else on the process of change surrounding an event, such as change of status, or in response to changes in the surrounding environment'(Hakim, 1987, 68). English and Italian CPNs are occupational groups which share a formal professional definition, whose occupational target is the care of mentally distressed people in the community, whose professional status is assumed to be changing, and which are both experiencing a stage of institutional transition as to the patterns of psychiatric care in their countries.

A case study approach allows an eclectic research strategy both because of the use of multiple sources, and because its focus may be on describing, exploring, or explaining causal links between events. According to the theoretical framework of the present research, case study is here intended as both a descriptive and exploratory strategy. The study does not aim at identifying causal relationships between variables because the different elements are assumed to interact and feed-back as part of a system.

A multiple case study design is pertinent when each case is studied in order to replicate or negate the propositions of the theoretical framework. In the instance of comparing English and Italian CPNs, the investigation in two different countries (units of analysis, i.e. cases) aims at identifying those elements which, beyond national diversities, help in defining the universal character of the occupation and its function within the psychiatric system. The analysis of the interdependence between organization of work, ideology of care, and professional cultures is tested in both countries in order to understand which differences are pertinent to contextual conditions, and whether there is a trend in the development of CPN common to both countries and can be elicited from these structural conditions.

Among the requirements for case study research design, four are listed by Yin as the fundamental tests which the strategy needs to undertake. These are: 1) construct validity i.e. elaborating operational measures for the concepts being studied; 2) internal validity, i.e. the establishment of causal relationships (this requirement is considered valid only for explanatory or causal research); 3) external validity, the definition of the domain to which the results can be extendable; and 4) reliability, the demonstration that both the tools and the data collections can be repeated with the same results. With relevance to point 1, the choice of the tools of investigation and its rationale will be explained in the following pararaph. Point 2 does not apply to the present research design, as its aims are exploratory and descriptive. External validity

(point 3) stands as a crucial element, as the study aims at generalizing from the analysis of particular cases (the search for universal attributes and function of the occupation). At the same time, however, it is not aimed at achieving results extendable to the whole of the countries investigated. The study is in itself speculative and its results can be disputed in terms of the analytical generalization achieved, but not as to its reliability on a comparative national scale because this it is not a research aim. Point four - the reproduction of results given the repetition of methods - becomes an artificial issue whenever the personality, nationality, and background of the researcher are not taken into account as relevant variables in the interface with the object of study. It can therefore be assumed that the measurement and to some extent even data are repeatable, but not their interpretation whenever the aim of the analysis is to produce analytical generalization rather than statistical generalization. The researcher's background (her experiences in the field, and her studies on the subject), as well as her nationality (being from one of the two countries), and her personality are very likely to interact with the ways questions are asked, interviewees perceive the researcher, and data are interpreted.

4.5 Operationalization: choice of the tools for the investigation

The choice of the tools for the investigation is strictly linked with the research design, altough Yin (1984) observes that a case study approach is suitable to both qualitative and quantitative methods of analysis. With relevance to the present project, several methods could be suitable which might have had different strength to bring to the field work. In particular case vignettes, observation, semi-structured interviews, and questionnaires have been taken into account as potential tools.

Case vignettes could be useful at investigating nursing care approaches in the two countries. Yet this option raises a number of issues which could be a source of misinterpretation. In order to accomplish the comparative task of the research, it would be necessary to draw the same case vignettes for both English and Italian CPNs. An important assumption is that the methodology of English and Italian CPNs' work practices may be quite different . This makes it difficult to elaborate case vignettes which can equally represent both contexts of care, and therefore unlikely to produce identification of the interviewees with the cases presented.

The use of nurses' diaries has also been considered as a potential insight into nursing culture and ideology of care. Yet it could be predicted that Italian nurses are unlikely to keep a work diary or detailed records, and it would be difficult indeed to have them doing so just for the research purposes. In-depth interviews did not suit this stage of the study, although they had been useful during ground work in building the theoretical framework and defining the concepts to be investigated.

Questionnaires have been eventually preferred to semi-structured interviews. This decision has been mainly due to the comparative issue which requires abstract concepts, like culture and ideology, to be analysed according to indicators which need to represent both national contexts in order to allow the drawing of conclusions. In

addition, data collection and analysis had to fit within limited time and budgetary conditions. Semi-structured interviews are usually lengthy as to the collection and the analysis of findings. Retrospectively and despite the pilot study, however, it has become clear that complex and long questionnaires are very time consuming. Un-structured observation has been chosen as part of the research strategy following the indications of the ground work stage. The different ways of working, as well as the service setting of English and Italian CPNs may offer important clues as to how to interpret results. This consideration has led to the decision to administrate the questionnaires with a face-to-face contact rather than mailing them. Direct adiministration has allowed the researcher to visit the places where nurses carry out their activities, and occasionally to witness events relevant to the understanding of findings. Although observation has not been a central method during field work, it has helped in building the background for the analysis. Observation within CPNs' basis, where interviews have taken place, has helped in comparing the organization of care in the two countries, as well as provided insights about work styles. One component has been particularly important in interpreting findings, namely the individual nature of CPN care in England in contrast with the collective approach of the Italian style. Whilst during field work in England there have been few opportunities to witness nurses working with clients, in Italy this was recurrent as there is no physical separation between the social space and the space for care. This observation, together with the analysis of findings, has helped in understanding what is thought to be a feature of the English approach in contrast with the Italian. Mental health care is conferred a more private character in England than it is in Italy. Observation, therefore, underlines the analysis of findings as an additional guidance to the interpretation of the data.

Alongside the administration of questionnaires, informal interviews have taken place with nurses aimed to both prevent the potential uneasiness which may develop during formal interviewing, and to share issues of concern to the nurses which were

left out by the questionnaire. Such issues included the issue of how nurses experience individually their professional life both in terms of every-day work, and as a result of contextual events like policy changes. The mode of introducing such topics varied according to the site of interviewing, and the aditional information known to the researcher about organizational context and CPN team before staring the interview. New topics were introduced when thought to be of relevance for the context or the organization of work. Examples of the procedure are the following.

- 'I spoke yesterday with Paul, in the acute team. He told me that your team (rehabilitation team) is undergoing a managerial change, can you explain me what this is about ?' (re hierarchical relationships and policy change);
- 'I was told that you are the longest serving CPN in this hospital and that you pioneered CPN intervention in the area, I guess you have seen many changes since you started...'(re policy changes, professional culture);
- 'I saw little of the members of the elderly team during these interviews, do you know whether they are particularly busy at the time?' (re inter-team relationships);
- 'I saw many new nurses since the last time I came: I suppose they are from the new generation since they look very young.' (re inter-generational changes among Italian nurses: hospital culture against community culture);
- 'I read the last report about stress levels among psychiatric staff in the area: It seems nurses are the most affected by stress, I wonder why.' (reasons for stress among Italian CPNs).

The notes which resulted from the informal interviewing have been examined jointly with the questionnaires, helping the researcher in building an overall picture of the contexts of care in the two countries and the ways these were experienced by nurses.

The two questionnaires have been developed to investigate the following hypotheses:

1. The different professional training and the trend towards specialisation that characterize British nurses as compared to the Italians are expected to lead to:

1.a A different selection of client groups with whom nurses work in the two countries;

1.b A greater degree of standardization of nurses' patterns of work in Britain than in Italy: English nurses are expected to have more structured working practices than their Italian counterparts;

1.c A fragementation of the English professional nursing culture into a number of nursing sub-cultures attached to specialization, in contrast to the collective dimension of the Italian nursing professional culture;

1.d Different nurses attitudes towards the process of deinstitutionalisation : Italian nurses are expected to be more politically committed to the process, whereas English nurses are assumed to be strictly professionally concerned about the process with no room for individual political involvement;

1.e Different self-perceived psychiatric nursing identities: stronger perception of professional identity by English nurses as compared to the Italians.

This central hypothesis has been used as a means to indicate different professional perspectives, patterns of care, and ideologies of psychiatric care. Differences in terms of professional education and specialization are analysed through nurses' interaction with the organizational structures of psychiatric care in the two

countries, and in the light of the different role that professional nursing cultures assume cross-nationally.

Lastly, a hypothesis on nurses' ideological committment to several psychiatric care philosophies has been formalised as follows:

> 2. Due to the different structural and historical backgrounds in which deinstitutionalisation developed in England and Italy, nurses from the two countries are expected to have different ideological approaches towards psychiatric community care.

4.6 Questionnaires

The first questionnaire aimed at collecting data about nurses training, community practice, organization, and professional identity. The questionnaire includes eight sections (see appendix A):

section 1: biographical data;

section 2: training (hypothesis 1)

section 3 and section 4: nursing models of practice and clientele (hypotheses 1.a, 1.b);

section 5: professional nursing cultures as these come to be shaped according to different degrees of spcecialization in psychiatric nursing (hypothesis 1.c);

section 6: nurses' self-perceived professional identities (hypothesis 1.e);

section 8: the subjective professional experience of the process of deinstitutionalisation (hypothesis 1.d).

Most of the questions are based on multiple choice items, and some are open-ended.

The second questionnaire (see appendix B) focuses on the analysis of nurses ideologies of psychiatric care. Respondents have been asked to state their degree of agreement/disagreement about a number of statements on mental illness. The methodology for the development of this questionnaire is derived from A. Strauss (1964). His research on the relevance of psychiatric ideologies within two large mental hospitals was conducted through the analysis of the degree of professional approval and disapproval concerning specific ideological statements.

The analysis of the two questionnaires takes into account the comparative perspective of the research, therefore results are compared cross-nationally and not within countries. Although it was intended to initially include in-national comparison between the CPNs teams within each country, this has proven to be too complex. In order to preserve this opportunity data have been inputed both according to national divisions between teams and cross-national samples. The analysis of data within countries would in fact be interesting as to the testing of differences in the relationship between organization, ideology, and professional culture within the same country. In this sense, however, the cases or the units of analysis would be represented by individual CPN teams rather than by the two countries (see section on sampling). This part of the analysis is not included in the discussion of findings because it was considered beyond the comparative aspect of the study.

Chi-Square and Mann-Whitney statistical tests have been used for the comparative analysis whenever appropriate. These tests take into account the reliability of differences detected between the two samples by testing the null hypothesis that the two samples share equal characteristics. being non-parametrical tests, they are particulalry suitable for the analysis of degrees of difference in relatively small samples (Siegel & Castellan, 1956).

4.7 Pilot study

The questionnaires have been piloted with seven nurses from a community psychiatric nursing team in London. A nurse teacher, a social worker teacher, and a senior social worker also filled-in the questionnaires and gave suggestions concerning understanding and meaning of questions, as well as about the language used. The questionnaires were directly formulated in English in order to avoid the use of words which could be characterised by Italian influences. Given that the researcher is Italian, this was thought to be one of the possible biases which could occur. For the same reason the pilot study was only conducted in England. Priority was given to the construction of questionnaires in the English language and within the English environment in order to screen the possible difficulties of the tools within the foreign country. Difficulties arising within the Italian setting could in fact be better handled and forseen by the researcher given the common culture and language, and the experience in the field. Furthermore, during the ground work stage several Italian psychiatric nurses had been contacted in view of the sampling procedure, and a basic knowledge of the setting, the professional context, and the relational skills necessary for field work had already taken place.

The pilot study highlighted that the length of the two questionnaires required some modifications during its administration. The second questionnaire, which asked nurses to express considered opinions and judgements needed to be given in advance to the interviewees and to be personally filled-in by them without the researcher's presence. In fact, it was noticed that the questionnaire required the respondents to think at length before answering, and the presence of the researcher was felt to uneccessarily accelerate the procedure as well as to create some embarassement to respondents. Questions which had not been fully understood would then be discussed during the interview.

The first questionnaire was also provided in advance in order to inform nurses on the topics of the interview, although they were not asked to fill it in beforehand. The questionnaire was filled-in by the researcher, provided that nurses had a blank copy with them with which to follow the schedule of questions. It was useful to directly discuss with the interviewees the open-ended questions as thoughts would flow more freely, and independently from the need to articulate a written answer. The presence of the researcher was also useful in contributing to the understanding of the work environment and the relationships between nurses.

The pilot study clearly highlighted that hierarchical relationships matter to the organization of CPN teams in England. However democratic the style of leadership may be, the team manager is the person to be contacted first and to be used as a link for reaching the rest of the team. This was consistent during the field work stage in England. However, in Italy nurses operated individually in opting to participate in a research, and this choice is also expressed through the absence of team leaders.

A further important indication came from the procedure which the implementation of the pilot study required. The researcher had no previous acquaintance with the CPN team. This required the adoption of a formal application in order to undertake the pilot. Following this procedure, the CPN teams studied were selected with care in developing informal contacts beforehand (see following section).

Finally the sintax and the structure of some questions were changed following the results of the pilot study. The pilot respondents noticed that a question about nurses' age - initially formulated in open-ended way - might have been embarassing so that it was modified into age classes, eliminating the need to state their exact age. The lay-out of some questions was also changed as to increase the understanding of respondents. The use of a blank space for comments at the end of the first questionnaire was changed into a more informal discussion with the interviewees

which would take place both at the beginning of the administration as an introductory and open-ended talking stage, and at the end of the interview . Recurrent during both pilot study and field work was nurses' interest in their Italian and English colleagues as to work practices and the organization of work. Their comments were useful in further highlighting differences between the style of the two countries which the questionnaire did not directly point out in its individual and un-comparative administration.

4.8 Sampling

According to the case study research approach, the selection of a sample depends upon the definition of cases or units of analysis, which in turn rely upon the type of questions being asked. In the present study, the research questions focus on the comparison between English and Italian CPNs, the final aim also being to draw conclusions beyond national boundaries. Therefore, a first level of identification of the units of analysis is represented by the two countries which are supposed to offer similar or contrasting features re the phenomenon under scrutiny. England and Italy have been chosen both in light of common aspects and of contrasting features between CPN and between community care developments and philosophies. They do not represent a single case but two different cases. The research design is therefore based on a multiple case study approach.

The selection of units of analysis for a multiple case study tends to follow a logic of replication rather than that of sampling. 'Each case must be carefully selected so that it either predicts similar results (literal replication) or produces contrary results (theoretical replication)' (Yin, 1984, 48-49). Replication is distinguished from sampling logic because it does not attempt at selecting a sample representing a larger group of respondents: The research aim is in fact not to analyse the prevalence of a phenomenon (statistical generalization) but to elaborate a theory from a set of results

(analytical generalization).

The definition of each national unit of analysis has been one of the most difficult task of the study. By escaping a sampling logic, the units of analysis should be defined according to certain features which can indicate replication or negation of results: Yet in the present case, the definition of such features is one of the objects of the research rather than being pre-defined. More over, the analysis of ideological, organizational, and cultural patterns could in principle be compared not only across countries but within countries, from which a need would generate to distinguish more than one unit (case) within each country.

Following these considerations, the selection of each national sample has developed according to :

1. facility of access;
2. probability that it includes a high mixture of processes, people, and organizations which are an object of the research questions;
3. possibility for the researcher to assume an appropriate role, acknowledged and accepted by the organization;
4. reasonable assurance about the opportunity to ensure good quality of data collection (Rossman & Marshall, 1989).

The composition of each national sample ensures that more than one organizational site is included by allowing the opportunity to compare a range of organizations, professional cultures, and ideologies of care between countries, and, at choice, within a same country. However, this latter task has not been pursued during the analysis of findings due to the large amount of data generated by the cross-national analysis. The following is an account of the selection and composition of the two sample units in England and in Italy.

Three CPN units have been contacted in Cambridge, Porthmouth and London. This has allowed a relative range of geographical representation, as well as the inclusion within the sample-case of different nursing specialisation as to client groups and care approaches. Each of the three CPN units contains at least three community psychiatric nursing teams dealing with different client groups, whilst specialisation of care ranges across the teams. In Portsmouth and London a team manager has been contacted through common acquaintances. In both cases the contact happened to be with the leader of the rehabilitation team. The researcher discussed with the manager the aims and methods of the research, and asked the latter to illustrate the project to her colleagues, and to help involving the other CPN teams of the centre. It was stressed that nurses ' participation in the study had to be voluntary and not dictated by their team leader. For this reason, after informing CPNs of the study the team manager would draw a provisional timetable of the interviews. Nurses who chose to participate selected the day and time of interviews by filling in their names. By informing the other team managers, CPNs from other teams belonging to the centre manifested the intention to join the project. Members from the acute team of the individual units became also involved possibly responding to the need to be represented as well, in that an un-spoken rivalry between rehabilitation and acute teams seems to be a latent consequence of specialisation. There was low participation from the elderly team in one of the two centres, some of the nurses openly said to feel disconnected from the actvities of acute and rehabilitation teams in that their clientele had different needs and characteristics. A different attitude was instead observed for single CPNs who had developed a specialisation in drug and alcohol care approaches, as they were happy to pariticipate although their activity was organizationally disjointed from that of acute and rehabilitation teams. All the nurses willing to participate were interviewed, no enquire was advanced about the nurses who did not. 25 out of 57 and 15 out of 28 CPNs belonging from the Portsmouth and London teams respectively participated in the project.

The Cambridge site was contacted with the help of a nursing teacher working in the nearby teaching unit. He used to be a CPN and was well-known by nurses. The procedure adopted for scheduling interviews was the same as for the other two centres. In Cambridge elderly, acute, and continued care teams appeared to operate jointly, although their individual organizations were formally separated. Although differently specialised, the three teams manifested a feeling of belonginess to the central unit which also made it easier in terms of their collective involvement in the research. It is also possible that by recruting nurses through an external acquaintance (the nurse tutor), none of the CPN teams felt discriminated. 23 out of 28 CPNs in Cambridge participated in the study. The total number of CPNs from the English sample is therefore 63.

Italian nurses were sampled among three health districts in West and Northern Italy . Community psychiatric nurses in Italy are attached to community mental health centres. They do not constitute themselves a team but are part of the CMHC's team. Nurses interviewed are attached to eight community mental health centres (six in the East North, and two in the West North). One team is based in an ex-psychiatric hospital, now converted into residential facilities, a bar, and some users' associations. It is based in Grugliasco, at the periphery of Turin. Most of the nurses working in this centre have had the dual experience of hospital and community care. The team leader, a psychologist, was contacted first. The previous knowledge of the centre and some past research collaboration with the team leader, facilitated the recruitment of nurses. 12 out of 15 nurses were interviewed in Grugliasco. A second team is based in a small town - Santhià - in Piedmont. The team is composed of both ex-hospital nurses and newly qualified general nurses. Some of the nurses from the team in Santhià had already participated in a past research project. The introduction of the researcher was completely informal. Nine out of nine nurses participated in the study. The other six teams belong to the health district of Pordenone, one team being in Pordenone and the other five in the countryside (Azzano X, Cordenons, Sacile, Maniago, S. Vito). Most

of the nurses here did not have a hospital experience, as Pordenone did not have a psychiatric hospital itself. However, they pioneered the implementation of community care by being in close contact with the Trieste experience. Access to the teams was facilitated by the contacts developed during ground work and previous researches. Similarly to the other two teams, the status of the researcher was here closer to that of an insider than to that of an external investigator. 35 out of 42 nurses from Pordenone and the other six centres were interviewed. In all of the centres, the same procedure as in the English case was used to arrange timetables for the interviews. A total of 56 Italian nurses participated in the research.

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CHAPTER 5 COMMUNITY PSYCHIATRIC NURSES: FROM 'JACK OF ALL TRADES AND MASTER OF NONE' TO THERAPEUTIC AGENTS - A PROFESSION IN DEVELOPMENT.

5.1 Introduction

The present chapter will focus on the analysis of findings from questionnaire A (see appendix A). Following the research design, differences between the training of British and Italian CPNs are used as a means of comparing nurses' clienteles, work practices, and professional identities. Training, practice, and identity are therefore central to the discussion in this chapter. The analysis of organizations, which provide the environment for nursing practice, is developed across the three elements as it is determinant to a cross-cultural understanding of the profession.

The picture which emerges from such a comparison is of two different ways of being psychiatric nurses in Britain and Italy, possibly representative of two stages of the professional development from hospital to commmunity. It is not for the author to judge whether one, British or Italian, is better than the other. It is instead quite clear that the evolution of British and Italian community psychiatric nursing is representative of the current psychiatric systems in the two countries.

British CPNs appear to be one of the most interesting vanguards of community care in Britain. Reflecting a trend which is more widespread in Britain than in Italy, they tend to be specialised and to target specific client groups. Their structured training and professional identity is mirrored in a well established organizational environment which on the one hand allows nurses a considerable degree of autonomy from the medical sphere, and on the other hand helps in standardising practices and individual tasks.

At the other end of the continuum, Italian nurses are representative of another

way of implementing community care. One that is the expression of the legacy of the psychiatric reform and of its ideology. There is in Italy a lack of institutionalised community training which is linked with a limited standardisation of operational and organizational practices, and which reflects the epistemological assumption that community care demands a trial- and- error procedure, for improvisation and creativity, and for theory to be grounded in everyday practice. Flexibility and unpredictability, rather than specialisation, go with this approach .

As a result of the psychiatric history and culture of their countries, both British and Italian CPNs appear to be 'jacks of all trades and masters of many' either by means of structured training or by means of structured experience. There is certainly a contact-point within this continuum, where two different ways of being psychiatric nurses meet in overcoming the custodial role of the past by acting the therapeutic role of the present.

Amongst the differences, a common element emerges from findings which possibly indicates an important universal feature of community psychiatric nursing, one that may be relevant to the analysis of professionalisation. This is the uniqueness of the occupation, described by the interviewees as a person-centred job unlike any other types of nursing which are instead task-centred. The priority and the priviledge that are given to the person's needs rather than to the tasks, certainly introduce several elements unique to the profession as compared to the past hospital role. The relationship between CPN and client goes beyond the execution of routine tasks and is instead addressed to the establishment of a professional one-to-one rapport that is more similar to that of an independent practitioner. This centring on the person rather than on the task is also a source of unpredictability, and demands flexibility of practices, professional autonomy and responsibility. Eventually, it is the job description itself which emerges significantly modified, so that the practice of community psychiatric nursing is possibly alrealy beyond its formal requirements.

Apart from the national differences, the comparison that follows highlights a profession in transition whose final conceptualization seems to depend upon nurses themselves and their awareness of being pioneers of a new occupation.

5.2 Biographical data

This section provides information about nurses qualifications, age, sex, previous working experiences, team composition.

5.2.1 Qualifications.

Interviews have been carried out with 63 nurses in Britain and 56 nurses in Italy. The British sample consists of nurses working in three CPN units (Tower Hamlets; Cambridge; Portsmouth). The Italian sample includes nurses working in eight community mental health centres, attached to three health units (Pordenone, S.Vito, Maniago, Sacile, Azzano, Cordenons; Grugliasco; Santhia').

British nurses interviewed belong to CPN teams exclusively composed of nurses. Italian nurses are attached to community mental health centres (CMHCs) with a multidisciplinary composition. Community psychiatric nursing in Italy is not considered as a professional specialisation, nor as an autonomous organizational structure. Nurses employed within the psychiatric sector either belong to community multidisciplinary teams, or to hospital teams attached to the psychiatric ward in district general hospitals.

All British nurses are qualified Registered Mental Nurse(RMN), and 20.8% are also qualified Community Psychiatric Nurse (CPN). The list of nurses qualifications is here reported according to the respondents' indications.

RMN	**52.4%**
RMN/CPN	**20.8%**
RMN/EMN	**1.6%**
RMN/RGN	**12.6%**
RMN/SRN	**12.6%**
TOTAL	**100%(63)**

RMN= Registered Mental Nurse ; EMN= Enrolled Mental Nurse ; RGN= Registered General Nurse; SRN= State Registered Nurse ; CPN= Community Psychiatric Nurse.

42.9% of Italian nurses are qualified Registered Nurse (Infermiere Professionale), 30.4% are qualified Psychiatric Nurse (Infermiere Psichiatrico), 23.2% have a generic qualification as Professional Worker (Operatore Professionale), and 3.6% have the qualification of Health Assistant. As indicated in Chapter III, psychiatric nurses are a dying professional category, residuals of the hospital regime in psychiatry, whose professional competences were closer to a custodial role than to the present socially-oriented role. The qualification 'psychiatric' should not therefore be considered a specialisation, rather a legacy of the hospital regime in psychiatry.

RN	**42.9%**
PN	**30.4%**
PW	**23.2%**
HA	**3.6%**
TOTAL	**100%(56)**

RN= Registered Nurse ; PN= Psychiatric Nurse ; PW= Psychiatric Worker; HA= Health assistant.

Both in Britain and in Italy a majority of women were interviewed according to the following figure.

Table I: Nurses distribution by sex.

Country	FEMALE	MALE	Total
BRITAIN	58.7	41.3	100%(63)
ITALY	67.9	32.1	100%(56)

Both for the British and the Italian sample the majority of nurses are between 20 and 40 years old.

Table II: Nurses distribution by age.

AGE	BRITAIN	ITALY
20-30	19.0	30.4
31-40	46.0	39.3
41-50	20.6	17.9
51-60	14.3	12.5
Total	100%(63)	100%(56)

5.2.2. Job records

Among the British sample only 14.3% of nurses had just one job previous to the community job. The rest of nurses had from 2 to 9 previous posts, with a modal value of 27% of nurses who had three previous working experiences. Nurses from the Italian sample had from 1 to five past working experiences, with a modal value of 37.5% of nurses with two previous posts. The comparison between the two samples is as follows.

Table III: Number of employments previous to community post.

N/POSTS	BRITAIN	ITALY
1	14.3	19.6
2	17.5	37.5
3	27.0	21.4
4	17.5	16.1
5	3.2	5.4
6	9.5	/
7	7.9	/
8	/	/
9	1.6	/
Total	100%(63)	100%(56)

Mean: Italy=2.50 Std Dev: Italy=1.14
Britain=3.48 Britain=1.91

T Test significant at p=.001
Chi-square significant at p=.003

95.3% of British nurses and 98.2% of the Italians had past working experiences in the nursing sector. Whilst for 76.2% (48) of the British sample changes in posts meant a career move, only 10.7% (16) of Italian nurses had a career move by changing post (Chi-square significant at p.= .000). It can be inferred that there is a much higher mobility in the British nursing sector than in the Italian, which is nearly static. This because, as the section on training will outline, there are few career opportunities for community psychiatric nurses in Italy.

5.3. Training and specialisation

Nursing training was analysed by means of quantitative measures -number of training courses attended, years spent in education -and qualitative indicators - type of specialisation achieved, level of satisfaction about the education received, willingness to extend training if further education was made available. The type of training received could be inferred by nurses qualifications.

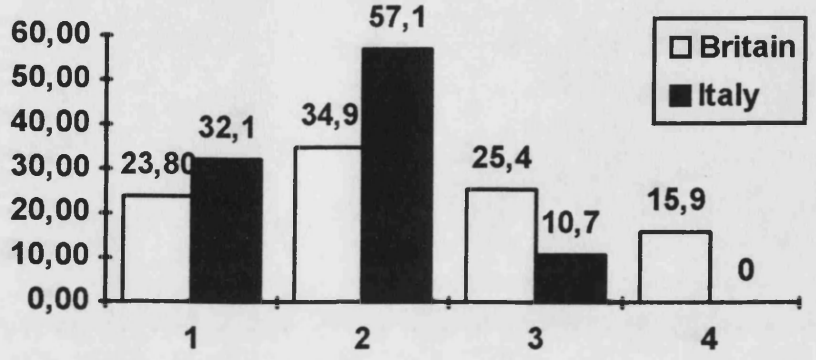
The Italian sample includes the three varieties of nursing qualification currently present in Italy i.e. psychiatric nurses trained in hospital, registered general

nurses, and psychiatric workers (operatori) trained in the community.
All British nurses have had an RMN training, and about one fifth of them also undertook the CPN post-qualifying course. That only a minority of British nurses have received specific CPN training seems to confirm the outstanding concern about lack of mandatory CPN training and the provision of adequate conditions for undertaking this.

There are many significant differences between British and Italian nurses educational background. Yet, it is quite clear that there is a gap between theory and practice in psychiatric community care for both countries, whereby CPN practice seems to be more advanced than its educational development.

Comparatively, Italian nurses have had less professional education than their British colleagues, both in terms of number of courses attended and of time spent in training.
The number of professional courses attended by British nurses is from 1 to 5, and from 1 to 3 for Italian nurses. As shown in Graphic 1, attendance at two professional courses is the modal value both for Britain and for Italy, respectively with 34.9% and 57.1%. By adding the following values (3/4/5 number of courses attended) we have that 76.2% of British nurses, and 67.8% of Italian nurses have attended at least two professional courses. In terms of time spent for professional education, training lasts for a total amount of at least three years for 93.9% of British nurses and 48.2% of Italian nurses (see Graphic 2).

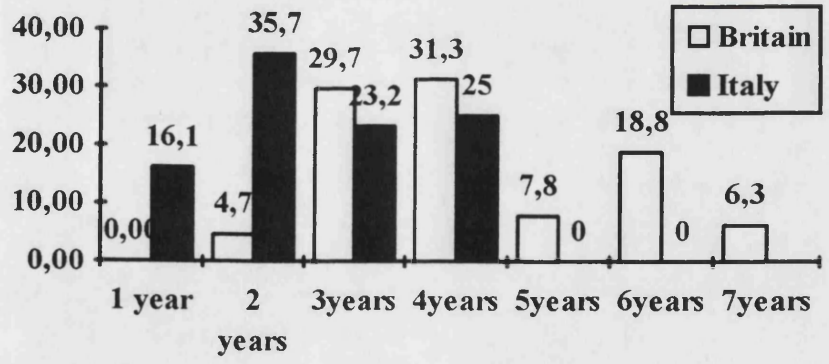
Graphic 1: Number of training courses attended



Britain mean: 2.34 StDv:1.04
Italy mean: 1.78 StDv: .62

T Test significant at :p=.000

Graphic 2: Period spent for training



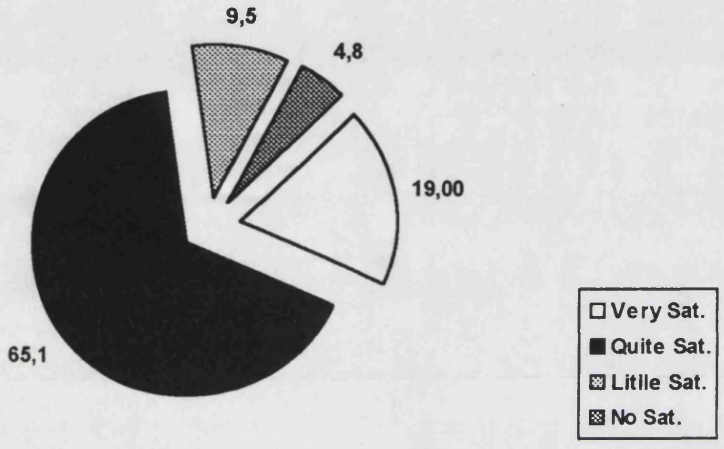
Mean Italy: 2.57 StDv Italy
Mean Britain: 4.32 StDv Britain

T Test significant at p=.000

Training satisfaction ranks higher among the British sample where only 14.3% of nurses show little or no satisfaction as to the professional education received, compared to 46.4% of Italian nurses. For both samples the modal value concentrates

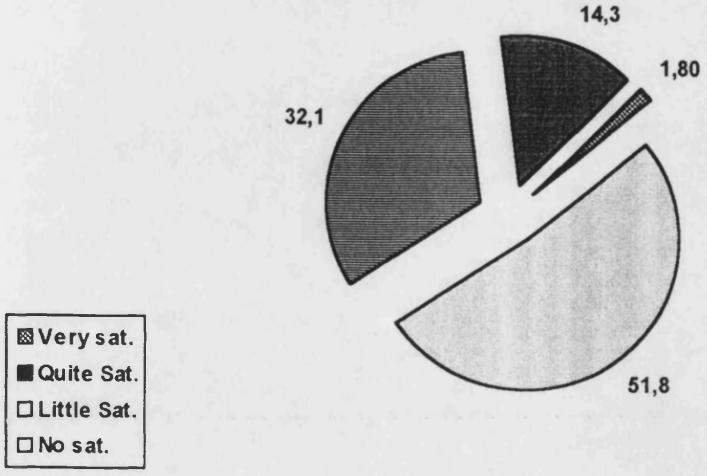
in the position of 'quite satisfied', but whilst the majority of British nurses express satisfaction about training, Italian nurses are almost equally split between those who are satisfied and those who are hardly satisfied (graphic 3 and 4). The comparison between the two sample groups is statistically significant (Chi-square p.=000).

Graphic 3: Training satisfaction : Britain



*Among the British sample one respondent did not answer the question, and has not been included in the Graphic.

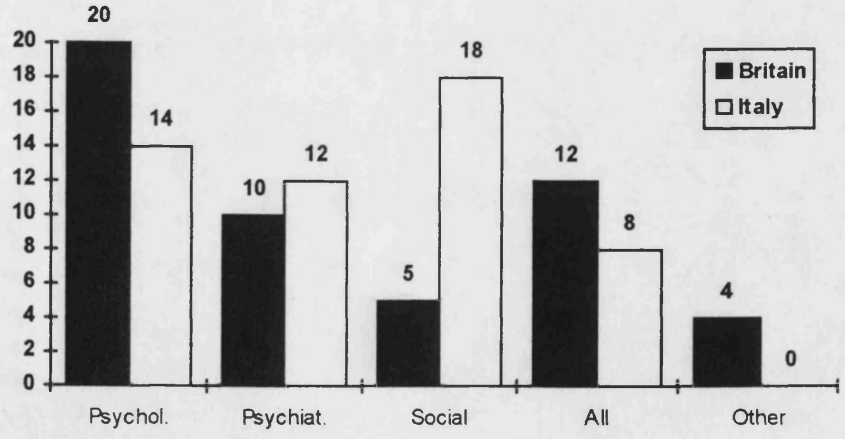
Graphic 4: Training satisfaction : Italy



There is a significant difference between nurses attitudes towards the professional education received. The training received is according to 60.7% of Italian nurses un-suitable for their present community job, whereas only the 25.4% of British nurses found their professional education inadequate to their actual post (Chi-Square significant at p=.000). Despite this difference, both Italian and British nurses expressed a strong need to further their professional education (92.9% of Italian nurses and 82.5% of British nurses respectively expressed willingness to further their professional education). Given the choice to further their training among the psychiatric, social, psychological, and medical fields, answers from the two samples were the following. British nurses give priority to the psychological field, followed by the psychiatric, and lastly by the social. Italian nurses' priority is instead about the social field, followed by the psychological and the psychiatric (See Graphic 5).

However, many CPNs in both countries expressed willingness to widen their professional education in more than one field, as this would better represent the holistic character of their job.

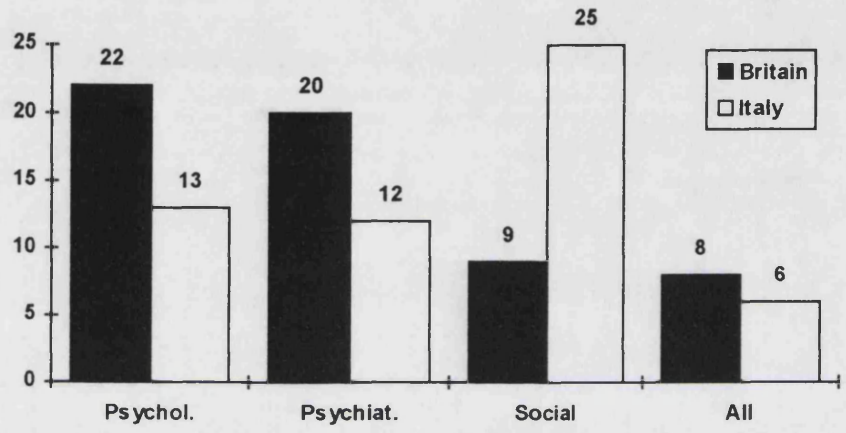
Graphic 5: Preferred subjects to further CPNs professional education



This seems to reflect the orientation of nurses' practices in the two countries, which results being psychologically/psychiatrically oriented in Britain, and socially/psychologically based in Italy. In fact, when asked to point out sectors which

best represented their practice, British nurses indicated the psychological sector as most suitable to their job, followed by the psychiatric and the social sectors. Whilst Italian nurses indicated the social sector as the most adequate to their work, followed by the psychological and psychiatric sectors.

Graphic 6: Subjects regarded more suitable to CPNs' present job



Psychiatric specialisation occured more among British CPNs than Italians. The trend towards specialisation is marked among the British sample, where 43 nurses out of 63 specialised in some therapeutic approach as compared to only 15 Italian nurses out of 56 who specialised (chi-Square significant at p.=.05).

Specialisation occured mainly in the three areas of behaviour therapy, family therapy, and counselling for British nurses. There is no prevalence of one therapeutic approach over the others.

The 15 Italian nurses who specialised are shared equally among behaviour therapy, family therapy, and cognitive therapy.

Furthermore, 90.5% (57) of British nurses specialised in the care of particular client groups against 37.5%(21) of nurses from the Italian sample (Chi-Square significant at p=.000).

In the British case the preferred client groups are 'rehabilitation, followed by 'acute',

and by 'elderly'. Few of them also specialised in 'drug/alcohol', and 'child/adolescent' groups. Specialisation in client groups occured among the Italian sample prevailingly in the rehabilitation sector.

It is nevertheless important to point out that, unlike Britain, psychiatric teams in Italy are not organizationally sub-grouped according to the type of clients they deal with. In practice, this means that client groups are not formalised or identified according to defined criteria. The analysis of nurses' clientele will show that Italian nurses have on their case-load a majority of long-term mentally ill users. This would correspond with the British classification of rehabilitation teams. Hence, if it is realistic to say that Italian nurses did not formally specialise in any client-group, it is also true that specialisation occured in practice. This explains why some of them stated that they specialised in rehabilitation-clients. Although not officially acknowledged they felt that according to their professional experience, professional specialisation in this field could be claimed.

Although these differences in specialisation between British and Italian nurses exist, they appear to share a common opinion about the need for specialisation. Professional specialisation is regarded as fundamental by 50% of Italian nurses and 47.6% of British nurses respectively, and as 'important in some cases' by 50% and 52.4%. Italian nurses who did not specialise said they were not interested in this aspect, mainly because specialisation is seen as demanding more rigidity in work practices rather than flexibility and competence.

Overall the comparison between training practices in the two countries indicates that Italian nurses have been quantitatively and qualitatively less trained than their British colleagues. Specialisation in psychiatry occured for Italian CPNs while already working, mainly under the form of an on-going professional education tailored according to the organizational needs and philosophy of the community centres where they practice. On the one hand, therefore, there is a lack of formal

acknowledgment of this form of training, as there is no provision for making it institutionalised and officially recognised. On the other, there is no standardisation of community nursing practice and as a consequence nurses enjoy considerable professional autonomy, but also lack means of identification with the profession.

That both British and Italian respondents expressed the need to further their professional education indicates the transitional character of the professional role, as a result of the move from the hospital to the community. Although better trained, British nurses appear in fact to face the need for modifying the hospital-based role internalised during training. Indirectly this indicates that the shift from hospital to community does not only imply a physical move of the place of care, but actually the need for codifying new intervention models according to the community needs. The development of the present chapter will progressively add elements to support this hypothesis.

5.4. Clientele and work practices

The investigation of nurses' work practices needs to take into account the organisational environment where CPNs carry out their activities. The type of clientele served, the care approaches adopted, and the internal organisation of the teams are relevant to understanding the nature of nurses performances.
In this respect, some interesting differences are to be found in the comparison between British and Italian nurses' work practices. As often happens with cross-cultural analyses, such differences cannot be exclusively measured quantitatively. They actually need to be understood in their qualitative nature, i.e to be linked with the context of care, the history of psychiatric care, and nursing professional developments in the two countries.

The present section first adresses a comparison between CPNs caseloads, type of clientele, and referral systems. This is meant to provide an adequate background to the analysis of nurses' work practices, which then follows.

5.4.1 Size of caseload.

The comparison between Italian and British nurses'clientele presents interesting differences. British nurses have a higher number of clients on their caseload (a mean of 25.73 clients per nurse (StDv=16.28) against a mean of 10.62 (StDv=6.68) of people on Italian nurses caseloads. Standard Deviations indicate that there are also huge disparities between individual caseloads. This may depend on nurses practice. For instance a British respondent said she had many clients on her caseload because her main activity consisted of giving depot injections.
Italian nurses appear to have a 'heavier' caseload in terms of type of clients and length of the therapeutic relationship.

However, it is important to point out a peculiarity of the Italian caseload-system : it has been possible to estimate an approximate caseload only for 42 of the nurses interviewed. This happened because in many Centres there is an organizational practice, called 'team-caseload', according to which clients are referred to nurses and other workers (psychiatrists/psychologists) according to daily avaliability or urgent needs. Additionally, almost all of the Centres researched had day-centre activities in which a large number of clients would participate. Nurses and other professionals supervising these activities use to rotate either daily or weekly. In practice this means that there is not, as in the British case, a key-worker for each client, but usually more than one and eventually the whole team would attend to the same client.
When asked about the size of their caseload, Italian nurses would often not know how to estimate it because of its flexibility. As a consequence many of them provided an average number of clients, and others said they were unable to answer because of the above reasons.

Although I could have estimated an average number per nurse myself using the services' caseload registers, I decided not to in order to report what looks like an important organizational feature of Italian psychiatry. However, my experience as a researcher in several psychiatric services in Italy indicates that on average nurses have from 15 to 20 clients on their caseload. Furthermore, data from the present research appear to confirm what has elsewhere been observed by British researchers (in Brooker and Simmons, 1986). That is, Italian nurses tend to have a smaller number of clients on their caseload than British nurses, due to the nature of the rehabilitative programmes they undertake. Such programmes would require flexible working schedules, with intensive workers' involvement and ability to visit clients at need, hence also during weekends or at night.

5.4.2 Type of clientele.

There is a highly significant difference between the two samples in the comparison between the number of long-term mentally ill clients on nurses' caseloads. All Italian nurses have on their caseload long-term mentally ill clients, and 48 out of 56 have at least more than half of their caseload made up this category of client. 11 British nurses do not have long-term mentally ill clients on their caseload, and 32 out of 63 have more than half of their caseload consisting of this type of client (see Table IVa).

Table IVa: Number of long term mentally ill clients on nurses caseload.

N/Clients longterm	BRITAIN	ITALY
None	17.5(11)	/
Less than half	31.7(20)	10.7(6)
More than half	19.0(12)	51.8(29)
All of them	31.7(20)	33.9(19)
No answer	/	3.6(2)
Total	100%(63)	100%(56)

Mann-Whitney corrected for ties 2-tailed p.=.001 [7]

46 out of 56 Italian CPNs have more than half of their caseload made up of clients who had a previous hospital admission. This is true only for 32 British CPNs out of 63 .(see Table IV b)

[7] The statistical test Mann-Whitney has been used whenever the presence of cells with expected frequency < 5 did not allow a correct use of the Chi-Square test.

Table IVb: Clients with previous hospital admission on nurses'caseload.

N/Clients with previous hosp. admission	BRITAIN	ITALY
None	7.8 (5)	/
Less than half	41.2 (26)	17.9 (10)
More than half	24.0 (15)	50.0 (28)
All of them	27.0 (17)	32.1 (18)
Total	100% (63)	100%(56)

Mann-Whitney corrected for ties 2-tailed p.=.007

The type of clientele in terms of diagnostic categories also presents significant differences in the comparison between British and Italian nurses. There are 6 British CPNs who do not have clients diagnosed with psychosis and 31 of them who have less than half of their case load made up of clients diagnosed with psychosis. Whilst all Italian CPNs have on their case load clients diagnosed with psychosis, and for the majority of them the case load consists of this category of clients.
Conversely, 28 Italians do not have clients with neurosis as against 45 of British who do have on their case load clients diagnosed with neurosis.(See Tables Va; Vb)

This division between neurosis and psychosis does not take into account the variety of diagnoses which may be used in psychiatric services. In fact, it may be observed that among British nurses there are eleven who do not have neither groups of client (17neur.-6psych.). Seemingly, these nurses target particular clients group, such as the elderly -whose most frequent diagnosis is dementia precox- or children. Moreover, it is certainly true that this broad division between neurosis and psychosis is more used in Italy, where this demarcation mainly indicates the border between 'hard' and 'soft' clients. Also, there is in Italy a widespread attitude about not going in depth with diagnostic categories, on behalf of qualitative reports about clients' needs and situation. It is so that 'psychotic' and 'neurotic' become functional categories within the staff jargon to indicating a broad division within services' clientele.

Table Va: Clients with medical diagnosis of psychosis.

N/Clients	BRITAIN	ITALY
None	9.5(6)	/
Less than half	49.2(31)	10.7(6)
More than half	33.3(21)	67.9(38)
All of them	7.9(5)	21.4(12)
Total	100%(63)	100%(56)

Mann-Whitney corrected for ties 2-tailed p=.000

Table Vb: Clients with medical diagnosis of neurosis.

N/Clients	BRITAIN	ITALY
None	27.0(17)	50.0(28)
Less than Half	46.0(29)	50.0(28)
More than half	22.2(14)	/
All of them	4.7(3)	/
Total	100%(63)	100%(56)

Mann-Whitney corrected for ties 2-tailed p=.000

The majority of Italian clients are on nurses' caseload indefinite time, whereas only 36.5% of British clients are on nurses'caseload for more than one year (Table VI).

This is a further significant difference that needs to be considered when comparing nurses' clientele and size of caseload in the two countries. It is again about clients' long-term care needs which require a broad and long-lasting range of interventions.

Table VI: Length on case load.

Length	BRITAIN	ITALY
1-2 months	7.9 (5)	/
more than 2 months	22.2 (14)	/
six months	11.1 (7)	21.4 (12)
6 months/ 1 year	20.6 (13)	/
more than 1 year	36.5 (23)	/
indefinitely	/	76.8 (43)
no answer	1.6 (1)	1.8 (1)
Total	100%(63)	100%(56)

Mann-Whitney corrected for Ties 2 tailed p.=.000

5.4.3. Referrals

Referral practices are organised differently in Britain and in Italy. For this reason it was not possible to statistically compare data from the two samples, which have instead been gathered qualitatively.

British CPNs receive their referrals mainly from two sources: GPs and psychiatrists. 28 nurses said the main source of referral was general practitioners, and 27 said psychiatrists. The rest of them get their referrals from other professionals such as health visitors, social workers, or sometimes families. The analysis of referrals in the British case should however be linked with CPNs base, which for two out of three teams in the sample was the hospital. In theory, it could be assumed that hospital-based teams are more likely than community-based teams to receive their referrals from the hospital, hence from psychiatrists.

In practice this does not seem to happen for the British sample, which despite having two hospitally-based teams out of three, have their referrals equally shared between psychiatrists and GPs.

Interestingly, this occurance seems to confirm what has been indicated as being a national trend among CPNs (White, 1991). In fact it appears that GPs have been increasingly referring their clients to CPNs rather than to psychiatrists. This might have caused worries among psychiatrists, who possibly see their ability to filter psychiatric referrals decreased, and overall their hegemonic position endangered by CPN development.

Italian nurses do not have an established referral system on their own, as referrals come to the mental health team as a whole. Referrals virtually never come from psychiatrists: there is no need to liaise with psychiatrists because they are part of the team, which is multidisciplinary. The mental health team does instead liaise with primary care professionals such as social workers, family advisory services, and alcohol services. GPs are usually those who refer more to CMHCs. However, this does not give the chance to nurses (as is the case in the British situation) to gain

control over some areas of the network, or to achieve a more powerful professional position. On the one hand, the multidisciplinary character of the team helps to increase interprofessional cooperation and break down professional barriers. On the other, it reduces the opportunity to establish professional hegemony. Last but not least, it ought to be remembered that consultant psychiatrists and not nurses are those in charge of the team.

5.4.4. Work Practices

The comparative analysis of nursing work practices confirms a trend towards specialization in British community psychiatric nursing which does not find an equivalent in the Italian case. British nurses' interventions relate to specific clinical areas, for which a knowledge base is usually necessary. On the other hand, Italian nurses make use of socially oriented practices which do not generally require specialization, and tend to produce a holistic style of intervention. Specific nursing clienteles are of course determinant in understanding this difference. The majority of long-term clients served by Italian nurses have rehabilitation needs that find an answer in socially oriented nursing models.

The analysis of work practices was carried out by asking nurses to rank in order of frequency ten listed activities - speaking with clients; speaking with relatives; helping with the house work; having leisure activities with clients; shopping with clients; monitoring medication; giving medication; counselling; family therapy; and behaviour therapy. Respondents often chose to give equal priority to more than one activity; it was not therefore possible to rank the listed activities from one to ten in a single table. Instead, figures are provided about the number of nurses who said they did not practice the activities, and individual tables for each activity illustrate CPNs' choice up to frequency order-five. Full explanation is provided in Appendix C.

A first significant difference is to be noticed among the number of nurses in both countries who said not to practice some activities. The table below illustrates the comparison (Table VIIa).

Table VIIa: Nurses work practices

ACTIVITY		BRITAIN=63	ITALY=56	Chi Sq.
Speaking with clients	yes	(56)89.0%	(56)100%	p=.05
	no	(7)11.0%	0	
Speaking with relatives	yes	(55)87.5%	(52)93.0%	/
	no	(8)12.5%	(4) 7.0%	
Helping with house work	yes	(19)31.2%	(33)59.0%	p=.01
	no	(44)68.8%	(23)41.0%	
Having leisure act.	yes	(27)45.3%	(45)80.4%	p=.01
	no	(36)54.7%	(11)19.6%	
Shopping with clients	yes	(26)42.0%	(48)85.7%	p=.01
	no	(37)58.0%	(8)14.3%	
Monitor medication	yes	(55)87.5%	(37)66.0%	p=.01
	no	(8)12.5%	(19)34%	
Give medication	yes	(36)57.8%	(56)100%	p=.01
	no	(27)42.2%	0	
Counselling	yes	(59)93.7%	(23)41.0%	p=.01
	no	(4) 6.3%	(33)59.0%	
Family therapy	yes	(35)56.2%	(18)32.0%	p=.01
	no	(28)43.8%	(38)68.0%	
Behaviour therapy	yes	(45)71.8%	(17)30.4%	p=.01
	no	(18)28.2%	(39)69.6%	

It could be argued that the activity 'speaking with clients' tends to overlap with 'counselling'. Some British CPNs in fact said so, and thought their choice was better represented by 'counselling'. Hence the 7 British nurses who appear not to 'speak with clients' chose to place themselves among counselling activities. Such distinction was considered useful with respect to the Italian sample. In Italy there is not a specialisation such as counselling, which is rather replaced by psychotherapy.

However, some Italian nurses felt they were able to give counselling/psychotherapy, although not officially qualified to do so.

It is open to discussion whether 'speaking with clients' could in itself be 'therapeutic', and whether its practice could actually include counselling patterns of which nurses are not aware. Again it is important to comment upon the relationship between training and practice. On the one hand, lack of structured training in the Italian case tends to limit the number of specialised activities nurses carry out. On the other hand, loosely defined professional boundaries allow Italian nurses to undertake appartently de-skilled activities like 'helping with housework', 'having leisure activities with clients', 'shopping with clients', and 'giving medication'. Once again it should not be taken for granted that the therapeutic outcome of these practices is not as valuable as that of family and behaviour therapy i.e could it not be that helping with the housework is a way of approaching family therapy?

The above table indicates that there is a reverse trend in British and Italian answers from the least to the most specialised activities. The comparison proved to be significant for all the activities included apart from 'speaking with relatives'.
Nurses' performances among the Italian sample are mainly developed in the areas of speaking with clients, with relatives, having leisure activities, going shopping, helping with housework, and giving medication. Conversely among the British sample there are high percentages of nurses who do not practice these interventions. Counselling, family therapy, and behaviour therapy are among the least practiced by Italian nurses and the most by British nurses.

It is interesting to comment upon the difference between the activities 'monitoring' and 'giving medication'.All Italian nurses said they gave medication, whereas more than half of them said they did not monitor medication. Viceversa, 85.7% of British nurses monitor medication and 27% do not give medication. In

order to understand this difference it is necessary to analyse how these two activities are perceived within the nursing professional culture in the two countries. There is in fact a need to consider that for a long time community psychiatric nurses both in Italy and in Britain have been associated with the admistration of depot injection i.e: giving medication . This has been badly tolerated within the nursing professional culture in both countries, as it was felt to define the profession as merely executive rather than therapeutic. In fact, both British and Italian nurses ranked their activities by giving higher priorities to practices which are not directly associated with the administration of drugs. Whilst giving medication is an executive task, the monitoring of medication requires specific skills which are usually ascribed to physicians. Although it is to my knowledge true that Italian nurses do monitor medication and actually change prescriptions before referring or consulting the doctor, they would rather not take direct responsibility for this. Conversely British nurses seem to ascribe themselves to a higher professional position by increasing the monitoring task rather than the administration. This would confirm that the trend towards specialisation identified in British nurses' practices is also reflected in their self-perceived professional identity. Vice versa, the less specialised practices of Italian nurses are such as to still have some influence upon their perception of 'drug-suppliers' professionals.

The following tables illustrate the comparison between British and Italian nurses' ranking choices about the ten activities. Percentages illustrated in the tables below are calculated on the total number of respondents from the two samples (63 for Britain and 56 for Italy). Such tables should be consulted together with Table VIIa which also indicates the number of nurses for each country who do not practice the activities. Also, the tables below only illustrate nurses ranking according to frequency order-five. Full account of nurses answers up to the tenth order of ranking is provided in Appendix C.

Table VIIb: Speaking with clients: nurses ranking according to frequency order - five .

SPEAKING WITH CLIENTS	BRITAIN	ITALY
1st	41(65%)	52(93%)
2nd	8(12.6%)	3(5.3%)
3rd	3(9.6%)	1(1.8%)
4th	2(3.2%)	/
5th	1(1.6%)	/

Table VIIc: Speaking with relatives: nurses ranking according to frequency order - five .

SPEAKING WITH RELATIVES	BRITAIN	ITALY
1st	1(1.6%)	1(1.8%)
2nd	12(19%)	18(32%)
3rd	18(28.5%)	14(25%)
4th	7(11.1%)	12(21.4%)
5th	8(12.6%)	4(7.1%)

Table VIId: Having leisure activities with clients: nurses ranking according to frequency order - five.

HAVING LEISURE ACTIVITIES	BRITAIN	ITALY
1st	/	/
2nd	3(4.7%)	8(14.2%)
3rd	2(3.1%)	14(25%)
4th	5(7.9%)	9(16%)
5th	4(6.3%)	8(14.2%)

Table VIIe: Helping with the housework: nurses ranking according to frequency order - five .

HELPING WITH THE HOUSEWORK	BRITAIN	ITALY
1st	1(1.6)	2(3.6)
2nd	/	5(8.9)
3rd	/	5(8.9)
4th	1(1.6)	1(1.8)
5th	1(1.6)	3(5.4)

Table VIIf: Shopping with clients: nurses ranking according to frequency order - five.

SHOPPING WITH CLIENTS	BRITAIN	ITALY
1st	/	1(1.8)
2nd	1(1.6)	5(8.9)
3rd	3(4.7)	7(12.5)
4th	2(3.1)	16(28.6)
5th	4(6.3)	7(12.5)

Table VIIg: Monitoring medication: nurses ranking according to frequency order - five.

MONITORING MEDICATION	BRITAIN	ITALY
1st	1(1.6)	1(1.8)
2nd	11(17.2)	5(8.9)
3rd	13(20.3)	3(5.4)
4th	14(21.9)	4(7.1)
5th	6(9.4)	12(21.4)

Table VIIh: Giving medication: nurses ranking according to frequency order - five.

GIVING MEDICATION	BRITAIN	ITALY
1st	1(1.6)	6(10.7)
2nd	3(4.7)	13(23.2)
3rd	9(14.1)	12(21.4)
4th	4(6.3)	7(12.5)
5th	6(9.4)	10(17.9)

Table VIIi: Counselling: nurses ranking according to frequency order - five.

COUNSELLING	BRITAIN	ITALY
1st	17(26.6)	2(3.6)
2nd	14(21.9)	4(7.1)
3rd	9(14.1)	4(7.1)
4th	8(12.5)	2(3.6)
5th	5(7.8)	2(3.6)

Table VIIl: Family therapy: nurses ranking according to frequency order - five.

FAMILY THERAPY	BRITAIN	ITALY
1st	1 (1.6)	/
2nd	2(3.1)	2(3.6)
3rd	2(3.1)	1(1.8)
4th	6(9.4)	2(3.6)
5th	7(10.9)	/

Table VIIm: Behaviour therapy: nurses ranking according to frequency order - five.

BEHAVIOUR THERAPY	BRITAIN	ITALY
1st	1(1.6)	/
2nd	8(12.5)	3(5.4)
3rd	2(3.1)	1(1.8)
4th	7(10.9)	5(8.9)
5th	10(15.6)	/

Home visiting is instead an important practice both for British and Italian nurses: 88.7% and 92.9% respectively use this model of intervention.

Differences in nursing practices are to be found also at the level of the organisation of work. British nurses appear to be highly formalized in the organization of tasks and responsabilities. On the contrary, Italian nurses have a weaker formalization of their daily practices, with a lack of standardization of activities and competences. Professional boundaries between nurses are also less clear in the Italian case, due to the lack of a nursing hierarchy. The following tables (VIIIa, VIIIb, and VIIIc) illustrates the comparison between British and Italian nursing organizational practices according to the time-budget dedicated to each activity by individual samples.

Table VIIIa: Nurses' organizational practices.

B=Britain (63) I= Italy (56)	Country	Plan	Evaluate
Daily	B%	74.6 (47)	49.2 (31)
	I%	51.8 (29)	28.6 (16)
Weekly	B%	22.2 (14)	34.9 (22)
	I%	39.3 (22)	46.4 (26)
Forthnightly	B%	3.2 (2)	14.3 (9)
	I%	5.3 (3)	19.6 (11)
Never	B%	0	0
	I%	3.6 (2)	5.4 (3)
Tot	B%	100% (63)	100% (62)
	I%	100 (56)	100% (56)
Chi Square		p= .05	p= .05

Table VIIIb: Nurses' organizational practices.

B=Britain (63) I= Italy (56)	Country	Give- supervise	Have- supervise
Daily	B%	11.1 (7)	/
	I%	1.8 (1)	/
Weekly	B%	31.7 (20)	44.4 (28)
	I%	5.4 (3)	8.9 (5)
Forthnightly	B%	17.5 (11)	33.3 (21)
	I%	/	/
Monthly	B%	23.8 (15)	17.5 (11)
	I%	3.6 (2)	17.9 (10)
Never	B%	11.1 (7)	4.8 (3)
	I%	89.3 (50)	73.2 (41)
Tot	B%	100%(60)	100%(63)
	I%	100%(56)	100%(56)
Chi Square		p=.01	p=.01

Table VIIIc: Nurses' organizational practices.

B=Britain (63) I= Italy (56)	Country	Coordin Services	Administrative Work
Daily	B%	52.4 (33)	79.4 (50)
	I%	5.4 (3)	12.5 (7)
Weekly	B%	25.6 (16)	20.6 (13)
	I%	21.4 (12)	14.3 (8)
Monthly	B%	14.5 (9)	0
	I%	48.2 (27)	30.4 (17)
Never	B%	6.3 (4)	0
	I8%	25 (14)	42.8 (24)
Tot	B%	100% (62)	100% (63)
	I%	100% (56)	100% (56)
Chi Square		p= .01	p= .01

The most important differences shown in the tables above seem to be those about planning, having and giving supervision, and the amount of administrative work carried out by the two samples. Once again a lack of structured practices appears to characterise the work of Italian nurses. Yet consideration should be paid to the different organization of work between British and Italian nurses. For instance, the activity 'coordinating other services' is supposively performed more by British nurses because they practice within mono-professional teams which require liaising with other professions - agencies - in order to provide clients with comprehensive services. On the contrary, Italian CPNs are attached to multidisciplinary teams which provide from within care packages according to consumers' needs. Hence there is little need to network with other community services, unless clients are referred by them to community mental health centres. However, as has been commented on in the section on referrals, community mental health centres receive most of their referrals from GPs.

Planning as well as receiving or giving supervision are not formally organised within Italian teams. In practice this means that there are not scheduled meetings for carrying out these activities, nor they are actually named as such. This highlights a cultural difference between Britain and Italy. Whilst it is part of the British system to organise and categorise activities according to their specific objective and target, Italian practices tend to be less standardised. Organization is often regarded as limiting creativity and flexibility. As a consequence activities are less predictable and within one formally labelled activity you may find many others carried out . This is the case for team meetings, which are very frequent and actually one of the few formalised practices in Italian services (together with individual consultations with users, outings, and group activities). Team meetings are used as a means of planning work, of receiving feedback from colleagues i.e. getting and giving informal supervision, and for evaluation. In fact, there is a significant difference between the frequency of team meetings between British and Italian CPNs.

The lack of formalized activities in the Italian case seems to be replaced by the frequency of team meetings wich is more than once a week for 44.6% of nurses, with 33.9% of nurses having daily team meetings. Comparatively, British nurses have a lower frequency of meetings per week, as shown in the following table.

Table IX: Frequency of team meetings.

Frequency	Britain	Italy
Monthly	6.3 (4)	/
Weekly	74.6 (47)	21.4(12)
More than once a week	14.3 (9)	44.6(25)
Daily	4.8 (3)	33.9(19)
Total	100% (63)	100%(56)

Mann-Whitney corrected for Ties 2 tailed p=.000

78.6% of Italian nurses and 87.3% of British nurses said they were satisfied about the frequency of team meetings; 12.5% of the Italians and 6.3% of the British would like to have team meetings more often than now; 8.9% and 6.3% respectively of Italian and British nurses would like to reduce the frequency of team meeting.

Individual meetings with other professionals are frequent both in the British (82.5%) and in the Italian case (96.4%). Respondents were asked to rank the frequency of their individual meetings according to a list of six professional categories :nurse, psychiatrist, psychologist, social worker, occupational therapist. Since respondents from both samples often chose to give equal priority to different professional figures, it was not possible to group together the six professional categories according to frequency order-six. Findings are therefore presented according to individual professionals and compared between samples. It emerges that 55.6% of British nurses meet most frequently with other nurses, as happens for 66.1% of Italian nurses , whereas 19.1% of the former and 12.6% of the latter do not have individual meetings with colleagues (Graphic 7 illustrates the number of British

and Italian CPNs who said they meet with nursing colleagues with a frequency from 1 to 6, and the number of those who do not meet with nurses). After nurses, GPs are seen most frequently by the British sample, whereas psychiatrists are in second place in the frequency of individual meetings for Italian nurses (see following tables). It is interesting to notice that there are high percentages of CPNs from both countries who do no have individual meetings with psychologists, although comparatively, Italians tend to meet more than their British colleagues with this type of professional. Also, 44,4% of British nurses and 91% of the Italians do not have individual meetings with occupational therapists. This finding was in fact expected from the Italian sample due to the almost total absence of this professional specialisation in Italy.

Graphic 7 : CPNs individual meetings with nurses colleague

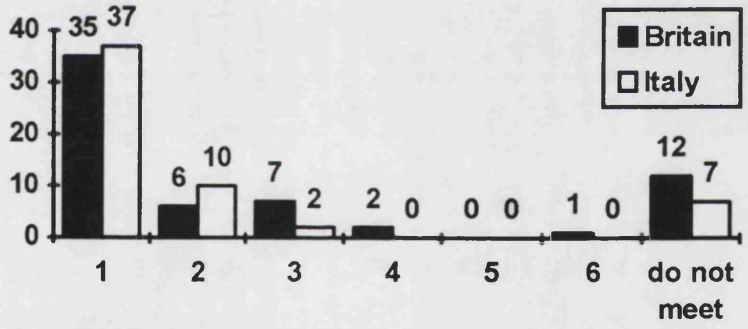


Table X: Frequency of individual team meetings with psychologist, social worker, and occupational therapist.

Psychologist	Britain	Italy	S.W.	Britain	Italy	Occ.T.	Britain	Italy
First	1.6 (1)	8.9 (5)	First	3.1 (2)	5.4 (3)	First	4.8 (3)	0
second	4.8 (3)	21.4 (12)	second	17.5 (11)	8.9 (5)	second	6.4 (4)	0
third	4.8 (3)	12.5 (7)	third	23.8 (15)	33.9 (19)	third	11.1 (7)	3.6 (2)
fourth	9.5 (6)	12.5 (7)	fourth	14.3 (9)	10.7 (6)	fourth	12.7 (8)	0
fifth	9.5 (6)	0	fifth	12.7 (8)	1.8 (1)	fifth	11.1 (7)	1.8 (1)
sixth	19.0 (12)	0	sixth	0	0	sixth	9.5 (6)	3.6 (2)
do not meet	50.8 (32)	44.6 (25)	do not meet	28.6 (18)	39.3 (22)	do not meet	44.4 (28)	91.0 (51)
total	100% (63)	100% (56)	total	100% (63)	100% (56)	total	100% (63)	100% (56)

The comparison between the type of professionals indicated by British and Italian nurses as the most consulted for individual meetings seems, once again, to underline the difference between the two organizational models. In fact, British CPNs are not multidisciplinary based and have a network system with community services which is much more developed than that of Italian CPNs. Viceversa, the multidisciplinary character of Italian community mental health centres tends to provide an autonomous network system within the service itself . Furthermore, the referral system in Italy tends to be channelled through GPs directly to the psychiatrist of the centre to whom nurses will then refer in the first instance, whereas in Britain there is often a direct link between GPs and CPNs. The tables below show the comparison between the level of consultation of GPs and Psychiatrists as ranked by British and Italian nurses with a frequency from 1 to 6.

Table XI: Individual nurses meetings with psychiatrists.

Psychiatrist/rank	**Britain**	**Italy**
First place	4.7(3)	30.4(17)
Second place	34.4(22)	39.3(22)
Third place	17.2(11)	12.5(7)
Fourth place	12.5(8)	5.4(3)
Fifth place	4.7(3)	/
Sixth place	3.1(2)	/
Do not meet with psychiatrist	23.5(14)	12.5(7)
Total	100%(63)	100%(56)

Chi Square significant at p=.01

Table XII: Nurses individual meetings with GPs

GP/rank	**Britain**	**Italy**
First place	12.8(8)	1.8(1)
Second place	9.5(6)	3.6(2)
Third place	12.8(8)	3.6(2)
Fourth place	19.0(12)	5.4(3)
Fifth place	7.9(5)	14.3(8)
Sixth place	7.9(5)	1.8(1)
Do not meet with GP	29.4(19)	69.7(39)
Total	100%(63)	100%(56)

Chi-Square significant at p=.01

5.5. Professional culture and identity.

Having commented upon the differences in training and work practices between CPNs in Britain and Italy, it seems reasonable to conclude that two different ways of being community psychiatric nurses are possible. Yet the central role of CPN in Britain and Italy proves that both ways are important to the development of community psychiatric care. So, how does it feel to be a community psychiatric nurse in Italy and in Britain ? Are there differences between the self-perceived professional role and identity ?

In order to answer these question it is important to address the analysis of professional identity in relation to training, practice, and the changing institutional environments where nurses are called to express their profession.

It is assumed that the rapid development of community care paralleled by a decrease in hospital care facilities has had consequences on CPNs professional identities. Even more so in Britain, where the change is strongly supported by the government rather than by professionals, as was the case in Italy.

Professional identity is therefore analysed in its relationships with education, practice, and the change brought about by the implementation of community care.

The degree of satisfaction which nurses express about their profession has been considered important in understanding the issue of identity. Career issues, as well as perceived advantages and disadvantages in nursing were regarded as meaningful variables to improve this understanding.

Deinstitutionalisation remains central to the analysis. The investigation of nurses' experiences of the process of change highlights differences and similarities between nurses self-perceived professional role and identity.

Nurses were also asked to indicate what is the unique component that made their profession become central in the implementation of community care. This is meant to provide useful indications to the analysis of professionalisation in psychiatric nursing. The underlying assumption is that psychiatric nursing has been, for some reason, particularly suitable to the new care needs brought up by deinstitutionalisation.

The present section compares nurses' career experiences; motivations to the job; the perceived influences of deinstitutionalisation upon nurses current roles; perceived advantages and disadvantages in the profession; attributes of professional uniqueness; and attitudes towards issues of professional responsibility and autonomy.

5.5.1. Career

The nursing career is regarded as unsatisfactory by the majority of both British and Italian nurses (74.6% and 82.15 respectively). The rationale for disatisfaction is different for the two groups. British nurses complained about difficulties in pursuing their career's goals, whereas Italians criticised the absence of career opportunities in psychiatric nursing. As previously underlined, there is no hierarchy in Italian psychiatric nursing, i.e. the choice is either to be or not to be a nurse.

In fact whilst 73% of British CPNs have got specific career objectives, this is true for only 10.7% of Italian CPNs (Chi-Square significant at p=.000).

Among the career goals most pursued by British nurses are up-grading courses and increase of professional skills.

5.5.2. Deinstitutionalisation

The development of community care appears to have affected nurses' professional experiences in both countries. But whereas for the majority (66.1%) of Italian CPNs deinstitutionalization has brought positive changes to their professional life, this is true only for 31.8% of British CPNs. 44.5% British nurses and 32.2% of Italians think that the process of deinstitutionalization has not changed their professional career. As for the Italians, most of them did not actually experience deinstitutionalisation because it was already in place when they entered the job; in this sense it can be said it did not influence their career.

The Table below shows the comparison between the two groups.

Table XIIIa: Influence of deinstitutionalization on professional career.

Type of Influence	BRITAIN	ITALY
Positive Influence	31.8	66.1
Negative Influence	17.5	/
No Influence	44.5	32.2
No answer	6.3	1.8
Total	100%	100%

Chi-Square significant at p=.01

* The category 'No answer' has not been included in the calculation of Chi-Square.

That 17.5% of British nurses experienced deinsititutionalisation negatively highlights the difficulties British professionals were faced with while undertaking a significant role change. This might be linked to the ways through which professional identity was shaped during training. The more training is structured, the more it becomes difficult to change patterns of professional intervention learned during training.

An indication of nurses'experiences of community care is given by the answer to the question "Where do you think your professional capacity is better used?". 48 (85.7%) out of 56 Italian nurses think their capacity is better used in the community.

This is true only for 37 (58.7%) British nurses out of 63, whereas 26 of them find their capacity is equally expressed in the hospital and in the community (the correspondent figure for the Italian sample is 8 nurses). Table XVb illustrates the comparison.

Table XIIIb: Where is your capacity better used by Nation.

	BRITAIN	ITALY
Community	37(58.7%)	48(85.7%)
Community/hospital	26(41.3%)	8(14.3%)
Total	63(100%)	56(100%)

Chi-Square significant at p=.01

This comparison may be interpreted in two different ways. a) British nurses training is such as to render them flexible to both hospital and community care. b) Community care may be experienced by British nurses as a shift to a different care place but not to different care patterns. On the contrary, Italian nurses tend to prefer the community as the most appropriate place for the expression of their professionality.

To understand these findings, the different experience of deinstitutionalisation in the two countries has certainly to be considered. The professionals-led movement for de-hospitalisation in Italy has most likely influenced nurses' perception of change. The transformation in fact did not come from the outside -government directives - as in the British case, but from inside the professional environment. Although community care has a longer history in Britain, in Italy it has been implemented much more radically and with a professionally supported political philosophy. As a consequence, Italian professionals tend to reject the hospital as an adequate care ground, and there is a widespread belief that community care is the only feasible option.

5.5.3. Job Motivation

The analysis of nurses' motivation to the job highlights the fact that for both samples psychiatric nursing has not been a vocational choice. It rather seems that a mixture of personal reasons determined the decision. The choice of the psychiatric specialisation has been determined by the willingness to help mentally distressed people for 22.2% of British nurses (modal value), the highest value after this amounts to 15.9% for which the choice of psychiatric nursing has been casual. A modal value of 33.9% of Italian CPNs is in the job as a result of casual choice, and 26.8% of them chose psychiatric nursing because of their willingness to help mentally distressed people.

17.4% of British nurses and 14.3% of Italians are in the job for practical reasons (absence of alternatives/more chances to get a job). The casual choice is instead highest among the Italian sample. (See table XVIa)

Table XIV: Choice of psychiatric specialisation.

Type of Choice	Britain	Italy
Absence of alternatives	9.5	3.6
More chances to get a job	7.9	10.7
example from relatives/friends	8.0	9.0
willing to help mentally distressed people	22.2	26.8
casual choice	15.9	33.9
personal history	4.8	7.1
vocation	12.7	8.9
mix of choices	11.1	/
Total	100%(63)	100%(56)

* Five British nurses did not answer.

It is interesting to notice that the reasons for choosing psychiatric nursing do not seem to be influencial on the motivation for staying in the job. Only about one third of British and Italian CPNs would change their job if they had the chance to: 33.3% and 33.9% respectively. 20.6% of the British nurses would choose a non-nursing job, as is the case for 26.8% of the Italian.

Negative attitudes towards the professional career are not to be linked with structural factors external to the profession, such as the changing organizational environment . Neither should they be related to individual nurses' choices towards the profession, such as the motivation to take up the job. They rather highlight the fact that disatisfaction is linked with factors internal to the profession. In this case the relevant elements are difficulties in pursuing career opportunities for the British sample, and absence of career opportunities for the Italian sample.

5.5.4. Perceived adavantages, disadvantages and uniqueness in psychiatric nursing.

Questions about professional advantages and disadvantages, as well as about the unique character of the profession were left open-ended on purpose in order to give wider opportunity of expression to respondents. Nurses' answers are reported here fully (see following lists), as attempts to standardise findings tended to reduce the variety of observations as well as their liveliness. However, it was possible to group CPNs' replies according to several categories which summarise, whenever possible, the samples' opinions and make them comparable cross-nationally.

By adding up nurses observations about advantages, disadvantages, and the uniqueness of the profession a picture emerges which reflects, perhaps better than any statistics, the self-perceived professional role in the two countries. Interesting enough, while there are some differences between perceived advantages and disadvantages between the British and Italian samples, they both seem to agree on the unique character of the profession. Such findings could in fact indicate the existence of universal psychiatric nursing features, which in turn may imply a condition of mental illness with its related needs which goes beyond cultural and historical differences.

BRITAIN ADVANTAGES: RELATIONAL
Working directly with people; training aspects.
Enjoy working with mentally ill people.
Face to face contacts, professional image not threatening to people.
Contact with people.
Working with people with psychiatric problems.
Contact with people, exciting innovations within the profession.
Being able to work with a wide variety of people.
Close personal contact with clients.
Opportunity to work with people.
Caring, working with people.
Understanding of human behaviour, relating to people.
Close personal contacts, job satisfaction, feeling useful.
Challenging, client-centred, responsibility, satisfying, room for development.
Job satisfaction, personal contact with people.
Broad variety of clients, work experience.
Total: 15 (23.8%)

BRITAIN ADVANTAGES : AUTONOMY/FLEXIBILITY
Wonderful opportunities and professional autonomy.
Autonomy and flexibility, broad range of skills.
Autonomy.
Autonomy.
Independence.
Autonomy.
Various, stimulating, autonomous.
Autonomy, freedom, respondibility.
Autonomy, responsibility, job satisfaction.
Autonomy and appreciative client group.
Choice of the way I work with clients, autonomy.
Community based, autonomy, responsibility.
High degree of autonomy, able to make my own decisions and act upon them.
Helping people, being autonomous, having teaching opportunities.
Autonomous organization of work, working in more places.
Flexibility, possible to take on responsibility.
Flexibility, confidence, trust of other professionals, self-directing.
In psychiatry things are more flexible rather than being task oriented.
Total: 18 (28.6%)

BRITAIN ADVANTAGES : STATUS/SECURITY/PAY
Stable job. Good work relationships, work less dependant on market, allows me to explore something I enjoy. Community and public opinion respect you because you are a nurse; it makes you look at yourself. Respectful profession, satisfying and rewarding job. Varied, fullfilling, challening, respected in the community. Prestige and pay. Job satisfaction, security. Satisfaction for doing a useful job, social prestige, salary. Easy to get a job, rewarding, fair bit of control on your own doing. Qualification is recognised all over the world. Respectable job, learned a lot about myself, stimulating, rewarding.
Total: 11 (17.5%)

BRITAIN ADVANTAGES : KNOW-HOW
Knowledge base, expertise skills. There is always room for further knowledge. Professional knowledge that gives you a good insight. Ability to carry out mental state assessments. It gives you the skills to be able to help people and prevent.
Total: 5 (7.9%)
BRITAIN ADVANTAGES: VOCATIONAL/SELF-GROWTH
Able to help the most vulnerable and their families, skills and knowledge. Sense that I am doing something worthwhile and valuable to help people. People in need of psychotherapeutic help. Self-awareness, I have learned to be less judgemental and the meaning of prejudice, I like myself. Clients'contact is of value also for family and society.
Total: 5 (7.9%)
BRITAIN ADVANTAGES: ORGANIZATION
Work as equal in a multidisciplinary team. Ability to work in a team, ongoing education.
Total: 2 (3.2%)
BRITAIN ADVANTAGES: POLITICAL
The move of care towards community, discouragement of deinstitutionalisation.
Total: 1 (1.6%)
Total No Answer: 6 (9.5%)

ITALY ADAVANTAGES : RELATIONAL/ HELPING CHARACTER
Opportunity to understand mental illness and to relate to people, team work.
Relationships with people, the need to always invent something new, the need to look upon yourself.
Very human job, opportunity to help people, it is the thing I was looking for.
Opportunity to help those who are in need.
Rapport with patients.
Constant contact with different people, open to many views.
Understanding of people with problems.
Helping people makes me feel good.
Human rapport with people.
To be useful to others.
To help people to get better.
Contact with people and freedom of thought and proposals.
To know people, to learn how to face problems, to travel.
Not to be in the close of hospital environment, continous contact with the community, helping people living a more dignified life.
To know different situations, to talk with people about everything.
Total: 15 (28.6%)

ITALY ADVANTAGES: SELF_GROWTH
Self-growth.
Personal growth, new approach to the world.
Self-growth.
The oppportunity to express my subjectivity, I believe in what I do and I have learned from patients for my own benefit.
To understand myself and others.
I know myself better through understanding others.
It enriched me personally.
You acquire sensitivity and get into the major topics of life.
The opportunity of self-growth.
You acquire a better understanding of yourself through the relationship with people.
Self-involvement.
Understanding of myself.
Self-awareness and personal growth.
Self-growth: it frees your mind and overcomes your own limits.
It always makes me think about myself.
You acquire the ability to evaluate in more depth human relationships and people.
The hope to live a meaningful life.
More self-understanding, the attempt to change cultural attitudes towards marginalised and different people.
The knowledge you acquire while working, flexibility of mind, opportunity to think.
Personal growth.
Total: 20 (35.7%)

ITALY ADVANTAGES : AUTONOMY
Responsibility, autonomy, understanding of human problems. Independence. Autonomy. Autonomy. Responsibility, autonomy. Individual autonomy. Autonomy, contact with people, I know myself better , more culture. Autonomous planning. It is independent and self-directing.
Total: 9 (16%)
ITALY ADVANTAGES : SATISFYING/STIMULATING
Stimulating, non routine job. More intellectual stimula, more place for action. Satisfying. Fulfilling.
Total: 4 (7.2%)
ITALY ADVANTAGES : TIMETABLE
Timetable. Flexible timetable. The timetable is better than in the ward. Timetable and opportunity of self-growth.
Total : 4 (7.2%)
No answer total : 3 (5.4%)

As shown above, it is possible to distinguish three main groups among the British sample, followed by smaller subgroups; and two main groups among Italian respondents followed by smaller subgroups. There is one group of descriptions that is common both quantitatively and qualitatively to both British and Italian CPNs. Community psychiatric nursing is a relational job. It implies continuous contact with people which is clearly valued by both samples. 14 (22.2%) British nurses and 15 (28.6%) Italians listed this as one of the main advantages of the profession.

As often happens when analysing open ended questions, one category does not exclude another. It is therefore possible that some observations could be listed just under a different heading. However, the relational nature of the occupation appears to be linked with its variety and its autonomous character. The second main category among British respondents is in fact given by the autonomy and the independence identified as professional advantages. 18 (28.6%) British CPNs said a main advantage was the autonomy and the flexible nature of the job, it being self-directing, the opportunity that it offers to choose one's own way of working. Independence and autonomy are listed as exclusive advantages by a smaller part of the Italian sample: 8

nurses (14.3%). Conversely Italian respondents are more interested in the aspect of self-growth which seems to be implicit in the job. The relationship with people who are suffering is a means for self-understanding. It is the practice of the profession which has a direct consequence on the nurse as an individual, on his/her increased ability to understand herself and others. For 19 Italian CPNs (33.9%) the profession provides therefore the cognitive tools to better relate with reality. The job acquires instead a more instrumental character for 11 (17.5%) British CPNs who see psychiatric nursing as a means to have a stable and respectable position in society, and a relative wellpaid job. Another 6 British nurses consider the professional knowledge base a valuable advantage, possibly identifying in the professional know-how the core of their identity as nurses, the very thing that makes them feel professionals.

Overall the comparison between British and Italian samples seems to indicate two main characteristics which may help in understanding the self-perceived professional role on a national basis. 1) The Italian sample appears to be slightly more homogeneous in its answers about the professional advantages of psychiatric nursing than the British sample. There are in fact two main groups among Italian CPNs who identify as main professional advantages the relational and helping character of the job, and the self-growth it prompts. Together these two groups amount to 64.2% of the sample, the remainder of it is split between autonomy, satisfaction and timetable. Among the British sample 52.4% of CPNs see the autonomy and the relational character of the job as main advantages, followed by the professional status, the know-how, the vocational/self-growing character of the job and its multidisciplinary features. 2) The second observation that can be drawn by the comparison might be more relevant to an understanding of the profession cross-nationally. British and Italian CPNs appear to differ in the choice of advantages in that the former tend to select structural characteristics of the profession, whilst the latter point out cognitive features of the job. The autonomy, the status, the know-how, and the organization of the job are distinctive features of community psychiatric nursing which can be

considered as tools for the establishment of a specific professional domain within the mental health field.

In this sense, it can be said that British CPNs seem to have more of a professional attitude towards their job than their Italian colleagues. Italian nurses are in fact keener in exploring the cognitive aspects of psychiatric nursing which stem from its practice. The opportunity to relate continuously with different people and to gain from it in terms of self-growth appears to be more to the advantage of the nurse as an individual than to the nurse as a professional. Conversely in the British case autonomy, expertise skills and status are seen as to the advantage both of the individual and of the occupation as means of reinforcing its position among the healing professions.

In understanding these different attitudes it is possible that the professional identity, as it comes to be shaped by training, plays a part in it. British CPNs have the opportunity to build their identity as professionals during structured training programmes. Although some commentators might say that the RMN training does not provide the full range of skills needed in the community, it certainly enforces a professional image which is also equipped with a knowledge base. If anything, it says what you are - a mental nurse - and the role you are supposed to performe in your professional area. British CPNs appear to have benefitted from this but also to have overcome some of its constraints by appreciating the autonomy that the community job has conferred upon them, enhancing the opportunity to master their own work. Conversely, Italian CPNs who did not have the benefit of specific training programmes nor a psychiatric qualification to identify with, tend to see the individual advantages more than the professional. This does not exclude the existence of group coherence, and therefore on an identity. Yet such identity rather than being shaped according to specific professional attributes, appears to stem from the common experience and from the reflection that the professional life has on the private.

The analysis of the professional disadvantages indicated by the two samples seems to confirm this hypothesis. Again the British attention is more towards the structural constraints in the profession whilst the Italian points at the negative consequences that

nursing practice has on nurses as individuals.

BRITAIN DISADVANTAGES : STIGMA
We are still treated suspiciously by the general public.
Stigma.
Stigma, constraints of the traditional way of working.
Still seems less important in comparison with other sorts of medicine.
The label 'nurse' and the financial limits imposed by the government.
The 'nurse' image, lack of belief in ourselves as professionals able to influence and make decisions, our fear of being powerful.
People's pre-conceived ideas of what the profession is.
It has not got the same public sympathy as in other nursing; underfunded.
Sometimes poor for public image.
Image of nursing as a female nurturing job, stigma attached to psychiatry.
Need more staff, more autonomy, more respect as a profession in own right.
Poor public awareness and recognition.
Low pay, lack of professional recognition, lack of managerial support.
Not recognised by other professions.
Stigma still held by public.
Stigma.
Being labelled as a nurse carer, always being expected to know the answer.
Stigma, custodial role.
Total: 18 (28.6%)

BRITAIN DISADVANTAGES : UNDER FINANCED/ GOVERNMENT
Government's anti-social policy.
Lack of funding from the NHS; the psychiatrist has too much power over us.
Lack of resources.
The structure of the NHS.
Lack of resources.
Financial constraints.
Poor government funding.
Increasing administrative responsibility.
Lack of resources in the community.
Lack of consultation with regard to changes.
Lack of direction, hampered by the government.
Heavy caseload, lack of resources for discharging clients.
Total : 12 (19%)

BRITAIN DISADVANTAGES : STRESS/EMOTIONA INVOLVEMENT
Emotionally draining at times, isolation.
It is a bit lonely.
Isolation.
Overspills into social life, often feel surrounded by clients.
I worry that one day I will be demented and loose control.
Stress factor; political and financial situation.
Stressful; hierarchical.
Can be stressful.
Total : 8 (12.8%)
BRITAIN DISADVANTAGES : NO BOUNDARIES
The other side of autonomy is that we do not have enough boundaries.
Accountability to the medical profession, not clear about responsibility.
The power within the profession is a disdvantage, and too rigid boundaries.
Difficulty in specifying what we do as we are dealing with areas which are not measurable.
Can overlap with other professions like SWs.
Psychiatrists behave as we are subordinated rather than fellow colleagues.
'Jack of all trades and master of none'.
Lack of professional distinction.
Occasionally my opinions are taken as second to the medical ones.
Total : 9 (14.3%)

BRITAIN DISADVANTAGES : TRAINING
Lack of post registration training, lack of funding for further training.
Very difficult for career.
Lack of money for training.
Once you get into it it is more difficult to change.
Total : 4 (6.4%)
BRITAIN DISADVANTAGES : ORGANIZATION
Constant changes within the political hierarchy.
Sometimes staff attitudes can be difficult and inappropriate.
Rigidity of collegaues; size of the NHS, too many managers.
Limits my possibility to go abroad; I am exposed to heavy smokers very often.
Total : 4 (6.4%)
No disadvantages Total: 3 (4.7%)
No answer Total : 5 (7.9%)

ITALY DISADVANTAGES : STRESS
It is risky because of the emotional involvement.
Stress.
It is difficult because you always need to wonder about yourself.
Anxiety, continous contact with suffering.
Stress, lack of emotional disengagement.
You can see everything of life which is sometimes positive and on other occasions negative.
The continuous contact with mental illness is stressful and makes you become cynical.
Overinvolvement.
Stress.
Stress.
Mentally tiring.
Lots of work and emotional involvement.
Hard, stress.
You have always to measure up to yourself.
Overinvolvement that is with you at home too.
It is difficult because of the continuous contact with sufference.
Stress.
Stress.
You do not get to see results, stress.
Stress coupled with inadequate support.
Stress.
Stress, and a risk of self-limitation.
I rarely manage to stop working when I go back to home.
You bring home your worries.
Stress; the profession is not acknowledged as it should be; if you do not get constant supervision you run the risk to increase the level of chronicity.
Stress.
Overwhelming.
You run the risk of being too tolerant at the social level and this is not always good.
Total : 28 (50%)

ITALY DISADVANTAGES : ORGANIZATION
Management of team relationships; contacts with people with serious difficulties; lack of evaluation. Problems with colleagues. Organization of work: the only apparent way of working as a team. Too little time to make things happen: organizational problems. You always have to start every day from the same point. Too flexible timetables, you have to work at night or on Sundays. The organization of work I used to have in the psychiatric hospital. Organizational indeterminateness. Lack of structures. Lack of structures.
Total : 10 (17.9%)
ITALY DISADVANTAGES : ROLE/STATUS
Unmet expectations. Lack of role definition, little money. It is not recognised enough outside. Because I do not know much I often try hard to understand. Little status. Little space left for paramedicals like us to have a say, and during the last year the centre seems to be oriented towards a medical model which I think dangerous. Economically unrewarding as compared to other professions. Responsibility and autonomy, the other face of them. Lack of role definition. Disatisfaction when I do not succeed with people. Frustration because I am not able to do more.
Total : 11 (19.6%)
VARIOUS : Physical safety. **Total : 1 (1.8%)**
No disadvantage : Total : 6 (10.7%)

Although there are some British nurses satisfied with the professional status of psychiatric nursing, there are more of them (28.6%) who think the stigma attached to the profession is a major disadvantage. Their concern is about psychiatric nursing being still considered a marginal occupation whose professional expertise and rationale is not yet acknowledged enough by the general public. Some worries are also directed at the level of interprofessional relationships, which are still based on nursing subordination to the medical field. In terms of professionalisation this is an interesting finding as the awareness of a poor professional status shows an implicit willingness to improve the professional immage, and with this also the acknowledgement of the important role of psychiatric nursing in the community. The second main disadvantage is given by lack of adequate resources and insufficient government funding (19%). The blame is on the government and indeed this is well

representative of professionals attitudes and concern towards government in British psychiatry. Emotional overinvolvement, isolation and stress represent the third category of disadvantages expressed by British respondents, together with the lack of a specific role definition and the absence of professional boundaries. They both seem to be linked to the nursing role in community care, where the task-centred activities typical of hospital nursing are replaced by a client-centred practice that is certainly more unpredictable and emotionally involving.

The issue of stress and overinvolvement ranks high among the Italian sample, where 50% of respondents list this as a major disadvantage. The fact that the job overspills into nurses' personal lives is certainly to be linked to lack of individual supervision, which could control and channel the level of emotional involvement in CPN practices. It also seems to be the other side of the coin of 'self-growth', listed as a main advantage by Italian respondents. On the one hand personal involvement allows nurses to achieve a better individual conscience, on the other hand it is also a source of constant emotional tension. The lack of boundaries between personal and professional life generates anxiety. This may also be considered as a reflection of a professional education which stems more from practice than from standardised training. It should in fact be part of the nursing formal training as well as of that of doctors, that of acquiring an attitude of affective neutrality towards patients in order to avoid being emotionally overwhelmed by them and their illnesses.

The remainder of Italian CPNs expressed difficulties as to the professional role and status, and the organization of the job. However, it is important to notice that only a minority of Italian respondents complained about lack of role definition. Moreover there are only two observations about inadequate structures for community care. Comparatively it could be said that Italian CPNs have more to complain about here than their British colleagues. It is possible that not having experienced a structured professional role, Italian respondents do not have terms of comparison which could make them realise the difference with their present lack of professional boundaries. It

is also reasonable to suppose that they actually enjoy the flexibility and the self-directing character of their job, although they would rather find ways to cope with the stress factors which grow out of this condition. In this respect, during fieldwork the writer witnessed an interesting occurance that may throw light on the matter.

In a community mental health centre where nine nurses were interviewed, the consultant psychiatrist had recently left his post and been replaced by a new team leader. She was a psychiatrist as well, but contrary to her predecessor had more directive attitudes and authoritative manners. She required that any of the nurses intervention with clients should be checked and discussed prior to and after their performance. Her approach to mental health was also medically centred, whilst her predecessor was socially and psychologically oriented, granted freedom of action to nurses and trusted them in this. The group of CPNs was on its own side very cohesive, nurses were supportive of each other and immediately undertook action against the new consultant. She was constantly boycotted during team meetings, when nurses would refuse to report on their practice unless she would report on hers. In a very confrontational way nurses tried to make her understand that she had to be their equal, as the past psychiatrist used to be, otherwise they would not collaborate. I have recently learned that she resigned two months latter.

I cannot say that all the nurses belonging to the Italian sample would engage in similar behaviour. Yet my knowledge of Italian psychiatry indicates that whenever a democratic and charismatic leadership is replaced by a bureacratic or authoritative direction, the system falls into inertia. As nurses are usually the quantitative bulk of community mental health centres, it might be assumed that they tend to like a democratic and charismatic leadership that leaves more space to creativity and professional subjectivity better , than a bureacratic model based on standardization of practices. This is in a way a legacy of the psychiatric reform, whose ideology aimed at re-shaping professional practices by placing the client at the centre of intervention,

thus overcoming the custodial orientation of hospital based psychiatry. Indirectly, however, it might also be a consequence of the lack of structured and specific psychiatric training, whereby nurses find it easier to rely on their own direction than to conform to task oriented practices. To conclude, therefore, an attempt to structure nursing training and practice in Italy would perhaps need to be directed at the codification, monitoring and evaluation of the current organization of work, paying attention to not loosing the creative and self-directive character of professional interventions. The importation of a model similar to the British one could in fact be badly tollerated by professionals and clash with the ideology and style of services. This is to say that the disadvantages expressed by both British and Italian CPNs appear to originate from structural conditions of the systems of psychiatric care in the two countries. They are historically determined, yet whenever similar they may be interpreted as the expression of the evolution of psychiatric nursing from a hospital to a community based job. Both among the advantages and the disadvantages there are common traits in the two countries which lead to the idea of a pathway towards a new profession, currently in development and whose expression may assume different forms on a national basis. The autonomy of psychiatric nursing, its self-directive character, and its being relational, its demanding emotional involvement seem to be new professional traits which can only be assimilated to the hospital psychiatric nursing role with difficulty. The description of the uniqueness of the profession provided by British and Italian respondents supports this hypothesis.

BRITAIN UNIQUENESS : COMPARISON WITH OTHER NURSING - AUTONOMY, SELF-DIRECTING, COMMUNICATION SKILLS
More flexibility and autonomy, better communication.
Less task oriented it can be more emotionally demanding.
You need to have a lot more patience, a lot more talking and be prepared to be flexible.
It is not clear cut, always allows further exploration.
Less hierarchy with respect to doctors than other nursing, more freedom, more resources.
More a creative profession than other nursing, with fewer boundaries, it is not solely medical oriented.
Dealing with no-measurable problems.
Training that makes you able to deal with a broad spectrum of people, both well and unwell.
Self-directive training ability, holistic approach.
Psychiatric nursing has a body of knowledge in psychological care which is essential in cooperating with other kinds of nursing.
Psychiatric nurses can be more autonomous, there is room for multidisciplinary work and specialization.
It is more innovative than other nursing, and there is more emphasis on peer support.
Autonomy.
You are much more involved than in any other nursing job, much more team oriented and less hierarchy.
Quite challenging and interesting.
The ability to look at itself as a profession.
Extremely specialised, quite confrontative.
Job satisfaction.
Total : 18 (28.6%)

ITALY UNIQUENESS : COMPARISON WITH OTHER NURSING - AUTONOMY, CREATIVE, DECISIONAL
In psychiatry you need to use your person while in hospital you make use of techniques.
To work in psychiatry changes the mind of the nurse, it is a much more creative job.
They are two professions completely different, the hospital nurse has an executive job whereas the psychiatric nurse expresses his subjectivity.
In hospital you have to rigidly follow the hierarchical structure, here the job is much more rewarding.
In the ward you just execute, here you need to take decisions.
It is more of a mental job, in the hospital it is more practical.
In the ward you have little time and means to have human relationships, here it is the other way round.
Nursing is generally based on assistance whilst psychiatric nursing demands a total rapport with the person.
You think more and analyse behaviours, it is less of a routine job.
They are more technical, we are more human and social.
There are working differences, I would not be able to do what registered nurses do, they have a routine job.
The psychiatric nurses needs to be a bit of a sociologist and a bit of psychologist.
This is a more human and social field.
The ward nurse has a defined profession, but at the level of relationships we are better, they are more routinized.
Unlike the hospital we do not have an institution, you need to invent your job on the spot whilst in hospital there is more rigidity.
It goes beyond the nursing job, it is more intense and alive.
To know how to work with people and not with clinical records, to have a thinking head.
It is self-directive, whilst in hospital it is executive.
Much more responsibility.
Autonomy, asserting what I do.
The responsibility to carry out your job from the beginning to the end.
The opportunity and the responsibility to lead a therapeutic project.
You can be very autonomous, you cannot in the hospital.
You are brought into play, you cannot pretend to do if you are not, you do not have models to identify with.
You need to work on yourself as well.
You bring yourself into play.
Total : 26 (46.4%)

BRITAIN UNIQUENESS : CLIENT-CENTRED
More concerned with the person rather than with the diagnosis.
Deeper understanding of client's needs than in other nursing.
Individual rapport you can have with the client.
Social aspects, ability to be one to one with people, autonomy.
It looks at people as a whole.
Approach to clients, it is about treating them as individuals.
We have the time to invest in people in terms of intervention.
One to one relationship, psychoanalytic approach.
Our influence on people's lives which can be for good or for bad.
Interaction with clients: you see them as people not as patients.
Time to sit and talk with people which you do not have in the hospital.
Holistic approach.
Specialised in psychiatry yet holistic in approach.
Deal with patients as individuals, holistic.
Opportunity to see the person as a whole.
The individuality of each client's problem, and have to answer them accordingly.
The client is looked at as an individual, the work allows responsibility which general nursing does not.
Holistic approach to care.
The use of relationship and non-clinical knowledge with clients.
Holistic approach.
Personal contact with people and job satisfaction.
Psychiatric nurses have a better understanding of people's feelings.
Psychological, emotional needs catered for.
Holistic approach.
Opportunity to develop a therapeutic relationship with clients.
More time to offer appropriate in-depth help.
Close relationship with clients.
The therapeutic alliance with clients.
You need to know the person well, which you do not in general nursing.
Lack of barriers between nurses and clients, no prescribed method of helping somebody, greater flexibility of role.
Understanding of human behaviour, accepting people as they are.
Opportunity for developing relationships and allowing people to help themselves.
Total :32 (50.8%)

ITALY UNIQUENESS : CLIENT-CENTRED
The psychiatric nurse sees the person as a whole. Psychological rapport with the person and the ability to get into their world, in hospital everything is more technical. Total relationship with the person. Relational aspect which is secondary in hospital. Rapport with the patient. Interpersonal relationships and communication which do not exist in the hospital. To know people directly. Direct relationship with people. You can be more protagonist, and the client is the centre of the job. It is a job where you take care of the person globally. It is global in approach. The relationship with the patient which has no equal in any other nursing. In psychiatry you get the chance to understand people better. There is a common objective towards the client. There is more talking with patients, there is an interpersonal relationship from which at the same time you need to be detached in order to be objective. It is client centred.
Total : 16 (28.6%)

BRITAIN UNIQUENESS : VARIOUS
It can be a very individual subject. Self-awareness. Empathy and self-awareness. Client-group. The vulnerability of client group, it looks at feelings and emotions, social skills. Client group and style of intervention. People are false and do not support each other.
No answer : 4
No uniqueness : 2
Total : 13 (20.6%)

ITALY UNIQUENESS : VARIOUS
Psychiatric nursing is totally different. They are completely different. There is a barrier, they are two jobs completely different. The team work. Team work, the community, the relationship with people also beyond the health sector. When you work with acute suffering you get closer to your colleagues. It is vocational. We would need to have a special school not nursing based.
No uniqueness : Total 4
No aswer : Total 2
Total : 14 (25%)

The first interesting finding emerging from the tables above is that the great majority of both British and Italian CPNs seem to enjoy their job. There is something alive and enthusiastic in the description of the unique character of psychiatric nursing which can be considered as an indication of the satisfaction towards the job. Also, there is a sort of pride in describing community psychiatric nursing in comparison with other nursing. With this in mind it is important to specify that the question was not directed at finding out unique qualities of psychiatric nursing compared with other nursing. It rather aimed at identifying elements which could characterize the job as unique, and therefore indicate a pathway to professionalization. Interestingly both British and Italian responents took for granted an implicit comparison with other nursing, and pointed out the differences. Indirectly this underlined that CPNs feel they perform a role which is significantly different from any other nursing, but especially from hospital nursing.

There are two main groups of answers common to both samples which ascribe elements of uniqueness to the profession. Psychiatric nursing is an autonomous, brain-using, creative and self-directing job, and it is client-centred rather than task oriented like hospital nursing. Respondents from both countries explained the routine character of hospital nursing roles, where the job is task-oriented rather than person-centred. It seems that the one to one relationship with the client is a particular feature of psychiatric nursing , not allowed by the organizational structure of the nursing job within a hospital environment.

Both British and Italian nurses explained the constraints that a nurse usually experiences while being on ward duty, that is having to switch from one patient to another in the accomplishment of technical tasks. In order to keep up with the criteria of efficiency required by the hospital structure, no space is left for a more human relationship with the patient. On the contrary, the goals and the organization of community care ask for the client rather than the technical task in itself as the specific care focus . This is an interesting insight into the profession that goes in the direction

of psychosocial analyses of nursing within the hospital environment (Menzies, 1973).

Menzies found out that a high level of nursing burn out in hospital wards was given by the demands put on the profession by the organization of the hospital. The hospital routine was such that nurses had little time left to spend in individual relationships with patients. This resulted in being a component of professional frustration because it did not allow the accomplishment of the vocational rather than technical goal of human care pursued by nurses.
Furthermore, the same hospital organization did not allow nurses to come in close contact with patients, and a precise system of rules had been established to accomplish this goal. For example, among the nursing hospital staff patients were not called by their names but by the numbers of their beds. Regulations in the hospital aimed at respecting standard of efficiency and at safeguarding the emotional distress of professionals who had to deal on a daily basis with human suffering.

Results from Menzies'study show that as a consequence of this system, nurses did not suffer from emotional stress but from the frustration derived from the impossibility of carrying out their role of emotional carers.

The difference pointed out by community psychiatric nurses between their job and hospital nursing, may suggest interesting comments about the reason for burn out rates in the community environment. By applying the same categories of analysis as Menzies, there is a need to answer the question of how nurses cope in the community without the hospital safeguarding environment for their emotional distress. The high level of stress pointed out by Italian nurses might indicate that no new coping strategy has been adopted in place of the hospital stress-safeguarding routine measure. In the British case hierarchy together with specialisation could be regarded as a functional answer to stress, which appears to be at lower levels among British nurses.

CPNs' descriptions bring to the surface the picture of a job that asks for the individual capability of deciding and operating on not-codified models of intervention. The non-clear-cut character of community psychiatric nursing is also a safeguard against routine, it is therefore challenging and intellectually stimulating. What seems to be missing from this description is the lack of comparison with other mental health professions. On the one hand it is clear that CPNs are keen to distinguish their job from other nursing- it is somewhat different and sometimes even not comparable. On the other hand, a comparison could have been expected with social work, which could be thought to overlap with some of the descriptions provided by CPNs. Yet an implicit comparison could perhaps be drawn from CPNs accounts, leaving to the reader the task of judging on the rightness or wrongness of the hypothesis. It is true that social work is a person-centred job, that it is certainly more self-directing than hospital nursing and that it is socially and psychologically oriented. Nevertheless unlike community psychiatric nursing, social work is an established profession. It has a specific knowledge-base conveyed through training which also sets distinctions between what a social worker is expected to do and what is not of his/her competence. A social worker is not for example expected to give depot injections. Conversely community psychiatric nurses are in the position of giving depot injection, providing counselling, paying attention to the social and rehabilitative needs of the person, perhaps dealing with housing problems, filling-in clinical reports, monitoring medication, sometimes shopping with clients, helping with the housework or having leisure activities. All this very often without a specific community training to back up nurses interventions, as even the RMN training in Britain is aimed at educating the nurse to ward duties rather than to community needs. If anything, the difference from social work is therefore that CPN is a profession in development, as respondents said it is not clear cut. It is something different from the past hospital role, the areas of its competence are not yet defined and can be virtually anything that has to do with the clients personal and social life.

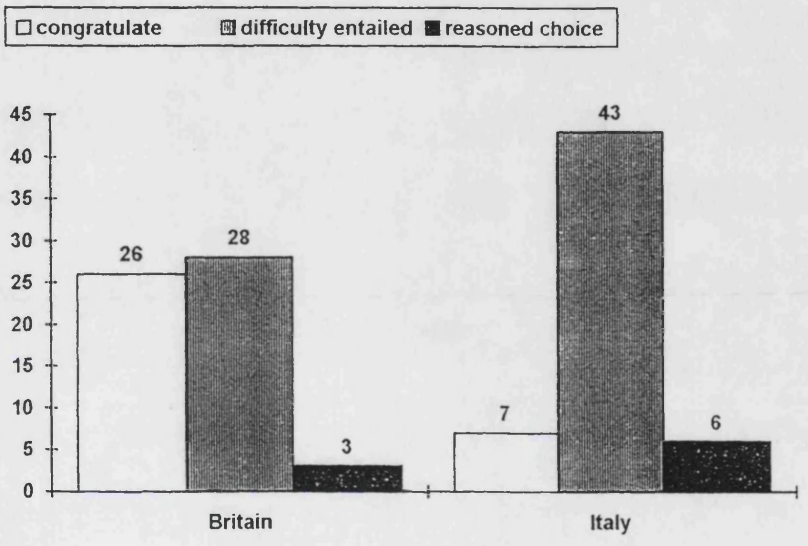
Recent developments in nursing training programmes both in Italy and in Britain could change this condition of uncertainty. In Italy nursing is being assimilated into short university diplomas, some of which have included the psychiatric specialty. In Britain the implementation of Project 2000, with a bulk of common training for all nurses and branches for specialisation, might significantly modify psychiatric nursing in the community, but specifically the professional identity as it emerges from this research. By considering the interest of respondents in distinguishing their job from other nursing, it could be observed that the above training developments are not desiderable. They actually represent a step towards assimilating again community psychiatric nursing to other nursing, therefore to the medical field. It happened in the history of psychiatry that when a new psychological and social interest towards mental illness developed, the advent of psychotropic drugs re-asserted the medical hegemony in the field. Community psychiatric nursing with its new and developing role in the community, characterised by a greater degree of autonomy from the medical sphere is certainly a challenge to the status of psychiatry as a medical science. The experience of Italian nurses indicates that training, for good or for bad, is a powerful means of control on the professional identity. It would be desiderable that at a time when psychiatric nurses have freed themselves from the custodial and executive role of the past, new training developments will not stop such professional growth.

5.5.5. Psychiatric nursing as a reasoned choice?

British nurses seem to have fewer reservations about the profession than their Italian colleagues, as 41.3% would congratulate a new comer and encourage the choice of psychiatric nursing as a professional experience. Only 12.5% of Italian nurses are in the same position, whereas 76.8% of them chose to explain the difficulties entailed in the profession to possible nurse candidates, as is the case for 44.5% of British CPNs (Chi-Square significant at p=.000). Respectively 10.7% and

4.8% of Italian and British nurses said that the choice of psychiatric nursing has to be a reasoned one, in which positive and negative aspects need to be highlighted. Six British respondents did not answer the question.

Graphic 8 : Suggestions to a psychiatric nurse candidate (Would you a) congratulate the choice of psychiatric nursing, b) tell about the difficulties entailed, c) advise not to do it/ point out that it has to be a reasoned choice ?)



These answers seem to underline the difference in nurses professional experiences and personal history. A higher percentage of Italian nurses has chosen the profession because they are in need of a job or casually (about 48% against 33% of British nurses).

It can be assumed that because of the paucity or inadequacy of training, entering the profession must have been more burdensome and demanding for Italian nurses than for British, who on the contrary were provided with a professional psychiatric background, if not with a specifically community one. For the same reason, it can be hypothised that given the initial ardous character of the job Italian nurses have remained within the profession by virtue of its self-growing helping character (apart from the possible economic need to keep the job). This seems to be supported by the

answers given about professional advantages of psychiatric nursing which point out the self-growth process stimulated by the profession and it its caring character.

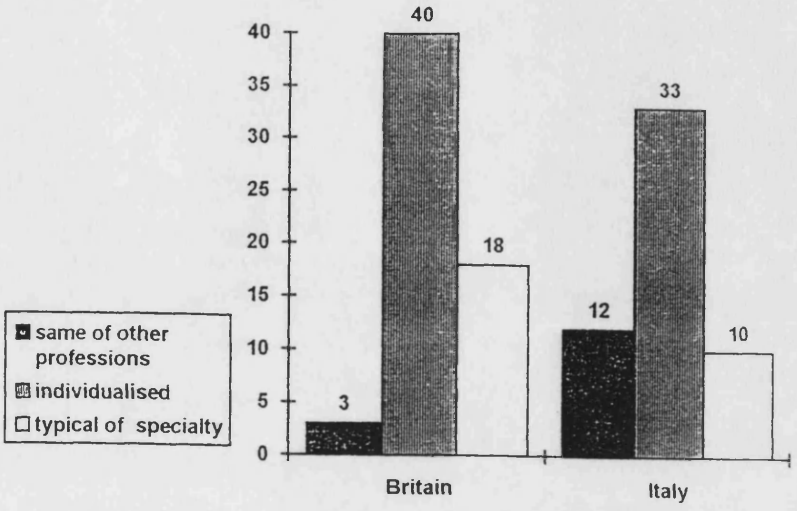
Whilst British nurses have a defined professional role and status -acquired through training or hierarchically administered- Italian nurses have had to look for a professional identity. This need could not be fulfilled with advocating specific professional competences, a code of practice, or professional ethics because these were either inadequate (registered nurses) or not-existent (psychiatric nurses/psychiatric workers). The reward and the prestige which usually originate from a specific professional identity have been found by Italian nurses in the process of self-growth and in the better understanding of human issues which is stimulated and, in a sense is, inherent to the profession. In other words, what could not be found in the profession as a detatched entity (as a role to be undertaken) has been identified with the person. This might be one of the reasons for which it is more difficult to describe the professional role of community psychiatric nursing in the Italian case. Even in the cases where training has been provided as an on-going process of learning from practice, the Italian strategy is not that of referring to codified models of intervention but of stimulating the individual contribution and creativity.
When there are no rules to follow or models to apply, one has to find within him/herself rules and models.

Understandably, this can be a tiresome process and a very stressful one, as it has been underlined by nurses' answers about their levels of burn-out (stress being among the perceived disadvantages). On the other hand, it has made Italian nurses more flexible to changes and enhanced their ability to cope with uncertainty. Viceversa, British CPNs seem to suffer less from stress, but more from the uncertainty derived by their not-clear-cut community role (among perceived disadvantages).

Whilst this perception in the British case seems to be due to the organizational environment where nurses practice i.e. community care; in the Italian case the data is most certainly to be attributed to the paucity of training. In fact, the majority of Italian nurses do not find their training suitable to their present job; viceversa the majority of British nurses do find the professional education received adequate to their community job.

An apparently controversial answer has been given to the question: ' Do you find your patterns of work a)the same as other professions in psychiatry, b) typical of your specialisation, c) individualized'. 63.5% of British CPNs described their patterns of work as individualized, 28.6% as typical of their specialisation, and 4.8% the same as other professions (3.2% did not answer). The equivalent answers for the Italian sample are 58.9%, 17.8% and 21.4% respectively (1.8% did not answer). By excluding the category 'no answer', Chi-Square test is significant at p=.01, thus indicating that there is a statistically significant difference between the two samples. Possibly such a difference emerges in that Italian CPNs tend to identify less than their British colleagues with a specific psychiatric nursing identity. 21.4% said in fact that their patterns of work are the same as other professionals, and only 17.8% identify with a professional specialisation.

Graphic 9 : CPNs perceptions of their patterns of work



By saying that their professional education is adequate for their job, and that their patterns of work are individualized British nurses may either express the flexible character of their training or the inadequacy of the organizational situation to the application of their specific professional knowledge. If this latter hypothesis is true, it would imply that the professional identity created through training is so strong that it is not possible for British nurses to conceive of their education and their role as inadequate, the only choice being left to explain their discomfort is the situation itself, i.e. community care. The not-clear-cut character of the community care role would force nurses to individualize their knowledge, not allowing or perhaps limiting the use of models of work learned during training. An important difference between British and Italian nurses is that the former have internalized their professional identity in the training setting-which in most cases has been staged in the hospital and not in the community- whereas Italian nurses have slowly built their professional identity during their community job. This might indicate that the cognitive models learned during training can be modified and have a flexible character, whereas the role-staging and the professional ideology internalized thorough analogic models are much more difficult to change. That 21.4% of Italian CPNs consider the patterns of their work the same as other professions indicates, on the other hand, that for a portion of Italian

nurses their professional identity has a loose character which does not allow identification with a specific profession.
However, that CPN is an independent and self-directing job, therefore individualized, has been indicated by both British and Italian nurses as a major professional advantage. The apparent incongruity represented by this set of answers seems to indicate the transitional character of the profession, that as a consequence of the shift from hospital to a community based setting appears not to have yet defined its specific parameters of intervention.

It should not to be forgotten that the majority of both British and Italian CPNs are happy with their job, and would not change it if given the opportunity. Despite the different problems identified on both sides, community psychiatric nursing is still a rewarding job because of its caring character, of its autonomy or holistic approach. The analysis of answers given about the uniqueness of the profession highlighted that CPN is a profession in development, perhaps more so in Britain where models and role internalized during training need to be adpted to a changing environment. In a way the not-clear-cut role indicated by British respondents also comes out from their answers to the questions, which sometimes show a stable and well defined professional identity, other times indicate the transitional condition experienced by CPNs, with the anxiety, unpredictability and uncertainty which are part of it. If on the one hand, there is pride about the autonomous and self-directing character of the job, on the other hand a certain degree of uneasiness may emerge as a result of un-met expectations towards practices and role learned during training.

This is also demonstrated by the fact that the majority of British and Italian nurses do not feel overburdened by the responsibility they are asked to undertake in their work. 82% of Italian nurses and 81% of the British chose not to change their degree of responsibility and 11% of the British and 9% of Italian CPNs want more responsibility than they actually have, in spite of the fact that 61% and 63%

respectively declared they have a high level of responsibility (39% of Italian nurses and 33% of the British said they have as normal a level of responsibilty as any other profession in psychiatry). Similarly, 98% of British CPNs and 89% of Italians have the opportunity to share the responsibility of their work with other members of the team.

Table XV: CPNs degree of responsibility

DEGREE OF RESPONSIBILITY	BRITAIN	ITALY
high degree	63.5(40)	60.7(34)
normal degree	33.3(21)	39.2(22)
no answer	3.2(2)	0
total	100%(63)	100%(56)

Table XVI: Which degree of responsibility would you like to have ?

OPINION ABOUT THE LEVEL OF RESPONSIBILITY	BRITAIN	ITALY
less responsibility	7.9(5)	7.1(4)
more responsibility	11.1(7)	8.9(5)
the same responsibility	81.0(51)	82.2(46)
no asnwer	0	1.8(1)
total	100%(63)	100%(56)

The sharing of responsibility with all the disciplines in psychiatry takes place for 87% of British nurses ; this is true for 61% of Italian nurses, whereas 21% of them said they find more support in nursing colleagues, the remaining of answers from both samples is equally shared among all psychiatric disciplines.

For 14 of British nurses and 15 of Italians there is a professional role more important than others in psychiatry. 8 British nurses found the nursing role as the most important, and 6 identified the psychiatrist as the most important post in the field. 13 Italian nurses indicated the psychiatrist as the most central role. However, it has to be pointed out that Italian nurses who indicated the psychiatrist as the most important professional role, highlighted this position because of the power it implies and not because of having specific responsibilities or more caring ability. As a matter of fact,

answers to this question were always given with a sarcastic tone.

5.5.6. Attitudes towards deinstitutionalisation

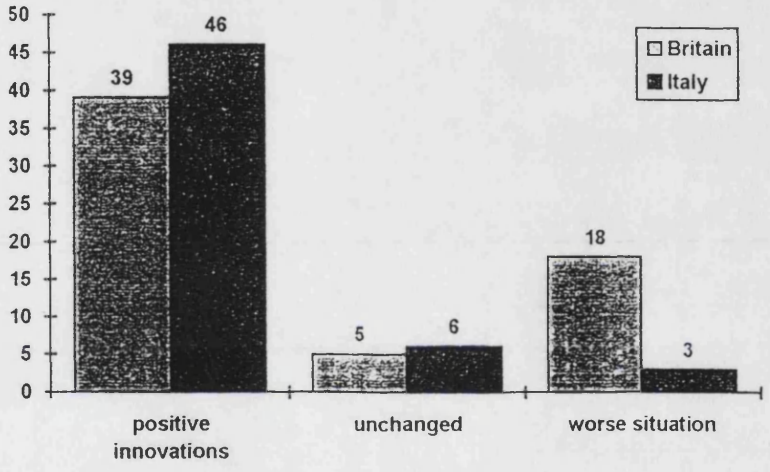
Nurses'attitudes towards deinstitutionalization reflect the experience of change as it developed at the national levels. Both by British and Italian CPNs deinstitutionalization is mainly seen as a mixture of problems at the economic, political and social levels. From both sides government policies and cuts on care expenditure are considered a main obstacle to the development of community care. British nurses seem to experience the process of change as a political decision put forward at an unecessary speed, because of economic reason and to the detriment of health issues. Despite the complains about lack of funds and structures where to host and take care of mentally distressed people, Italian nurses do not perceive the process of deinstitutionalization as 'external' to them and to their wills. The psychiatric reform has not been imposed upon professionals but promoted and activated by professionals. This historical difference in the development of community care in Italy and Britain becomes evident through nurses' perceptions and every-day experience of the process.

By looking objectively at the situation, Italian nurses could have more to complain about government policies during the last ten years than their British colleagues. Despite the considerable shortage of resources to implement projects and promote innovations, British nurses seem to have had much more than Italians in terms of training support and social research development in the field. Whilst these developments have mainly been imposed upon nurses in Britain, in Italy professionals have struggled to achieve them.

Politicians are blamed by Italian nurses because of the lack of interest shown towards mental health issues, because perpetuating the Cinderella role of psychiatric services but not because of having allowed the implementation of the psychiatric reform.

For 82.1% of Italian CPNs deinstitutionalization has brought positive and important innovations, this is true for only 61.9% of their British colleagues. 28.6% of British CPNs said that deinstitutionalization has worsened the situation of psychiatric care, against 5.3% of the Italians. For 7.9% of British nurses and 10.7% of the Italians the situation has been left unchanged.

Graphic 10 : Influence of deinstitutionalisation

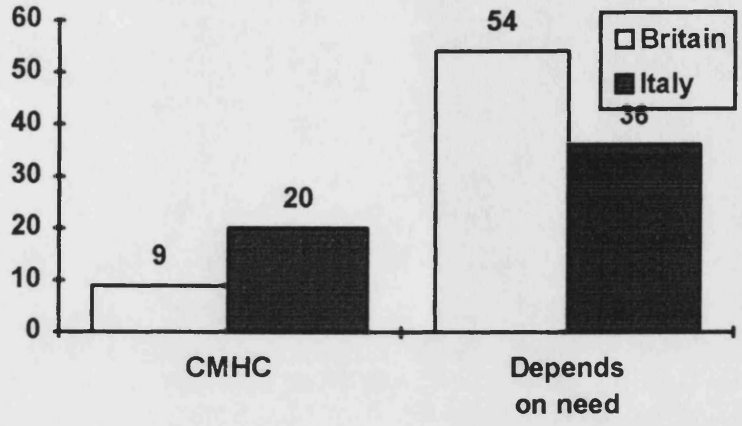


Chi-Square significant p.=002

* One respondent from each sample did not answer the question and has not been included in the Graphic.

Given the choice between a CMHC, a hospital, a private clinic, and of judging by the nature of the need 14.3% of British CPNs would refer a relative in need to a community mental health centre as 35.7% of Italian CPNs would choose to do. 85.7% of British nurses and 64.3% of Italian would decide according to the nature of the relative's need. The comparison proves to be statistically significant (Chi-Square p=01).

Graphic 11 : Where would you refer a friend or a relative in need?



Chi-Square significant p=01

The interpretation of this finding is difficult. On the one hand it is evident that Italian respondents show a higher preference towards community mental health centres than their British colleagues. Yet, given the positive value attached to community care by Italian respondents, a prevalence of answers to the item 'community mental health centre' could have been expected from this sample. The choice to 'judge by the nature of the need' obviously indicates the opportunity to refer an hypothetical mentally ill relative to other forms of care, possibly home-based private care, as it is quite unlikely for Italian CPNs to find desiderable an in-patient condition. Indirectly this finding indicates a mistrust on the side of Italian nurses towards the effectiveness of community care in Italy. Answers to the second questionnaire about ideologies of mental health, will show that Italian respondents have very distinctive opinions against hospital care, showing a significant propension towards community based care models. Rather than judging this as an incongruence in answers from Italian CPNs, it would appear that their sceptiscism is directed against the implementation of community care, but not against the concept of community care in itself.

Instead a different interpretation needs to be given to answers from the British sample. It is in fact likely that, having to refer a mentally ill relative, British CPNs chose to 'judge by the nature of the need' depending on the prevalent British approach to mental health care. As it has been repeatedly underlined, community care in Britain tends to be considered as one of the care options available, but not necessarily the best one. Decisions upon the desiderable form of care are therefore according to the patient's needs and situation. Hence either in-patient care or community based facilities will be targetted according to the need.

5.6. Conclusions

The present chaper attempted to accomplish some of the research objectives elucidated through the research design and the theoretical framework. It was there assumed that in order to undestand the development of community psychiatric nursing cross-nationally, and to analyse whether such a development could be considered a pathway to professionalisation, it was necessary to investigate three main variables: organization of work; ideology of psychiatric care; and psychiatric nursing professional culture and identity. These three variables were supposed to be inter-dependent, so that their interaction would constantly influence the whole system under investigation, and that no one of them could be considered causal to the others. The task was therefore to assemble the many pieces of a mosaic which could eventually represent contemporary community psychiatric nursing in Britain and in Italy. In Chapter 4 the nursing professional culture and identity and the organizational structure where this is put into practice have been presented through the analysis of their components. Training was regarded a priviledged variable to the explanation of differences between community psychiatric nursing in Britain and Italy, the background of the analysis being the psychiatric history of the two countries and the different approaches to the implementation of community care.

Community psychiatric nursing is in fact representative of the evolution of psychiatric care in the two countries. Both British and Italian CPN originated from hospital based psychiatry. In the British case the hospital link has been maintained throughout the development of community care, and perpetuated through training. Conversely in Italy the advent of community care implied an epistemological schism with hospital based care models. The consequence is that two distinctive approaches to community psychiatric nursing become visible from the comparison.

The British nurse is characterized by neatly defined professional traits. The avaliability of a specific professional education in mental health makes of British community psychiatric nursing an occupation with an expertise in the psychiatric field. Such professional identity is inherited from the hospital culture and comes along with training programmes which are, for at least three quaters of the time spent in education, hospital based.

Italian psychiatric nursing, on the other hand, has progressively lost its hospital identity. The new community nurse appears to be something in between a health worker and a social worker with some nursing competences. The adjective 'psychiatric' has been erased from the qualification of nurses operating in community psychiatric setting, thus increasing the latent character of the professional identity. The current trend in Italy is to employ registered nurses whose professional education has no links with psychiatry. There is lack of institutionalised community trainining, which is instead occasionally provided on a local basis by community mental health centres where the nurses are working.

The two different training models also find their rationale in a different organization of community care in Britain and Italy. Findings in this Chapter indicated that British CPNs tend to target specific client groups, which also prompts

the development of specialisation among nurses. Nursing practice is defined according to specific areas of intervention and tailored on the client group. Counselling is among the most common activities.

British nurses tend to have bigger caseloads than their Italian colleagues, but at the same time they deal less with long-term clients, whereas Italian nurses are not specialised according to client groups but deal indistinctively with any mental health related need. Yet, due to the fact that to a large extent community care has replaced hospital care, Italian CPNs have on their caseloads a considerable number of clients with serious mental health problems. As a consequence the practice of Italian nurses tends to accomplish the rehabilitative needs of this type of clients. Interventions range from 'speaking with clients' to helping with the house work, shopping or having leisure activities with clients.

Nursing practice in Britain is channelled through structured organizational activities, like planning, evaluation and supervision, which conversely find a much confined development in Italy. Last but not least, the nature of multidisciplinrary work is substantially different in the two countries. Multidisciplinarity is in Britain ensured by an organised system of liaison with other community services. British community psychiatric nurses are mono-disciplinary based and refer to other community agencies or professionals when in need. In Italy instead the nature of work is specifically multidisciplinary. CPNs are attached to community mental health centres whose composition is multidisciplinary. The holistic character of the intervention is therefore not only achieved by avoiding specialisation, but also by grouping different professional competences at the service of clients.

Overall a major difference emerging from this findings is the contrast of the Italian collective approach to psychiatric care with the British individualised style of intervention. It is interesting to notice that recent developments of the case management model in Britain aim at avoiding the fragmentation of care by producing care packages that deal at once with all the client's needs. Even more relevant to the

development of CPN is that community psychiatric nurses are among the candidates for becoming case managers.

This observation in fact leads the discussion towards the common elements which emerged from the analysis developed in this Chapter. Whenever the focus of investigation shifted from the analysis of structural elements of the profession to the study of the perceived professional role, some interesting common traits arise from the comparison between British and Italian CPNs. Whilst the differences observed between British and Italian CPN are to be linked with diverse community care philosophies and their organizational implementation, the common traits between the two countries appear instead to describe a universal condition of contemporary community psychiatric nursing which in turn reflects the current evolution of psychiatric care.

Both British and Italian nurses enjoy a considerable degree of autonomy and professional independence, and both appreciate the responsibility attached to the nursing role in the community. The most interesting finding is given by nurses' indications about the attributes of uniqueness ascribed to the profession. From such description community psychiatric nursing appears as an occupation that has little in common with other nursing. It is in fact a client-centred profession in contrast with the hospital task-centred nursing. This allows CPNs to be creative and innovative, to be protagonists of the care project and not subordinated to superior directives, but at the same time increases the not-clear-cut character of the job. CPN appears therefore to be a profession in transition, that is moving from its hospital origins towards new and un-explored community developments.

British CPNs, more than their Italian colleagues, are caught in this transitional stage and are pulled between the hospital identity conveyed through training , and the professional freedom promoted by the community experience. Attitudes of resistance towards the process of de-hospitalisation appear to be due to this situation of

uncertainty, where the known is being left for the unknown. Contradictions which here and there have been pointed out by findings, can be explained by this transitional context. A new professional identity is developing, but not yet definitely shaped, so that an alternation between the old identity and the community professional achievements becomes visible from nurses' accounts. It is less so in Italy, due to the radical character of deinstitutionalisation that left very little space and consideration to hospital psychiatry.

The analysis of nursing ideologies of care that follows is aimed at increasing the understanding of this professional condition. It provides indications about the conceptual framework which lays behind CPNs practices, and therefore concludes the investigation of that circle in which local organization of community care, nursing culture and identity and their ideologies interact, reflecting the image of a profession in development.

4.7 References

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CHAPTER 6: NURSING IDEOLOGIES OF CARE

6.1. Introduction

The present chapter focuses on the analysis of nurses' ideologies of care. The term 'ideology of psychiatric care' refers to the care of mental illness within given national and historical contexts. In accordance with Mannheim (see Chapter 3), ideology is what characterises the thought of an era. It provides an interpretation of reality that is dominant against others, and which represents the 'weltanschaung' of a given historical period.

An historically dominant ideology of care therefore provides a comprehensive framework of interpretation about mental illness. Hence it is meant to provide information about the aetiology of mental illness, the most appropriate methods of care, the related organization, the professional roles and their hierarchical structure.

It is assumed that the ways through which a dominant ideology of care is generated are historically determined. An interplay between society at large (lay people and politicians) and professionals in the field produces a dominant view about the phenomenon. In Gramsci's terms professionals are here regarded as the hegemonic community, i.e. those who, among society, have the power, provided by their expertise, to propose comprehensive explanations of the phenomenon and interpretations to suit. Such a dominant view has changed over the centuries and proved to vary between countries, so that, for instance, different countries are currently approaching the implementation of community care at a different pace and by means of different patterns.

In the case of Britain and Italy, the different ways through which community care is being developed show the diversity between the philosophies of care that lay behind the movement for community care in the two countries. Because of the centrality acquired by community psychiatric nursing in this process, the investigation of nurses'

ideological committment is thought to be relevant to understanding the changing professional role and identity.

Nursing philosophies of care and ideologies of mental illness have been analysed according to nurses' degree of agreement and disagreement about ideal-typified statements on mental health care. Following Strauss's approach (1964, ref. chapter 3), the elaboration of ideologies of care has been developed according to a 'purist' view:

> 'the clearest way to visualize each postulated ideology is through the eyes of a 'purist' or one who is a strong advocate of the particular position. We should expect a high order of consistency in his views about the aetiology of mental illness, the nature and amount of treatment, prognosis, and desiderable treatment settings, including the structures and functions of institutions that house mentally ill. [...] The ideological purist also should have strong opinions about intraprofessional and interprofessional role performances and about the functions and mandate of his discipline.' (Strauss, 1964, 55)

Five ideologies of care have been presented for nurses to state their own level of conformity. These are the political approach, the social, the biological, the psychological and the critical. The construction of each ideology of care has been developed according to the ideal-type method. Each philosophy of care has been expressed by means of statements ranked into 6 levels of agreement and disagreement, following the ranking used by Strauss (1964).

The five ideologies are thought to express a possible range of care approaches currently existing in psychiatry. Nevertheless, it is not the author's intention to provide a comprehensive theory of psychiatric ideologies. Rather, the elaboration of the five approaches reflects the author's view about the ways through which the

phenomenon of mental illness might be tackled within the professional field. Their analysis is meant to enhance the understanding of psychiatric nursing as it is professionally experienced by respondents in the two countries.

Data have been analysed comparatively and statistically tested with the Mann-Whitney test whenever a significant relationship was identified.

6.2. The political ideology of mental health.

The political ideology is meant to represent the position of those who view mental illness as an eminently political matter. Many of the statements listed under the social approach could fit into this ideology too. Those under the latter were separated when considered less radical, and therefore demanding less political committment than that required to adhere to the political ideology.
It was hypothised that the political ideology would better represent Italian nurses. This, because in Italy the movement for deinstitutionalisation had a significant and overt political basis. The analysis of findings produced the following results.

There are significant differences between British and Italian CPNs about the functions of psychiatric hospitals as they have been stated within the political approach. Tables XVII, XVIII, XIX, and XX below report the comparison. Testing with Mann-Whitney resulted in highly significant differences for all of the variables considered. Such a test takes into account the different levels of agreement/disagreement stated by nurses.

In all of the following tables the percentage of respondents who did not answer the question has not been included in the calculation of the Mann-Whitney test. This was possible because in all of the cases, the number of 'no answer' was small enough to be statistically insignificant. Not all of the nurses interviewed for the first questionnaire chose to answer this second one too. The sample to be considered for the analysis of the questionnaire on ideology consists therefore of 59 respondents for Britain and 50 for Italy.

Table XVII: The psychiatric hospital does not have a curative function.

Degree of Agr/Disagr.	BRITAIN	ITALY
Strongly A.	6.8(4)	48.0(24)
Moderately A.	18.6(11)	24.0(12)
Slightly A.	11.9(7)	20.0(10)
Slightly D.	10.2(6)	2.0(1)
Moderately D.	27.1(16)	/
Strongly D.	23.7(14)	4.0(2)
No answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XVIII: The psychiatric hospital has the funtion of controlling deviance.

Degree of Agr/Disagr.	BRITAIN	ITALY
Strongly A.	/	24.0(12)
Moderately A.	18.6(11)	34.0(17)
Slightly A.	25.4(15)	10.0(5)
Slightly D.	10.2(6)	2.0(1)
Moderately D.	22.0(13)	4.0(2)
Strongly D.	22.0(13)	26.0(13)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.002

Table XIX: Psychiatric hospitals are total institutions.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	20.3(12)	66.0(33)
Moderately Agree	20.3(12)	26.0(13)
Slightly A.	30.5(18)	/
Slightly D.	3.4(2)	2.0(1)
Moderately D.	18.6(11)	2.0(1)
Strongly D.	6.8(4)	4.0(2)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XX: Psychiatric hospitals deny human dignity and individual rights.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	1.7(1)	50.0(25)
Moderately A.	25.4(15)	30.0(15)
Slightly A.	35.6(21)	8.0(4)
Sligthly D.	18.6(11)	2.0(1)
Moderately D.	11.9(7)	4.0(2)
Strongly D.	6.8(4)	6.0(3)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XVII illustrates the positions of nurses concerning the statement 'The psychiatric hospital does not have a curative function'. Italian nurses show a high level of agreement with this. By adding levels of agreement, 37.3% of British nurses agree with the statement against 92% of the Italian nurses. Even by considering the positions of 'slightly agree' and 'slightly disagree' as neutral positions or as 'neither' positions, there still are 72% of Italian nurses in agreement against 25.4% of British nurses .

Similarly, Table XVIII indicates that a higher percentage of Italian CPNs than British agree with the statement 'The psychiatric hospital has the function of controlling deviance'. None of the British nurses has chosen the position of strong agreement, and 18.6% expressed moderate agreement. The respective positions for the Italian sample are 24% and 34%. 35.6% of British nurses neither agree or disagree (slightly agree/disagree) against 12% of Italian respondents.

Psychiatric hospitals are total institutions for 92% of Italian nurses and 40.6% of British nurses; 2% of Italians are in the 'neither' position against 33.9% of British. Likewise 'Psychiatric hospitals deny human dignity and individual rights' for 80% of the Italian sample against 27.1% of nurses from the British sample, and 10% of Italian respondents are in 'neither' position against 54.2% of the British.

It is interesting to notice that comparatively more British CPNs tend to choose milder positions than their Italian colleagues, as there are consistent percentages of respondents who ranked themselves among slight agreement or disagreement and

very few among strong agreement. This may indicate that the level of conformity to these statement from the British sample is quite limited, and certainly not representative of the majority of the sample.

There is then a need to explain the reasons for these differences between the two countries. It is important to remember that the critique of hospital psychiatry was a core part of the Italian psychiatric reform. Such a critique emerged from within the professional field and found significant social support and acknowledgement. According to this ideology, psychiatric hospitals are not curative and their hidden function is that of controlling deviant behaviour in society, that is separating different and malfunctioning members from the 'normal' and conforming population. This position reflects a political and sociological interpretation of psychiatry as a discipline, and implicity acknowledges the non-objective character of the means of care chosen in a given society.

Additionally, the physical conditions of psychiatric hospitals in Italy were certainly worse than those of British hospitals which also explains the social protest against the living conditions of the patients in Italy. Interestingly, 20 years after these developments, despite the numerous problems encountered in implementing community care, (the discouraging lack of funds and political concern, as well as the under-provision of specialised and post-qualifying training,) Italian nurses still show a high committment to the cause.

Beyond nursing, these findings rather highlight the pervasive character of the philosophy of the psychiatric reform, whose contents have become a well established layer in Italian culture and identity.

My feeling during field-work was that no other reading of the situation was conceivable to Italian professionals i.e: psychiatry is perceived as eminently political and demands a political struggle. Basaglia's conceptual approach and the experiences

which followed from it have become an integral part of nurses' culture and education, which is perpetuated through the service culture and ideology and transmitted to the new generation of professionals.

This does not mean that Italian professionals approach their daily work as a crusade, or that their idealism rewards them for the actual discontent and pessimism. In fact, it will be pointed out that nurses tend to adhere to this approach whenever it has been confirmed in their practice. Hence experience rather than conceptualization seem to matter for nurses. Yet it is beyond discussion that idealism, and the creativity which came at times along with it are still a powerful driving force for Italian professionals.

In Britain the absence of a pervasive reform movement capable of mobilising social action has certainly enforced different attitudes towards deinstitutionalisation. In the professional field this has been coupled with government pressures for the closure of mental hospitals, without a garantee of adequate funds to replace care in the community. Although fathering community care much earlier than Italy, the British approach has traditionally been that of regarding community psychiatric care as the appropriate answer to a number of minor mental illnesses, and as necessary to following-up clients discharged into the community. It is only during recent years that community care came to be identified by the government as an ideal solution for the replacement of large mental hospitals, whose administration had become increasingly demanding on public expenditure. Community care has been equated by the government with a cheaper option for the provision of psychiatric care. This has included cost-cutting in the area of community provisions and mental health personnel. Professionals in the field, well aware of this strategy, have resisted these new developments. A way chosen to activate this resistance has been that of holding on to the positive functions of psychiatric hospitals, and to highlight the negative consequences of an under-financed community care.

From a cultural point of view, empiricism seems to be part of the British culture as much as idealism and philosophy are part of the Italian culture. This might be an explanation of why the Italian psychiatric reform was conceived and implemented within a ten years period, whilst in Britain psychiatric community care was started 40 years ago, and is yet to be fully implemented. On the other hand, the Italian readiness to innovate and easy enthusiasm are being faced with lack of adequate organization and structures in community work, coupled with the paucity of evaluation studies in the field.

Comparatively, it is culturally acceptable for Italian professionals to embark on innovation projects equipped only with idealism and political committment. Whereas it is less acceptable for British professionals to be involved in projects with an un-predictable outcome and lacking a clear cut definition of responsibilities and roles.

The different attitude towards psychiatric hospitals appear to be the most distinctive feature between British and Italian CPNs with respect to the political ideology of mental illness. Levels of agreement are in fact similar between the two samples for another group of statements which tackle the analysis of mental illness from a political perspective.

The following tables illustrate the case.

Table XXI: Psychiatry brings into the medical field problems which are social in nature.

Degree of Agr./Disagr.	**BRITAIN**	**ITALY**
Strongly A.	16.9(10)	20.0(10)
Moderately A.	40.7(24)	48.0(24)
Slightly A.	28.8(17)	14.0(7)
Slightly D.	8.5(5)	8.0(4)
Moderately D.	5.1(3)	4.0(2)
Strongly D.	/	6.0(3)
TOTAL	100%(59)	100%(50)

Table XXII: Mental illness represents a contradiction of the capitalist system.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	10.2(6)	14.0(7)
Moderately A.	10.2(6)	14.0(7)
Slightly A.	25.4(15)	18.0(9)
Slightly D.	10.2(6)	8.0(4)
Moderately D.	15.3(9)	26.0(13)
Strongly D.	18.6(11)	14.0(7)
No Answer	10.2(6)	6.0(3)
TOTAL	100%(59)	100%(50)

Table XXIII: Mental illness comes from social and political contradictions.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	10.0(5)
Moderately A.	16.9(10)	28.0(14)
Slightly A.	39.0(23)	30.0(15)
Slightly D.	25.4(15)	10.0(5)
Moderately D.	8.5(5)	16.0(8)
Strongly D.	5.1(3)	4.0(2)
No Answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

For all the above results the Mann-Whitney test does not demonstrate statistical significance. This means that there are no significant differences between the two samples. Both groups of respondents repeatedly show similar levels of agreement with the statements. The majority of respondents from both samples agree with the fact that 'Psychiatry brings into the medical field problems which are social in nature'. There is a higher percentage of British and Italian nurses positioned among 'moderately agree' than 'strongly agree'. 28.8% of British nurses 'slightly agree' compared to the 14% of the Italians, whereas an equal number of respondents are in slight disagreement for both Britain and Italy (8.5% and 8% respectively).

Interestingly, there is quite a low level of agreement from both samples with the statements 'Mental illness represents a contradiction of the capitalist system' and

'Mental illness is generated by social and political contradiction'. A higher degree of agreement was expected from Italian nurses, who were thought to adhere more than their British colleagues to these views. A possible interpretation of this finding is that nurses tend to strongly acknowledge a position whenever this has been met by their practice. The case of views concerning the psychiatric hospitals stated above is enlightening. Prior to the psychiatric reform the status and role of Italian psychiatric nursing within the asylum was low- mainly custodial, and higly dependent on medical directives. In addition, many of the existing psychiatric hospitals presented appalling conditions of care which could be equated to those of total institutions.

This is certainly not true in the British situation, where nurses within the hospital have been involved in active programmes of care, enjoy a respectable professional status, and have career opportunities. It is therefore not surprising that comparatively more Italian nurses strongly oppose hospital care whilst British nurses acknowledge the existence of positive functions in the institution.

Likewise, the interpretation of mental illness as a contradiction of capitalism may as well not meet nurses' experience of mental illness. It is also undeniable that knowing that mental illness springs from capitalism is of little help in every day professional practice.

An interesting result is shown in the table below. Both British and Italian nurses expressed a significant level of agreement with the statement which mainly tackles the issue of hierarchical relationships between nurses and doctors.

Table XXIV: The traditional professional hierarchy in psychiatry is a consequence of the mystification perpetrated through the psychiatric hospital.

Degree of Agr./Dis.	BRITAIN	ITALY
Strongly A.	22.0(13)	26.0(13)
Moderately A.	23.7(14)	24.0(12)
Slightly A.	32.2(19)	26.0(13)
Slightly D.	11.9(7)	6.0(3)
Moderately D.	3.4(2)	12.0(6)
Strongly D.	5.1(3)	4.0(2)
No Answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

45.7% of British respondents and 50% of the Italians are positioned between a strong and moderate degree of agreement. Percentages of slight agreement are quite high for both samples, yet more than the double compared to the levels of slight disagreement. From a qualitative point of view this finding seems to underline that although there is not a consistent and uniform agreement with the statement, both British and Italian CPNs identify some truth in it.

This is particularly interesting because the issue of professional hierarchy is linked through the statement with the role of hospital psychiatry. Whilst Italian CPNs expressed a high degree of disagreement with such a role, British respondents appeared to acknowledge the existence of positive functions in the hospital regime.

It is then thought-provoking that when the point in question is hierarchy (and implicitly doctor/nurse relationships), British nurses show a significant level of group identity by agreeing with a statement which has got an important political connotation. It appears that professional identity and group cohesion become particularly evident when the traditional ancillary nursing role is brought to the fore. It is also important to underline that British nurses seem to acknowledge the linkage between their search for an autonomous professional identity and their community role. Such a role has indeed contributed to CPNs' ability to work independently from doctors.

White (1990) observed that the increasing importance acquired by CPNs in the development of community care might challenge the medical establishment. In particular, psychiatrists are thought to be over-concerned about the autonomy gained by CPNs in community care services.

> 'The Health Advisory Service (Baker et al., 1985) recently reported, however, that some hospital consultant psychiatrists were unduly anxious about the development of community psychiatric nursing services and felt the need both to control and restrict their development. Many feared that if a CPN was not directly responsible to a consultant psychiatrist, errors would be made, inappropriate patients would be treated and resources wasted. No evidence was observed to support the claim, though the Health Advisory Service found that such anxieties frequently surfaced among consultant psychiatrists'.(White, 1990, 198).

The concern shown by psychiatrists appears to be correlated with a significant reduction of referrals from psychiatrists to community psychiatric nurses. Referrals received by CPNs from consultant psychiatrists are said to have halved over the last decade. The national survey undertaken by White shows that something less than half of community psychiatric nurses' referrals come from consultant psychiatrists, and the other 50% from GPs and other community sources. This finding is actually consistent with that from the present research, as 47% of British CPNs ranked consultant psychiatrist as their first source of referral and the other 48% ranked the GPs.

The search for an autonomous professional role becomes evident in the recent literature on British CPNs. In fact, in a fairly recent proliferation of articles, there is a significant effort towards delimiting and specifying CPN areas of professional intervention and in distinguishing the profession from others in the area, like social work.(see chapter 2)

It is important to notice that Italian CPNs showed a very similar degree of agreement to the statement, although their professional position is quite different from that of British nurses. Despite the important role performed in the implementation of community care, Italian CPNs do not have the educational requirements to stand as independent practitioners and to acquire an autonomous place in the professional market. Nevertheless it is clear that, as a consequence of the shift from hospital to community care, they have experienced a significant change in their professional role and identity.

An important additional issue of the psychiatric reform has been that of redefining professional roles in community care. Professional hierarchy within the hospital was functional to demagogic rather than caring objectives. Traditional professional roles were to be given up in favour of multidisciplinary cooperation to which no hierarchical value should be attached. To some extent, this approach was carried out in several community mental health centres in Italy (Ramon 1983). In practice, it meant that psychiatrists' approaches to care could be questioned by nurses, as much as those of nurses and any other para-medical profession. Care programmes should be set up according to multidisciplinary agreement, and no single professional could have a greater say because of his/her professional qualification. This has certainly contributed to changing the nursing role in psychiatry by enhancing professional autonomy and responsibility. It is interesting to notice that nurses interviewed would not change their psychiatric role for any other nursing specialisation, although within general nursing there are more career opportunities. It seems therefore that lack of career prospects and adequate economic rewards are to a certain extent, compensated by the professional freedom ejoyed by Italian nurses in their community role. Similarly to their British colleagues, the relationship with the medical profession appears to be a core issue within professional experience.

6.3. The social ideology of mental health.

The protagonist of social ideology views mental illness as an eminently social phenomenon. The causes of mental illness, its treatment, the place of care, and the expertise necessary to provide this care are socially based. In ideal-type terms, the social ideology can be as radical towards traditional psychiatry as is the political ideology of mental illness. The framework of care is shifted from the clinical to the social field. In practice, the development of community care has enforced the social approach in psychiatry without necessarily replacing the medical treatment tout-court. The administration of drugs, for instance, often parallels the analysis of social factors in community treatment. The social approach tends to be considered as complementary to the clinical attention which mental illness demands.

The investigation of nurses' committment to the social ideology of mental illness presents interesting considerations. From an educational perspective, nursing is an occupation which has emerged and has been for long nurtured within the medical field. Nurses have traditionally been the executive arm of doctors both in general medicine and in psychiatry. Recent developments in community nursing have modified the relationship of the profession with medicine. This thesis is based on the hypothesis that community care has created the opportunity for nurses to become an independent profession as a consequence of the autonomy gained from the medical class. In order to achieve a better professional status, it is therefore expected that nurses will elaborate their own unique body of professional knowledge. One of the directions towards which this new expertise could be oriented is social.

On the other hand, nurses need to be careful in promoting their independence without invading other professional fields. The clearest example is that of social work, whose theoretical foundation is eminently social.

The relationship between training and practice is again at stake. Community practice urges nurses to evolve towards different, more socially- and psychologically-oriented, educational models. The ENB community psychiatric nursing training course in Britain demonstrates that this need is actually experienced by nurses. The challenge seems to be that of identifying a core of professional knowledge which needs to be both sufficiently detached from the medical field as to guarantee independence, and still sufficiently-clinically based so as to avoid overlapping with other occupations such as social work.

Community care requires hospital-based nursing competences to be modified. Professional resistance to the implementation of community care emerges whenever a threat is perceived to the professional expertise without a guarantee that a new body of knowledge could replace the existing occupational status.

Concerning the social ideology of mental illness, it is hypothized that the more structured the education received by nurses, the stronger should be the resistance to socially oriented care models when adequate training is not provided. Comparatively, British nurses are more likely to be resistent than their Italian colleagues, due to the longer and more structured education received. In terms of professionalisation this might be a contradiction in terms. If nurses need to evolve towards social practices in order to maintain and increase their independence from the medical class, it could be counter-productive to resist the new practices.

The analysis of the findings shows that there is a trend in nurses' answers to agree with the social approach. Interestingly, both groups disagree whenever the profession of nursing seems to be endangered by the content of some statements, whose consequences might be that of de-professionalisation.

British and Italian nurses have instead different opinions about the role of psychiatric hospitals as it has been expressed through the social ideology of mental illness. The case is very similar to that outlined in relation to political ideology. Unlike their Italian

colleagues, British nurses do not have radically negative attitudes towards the functions of psychiatric hospitals. The four tables below illustrate the comparison. For three out of the four the difference between the two groups has proved to be significant, as tested by the Mann-Whitney test.

Table XXV: The psychiatric hospital impairs mental health.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	48.0(24)
Moderately A.	22.0(13)	32.0(16)
Slightly A.	39.0(23)	2.0(1)
Slightly D.	13.6(8)	6.0(3)
Moderately D.	18.6(11)	10.0(5)
Strongly D.	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XXVI: Psychiatric hospitals must shut down.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	1.7(1)	66.0(33)
Moderately A.	15.3(9)	16.0(8)
Slightly A.	8.5(5)	6.0(3)
Slightly D.	11.9(7)	4.0(2)
Moderately D.	32.2(19)	2.0(1)
Strongly D.	30.5(18)	6.0(3)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XXVII: The only function of psychiatric hospitals is custodial.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	/	44.0(22)
Moderately A.	1.7(1)	28.0(14)
Slightly A.	11.9(7)	8.0(4)
Slightly D.	15.3(9)	4.0(2)
Moderately D.	23.7(14)	8.0(4)
Strongly D.	47.5(28)	8.0(4)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XXVIII: Chronicity is a consequence of the hospital system.

Degree of Agr./Disgr.	BRITAIN	ITALY
Strongly A.	6.8(4)	26.0(13)
Moderately A.	35.6(21)	36.0(18)
Slightly A.	32.2(19)	12.0(6)
Slightly D.	10.2(6)	10.0(5)
Moderately D.	11.9(7)	6.0(3)
Strongly D.	1.7(1)	10.0(5)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

The degree of disagreement for British nurses seems to vary according to the intensity of the critique of hospital's functions expressed through the statements: the more radical the statements, the lower the level of agreement.

The majority of British respondents agree that 'psychiatric hospitals impair mental health'. But nearly 40% of them only expressed slight agreement, whereas 48% of the Italian sample strongly agree.

There is an even clearer difference in the answers as to whether 'psychiatric hospitals must shut down'. Positions are here neat: British nurses disagree and Italians agree. Coherently, British nurses do not think that 'the only function of psychiatric hospitals is custodial', whereas Italian CPNs support this thesis highly.

A controversial finding is shown in table XXVIII. Both groups generally adhere to the opinion that 'chronicity is a consequence of the hospital system'. The inter-level comparison shows that 26% of the Italians and 6.8% of the British strongly agree whereas 36% and 35.6% respectively are moderately in agreement. The total of agreement for these two levels is 62% for the Italian sample and 42.4% for the British sample. 42.4% of British respondents and 22% of the Italian are in 'neither' position (slight agreement/disagreement).

To some exent such data are unexpected for both groups. Comparing these answers with those from the above three tables, the expectation would have been a stronger

support from Italian CPNs and a milder support from the British. In part this statement is slightly different from the others, in that it is less about principles and more about practice. Clients' chronicity is possibly experienced daily by CPNs interviewed.

Especially for Italian nurses it may by now be clear that an ill-financed community care can lead to chronicity, too. British nurses, on the other hand, seem to acknowledge the existence of both positive and negative functions of psychiatric hospitals. They are certainly against such a closure, and do not support in full the belief that hospitals impair mental health or that their only function is custodial. Yet they acknowledge that psychiatric hospitals may cause chronicity. Again the message from British CPNs seems to be that both hospital and community care are necessary, and that an incorrect use of hospital structures may produce chronicity.

In this case, as in that of the political ideology of mental illness, the different attitudes observed between the two groups about psychiatric hospitals need to be linked with historical, political, and cultural factors. It may be useful to anticipate that throughout the analysis of ideologies, the role and function of psychiatric hospitals will repeatedly be the threshold between British and Italian nurses' positions.

The two following tables provide a thought-provoking comparison between nurses'approaches in the two countries. The content of statements is apparently similar: 'mental illness has got social origins' and 'mental illness is a social matter'. Nevertheless nurses' answers differed.

Table XXIX: Mental illness has got social origins.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	33.9(20)	26.0(13)
Moderately A.	37.3(22)	48.0(24)
Slightly A.	22.0(13)	6.0(3)
Slightly D.	3.4(2)	4.0(2)
Moderately D.	1.7(1)	6.0(3)
Strongly D.	1.7(1)	8.0(4)
No Answer	/	2.0(1)
TOTAL	100%(59)	100%(50)

Table XXX: Mental illness is a social matter.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	10.2(6)	18.0(9)
Moderately A.	28.8(17)	56.0(28)
Slightly A.	25.4(15)	16.0(8)
Slightly D.	15.3(9)	8.0(4)
Moderately D.	11.9(7)	/
Strongly D.	8.5(5)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

The majority of both British and Italian respondents agree that the origins of mental illness are social (Table XXIX). Testing with Mann-Whitney proved that there is no significant difference between the answers from the two samples. Conversely, Table XXX illustrates divergent positions. When faced with statement 'Mental illness is a social matter', 74% of Italian nurses express a strong or moderate level of agreement against 39% of their British colleagues. 40.7% of British nurses and 24.2% of the Italian are in the 'neither' positions (slight agree/disagree). There is a considerable statistical difference between the two groups.

There are several possible explanations concerning this divergence. It seems to the author that differences between the two samples are produced by a diversity between the self-perceived professional role and identity in Britain and Italy.

To assume that mental illness has social origins may imply an acknowledgement of the sociological components of the phenomenon. To some extent this is also part of the

general philosophy about community care, and the 'normalisation' or 'social role valorisation' approaches are certainly based conceptually on similar assumptions. Both British and Italian CPNs seem to embrace this approach.

On the other hand, to acknowledge that mental illness is a social matter may carry different implications for the professional role. Such an assumption omits the clinical components of the phenomenon, as well as the psychological. For British nurses this would mean a rejection of a considerable part of their professional education, while at the same time it would emphasise social intervertions whose expertise is a legacy of social work.

The professional identity of Italian CPNs, on the other hand, has got significant social linkages. In most cases training received during courses for registered nurses has been rejected because it is hardly (or not at all) pertinent to community work. Training provided within community mental health centres is instead prevailingly socially oriented. By assuming that mental illness is a social matter Italian nurses do not betray their professional identity, but in fact acknowledge it.

The difference in the self-perceived professional identity between British and Italian nurses does not prevent either of the groups from taking the challenge and the opportunity which community care represents for the profession. Table XXXI well illustrates the case. There is no significant statistical difference between the two samples, and both groups agree that psychiatric nursing can have a therapeutic role because of community care.

Tables XXXII and XXXIII indicate other convergencies between British and Italian answers. Both groups show a high level of disagreement with the fact that 'everybody can cope with mental illness without the support of professional training'. The degree of agreement is quite low also for the statement 'a commonse approach is one of the best answers to mental illness'. In this latter case, the inter-level comparison highlights that levels of disagreement are higher for British nurses than for Italians, although not so higher as to represent a significant statistical difference.

It is interesting to note that, although stemming from different professional identities, both British and Italian CPNs show awareness of their professionalism and defend it from genericism.

Table XXXI: Psychiatric nursing in the community has got the chance to become an eminent social and therapeutic professional role.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	52.5(31)	42.0(21)
Moderately A.	32.2(19)	40.0(20)
Slightly A.	6.8(4)	14.0(7)
Slightly D.	5.1(3)	2.0(1)
No Answer	3.4(2)	2.0(1)
TOTAL	100%(59)	100%(50)

Table XXXII: Everybody can learn to cope with mentally distressed people without the support of professional training.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	6.8(4)	6.0(3)
Moderately A.	13.6(8)	10.0(5)
Slightly A.	18.6(11)	20.0(10)
Slightly D.	11.9(7)	10.0(5)
Moderately D.	28.8(17)	22.0(11)
Strongly D.	20.3(12)	32.0(16)
TOTAL	100%(59)	100%(50)

Table XXXIII: A commonse approach is one of the best answers to mental illness.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	14.0(7)
Moderately A.	25.4(15)	36.0(18)
Slightly A.	42.4(25)	20.0(10)
Slightly D.	8.5(5)	12.0(6)
Moderately D.	13.6(8)	12.0(6)
Strongly D.	6.8(4)	4.0(2)
No answer	/	2.0(1)
TOTAL	100%(59)	100%(50)

There is an interesting difference between British and Italian responses illustrated in Table XXXIV. Italian CPNs express a low level of agreement with the statement 'Professionals in the community must be on the same footing as clients'. To some extent this is an unexpected finding.

In Italy relationships between professionals and clients develop on a fairly informal basis. Because of the way teams are organized, contacts with clients usually go beyond the administration of treatment (either therapeutic interviews or giving injections). Clients spend a long part of the day with professionals, eat together, have parties together, go to movies, and sometimes also have holidays together. This is actually considered part of the intervention.

The intervention style of nurses interviewed within this study, is no exception to this philosophy of work. This is why the finding is unexpected. But again the explanation of this disagreement may relate to the issue of professional identity. It might in fact be a defensive attitude which aims at re-establishing the existence of professional competences which set boundaries between nurses and clients: it is a defence against genericism.

Compared with their British colleagues, Italian nurses do not have an externally acknowledged professional status and identity. Those who have been trained as registered nurses need to undertake further training in the community. Registered nursing training does not take into consideration community work, neither general community work nor specifically in mental health. Moreover, there are also nurses who do not have any formally recognised nursing training, who have been trained on an ad-hoc basis while already working. All nurses are called 'operatori' (workers) so that even their qualification does not acknowledge a specific expertise. Nurses themselves do not feel nurses any more, yet they do not have a substitute profession to identify with.

Nevertheless an expertise does exist, which has been progressively built thorough experience and on-going community training.

There are both positive and negative consequences coming from this situation. On the one hand nurses feel proud of their know-how because it has been independently built, grants autonomy and individuality in intervention styles, and is relatively free from medical interference.
On the other hand, nurses do not feel protected as a professional category because there is no legal definition of their expertise which identifies a specific professional capacity. It is necessary to remember that the adjective 'psychiatric' has been erased by the national legislation on nursing, so that psychiatric nursing is legally assimilated within general nursing although these types of nursing have little in common.

The situation is certainly different for British CPNs. Their training is specifically focused on psychiatry. Both RMN training and CPN training provide an expertise and a professional status which identify a profession: psychiatric nursing. To be on the same footing as clients may not imply to being un-professional, but entails the use of professional knowledge in the service of clients in a progressive and professionally un-dogmatic way.
There are positive and negative aspects of this situation too. On the one hand, British CPNs do not have to face a crisis in their professional identity as is the case for their Italian colleagues. They do have a profession to identify with, and also have associations like the CPNA (Community Psychiatric Nursing Association) which have enough strength on the labour market with which to defend the category. On the other hand, the experience of structured and lengthy training, partly hospital based, makes British nurses more resistant to change.

This seems to be the case illustrated in Table XXXV which says 'traditional professional competences are useless in community work'.
There is in fact a significant difference between British and Italian nurses' positions. Here levels of agreement are not high for either sample, yet they are comparatively lower in the British case. The total level of agreement for British respondents is

25.4%, and 16.9% of nurses are positioned at 'slight agreement'. In the Italian case,about half the sample agree with the statement (54%), and 14% of respondents only slightly agree.

It seems clear that British CPNs are more interested than the Italians in retaining traditional competences. Possibly this is because they fear the loss of some of their professionality, which has been partially built on traditional competences.

That this is a defensive mechanism seems to be demonstrated by answers shown in Table XXXVI :' professionals in the community must reject their traditional roles'. British nurses, like the Italians, show a general level of agreement with the statement which would confirm that they are interested in innovating their professional role, although they fear the loss of the known. In a way, British professionals seem to be more aware than the Italians of the danger which change might produce for their professional identity and status.

Table XXXIV: Professionals in the community must be on the same footing as clients.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	20.3(12)	8.0(4)
Moderately A.	28.8(17)	18.0(9)
Slightly A.	20.3(12)	14.0(7)
Slightly D.	13.6(8)	12.0(6)
Moderately D.	6.8(4)	22.0(11)
Strongly D.	6.8(4)	24.0(12)
No answer	3.4(2)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XXXV: Traditional professional competences are useless in community work.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	14.0(7)
Moderately A.	3.4(2)	26.0(13)
Slightly A.	16.9(10)	14.0(7)
Slightly D.	13.6(8)	16.0(8)
Moderately D.	35.6(21)	24.0(12)
Strongly D.	23.7(14)	6.0(3)
No answer	1.7(1)	/
Total	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XXXVI: Professionals in the community must reject their traditional roles.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	16.8(10)	26.0(13)
Moderately A.	33.8(20)	46.0(23)
Slightly A.	16.8(10)	12.0(6)
Slightly D.	13.9(8)	8.0(4)
Moderately D.	8.5(5)	6.0(3)
Strongly D.	5.1(3)	2.0(1)
No asnwer	5.1(3)	/
TOTAL	100%(59)	100%(50)

The strength of training in shaping professional identities is also shown in Table XXXVII :'psychiatric nursing in the hospital has a custodial function'. There is a statistically significant difference between the two samples.

This is a particularly interesting case because it combines British attitudes towards hospitals with the issue of professional education, which is central to this discussion. In line with their position on psychiatric hospitals, British CPNs do not think that hospital-based psychiatric nursing can only be custodial. Once again there is a neat difference between British and Italian attitudes towards traditional psychiatry. Italian nurses tend to break with the past quite radically, whereas British nurses assume a milder position. They are both interested in their new community role and in retaining what they consider good of their past hospital work.

Part of the explanation is certainly that the British nursing role has been professionally shaped within hospitals. In the Italian case, nurses did not feel that they had a professional role in hospitals, apart from guarding patients. In contrast, they feel that they have a role in the community, although its professional boundaries are loose and its status ill-defined.

Table XXXVII: Psychiatric nursing in the hospital has a custodial function.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	8.5(5)	42.0(21)
Moderately A.	35.6(21)	38.0(19)
Slightly A.	33.9(20)	10.0(5)
Slightly D.	5.1(3)	/
Moderately D.	10.2(6)	2.0(1)
Strongly D.	6.8(4)	8.0(4)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Psychiatrists' competences are still useful in community care both for British and Italian CPNs (Table XXXVIII). This confirms that there is an interest among both groups in demarcating lines of professional competences and intervention. This also seems to be directed towards the affirmation of inter-professional differences, therefore of a specific nursing identity.(see also Table XXXIX on multidisciplinary work).

British nurses belong to a professional environment where competences are well defined and separated among professional specialisations. Furthermore, psychiatrists do perform a different role in the community than nurses.

In Italy there is a less clear definition of both psychiatrist's and nurse's competences. It often happens that they both engage in similar activities. Informally nurses are allowed to change clients' medication as much as consultant psychiatrists are. The first interview with a client and a consequent diagnosis and prognosis are often carried out

within a multidisciplinary setting where each profession has an equal say. There is just one significant task which is not shared by the psychiatrist consultant with anybody else, namely supervision. In each of the teams investigated, the consultant psychiatrist performs this task. It is important to remember that supervision is not a formally defined area, instead it is carried out during the frequent team meetings which characterize the organization of Italian mental health centres. In most of the mental health centres in which the research has been carried out, the psychiatrists happened also to overlap with the charismatic leader of the team. In this sense, the psychiatrist is not only useful but essential.

Table XXXVIII: Psychiatrists' competences are useless in the community.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	16.0(8)
Moderately A.	8.5(5)	4.0(2)
Slightly A.	6.8(4)	/
Slightly D.	20.3(12)	12.0(6)
Moderately D.	35.6(21)	40.0(20)
Strongly D.	25.4(15)	28.0(14)
TOTAL	100%(59)	100%(50)

Table XXXIX: Multidisciplinary work is the basis of community care.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	64.4(38)	56.0(28)
Moderately A.	28.8(17)	28.0(14)
Slightly A.	6.8(4)	12.0(6)
Slightly D.	/	/
Moderately D.	/	2.0(1)
Strongly D.	/	2.0(1)
TOTAL	100%(59)	100%(50)

Finally, both British and Italian nurses attach a therapeutic value to the community (Table XL). More than half of both samples are positioned between the levels of 'strong ' and 'moderate' agreement. 33.8% of British respondents and 22% of

the Italians are among the 'neither' positions (slight agreement/disagreement). A realistic interpretation of these answers could be that both groups are pro-community care, although they do not think that the community without professional support can provide a good enough response to mental illness.

Table XL: The community is in itself therapeutic.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	28.8(17)	24.0(12)
Moderately A.	30.5(18)	40.0(20)
Slightly A.	15.3(9)	12.0(6)
Slightly D.	8.5(5)	10.0(5)
Moderately D.	8.5(5)	12.0(6)
Strongly D.	6.8(4)	2.0(1)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

6.4. The biological ideology of mental health.

According to the follower of this approach mental illness is a biological phenomenon. Biochemical imbalances are responsible for mental distress, and psychological or social interpretations are left apart within this 'ideal type' view. The unmbalance is modified through drugs, which are meant to provide the chemical adjustments able to repair the damage. Because social or psychological conditions are not thought to be of primary importance, the ideal place of care is the hospital rather than the community, where mental illness can be controlled and studied. Patients, whose disease has made them unable to decide upon their own life, need to be guided and watched for their's and society's safety.

Overall, British and Italian CPNs have shown a very low degree of conformity with this approach. Yet, for some statements focusing on the role of psychiatric hospital, British nurses expressed a higher level of agreement than their Italian colleagues. As has been commented on above, it does not seem to be part of the British psychiatric nursing culture to hold as critical a view about psychiatric hospitals as it is for the Italians. The British professional identity, shaped within the hospital environment by means of lengthy and structured training programmes, partly explains this different attitude.

Nevertheless, the high degree of agreement given by the British sample to a statement which carries a strong biological weight (ECT is a useful remedy for some kind of illnesses), is meaningful of a position towards mental illness that expresses significant differences from that of Italian nurses.

The following tables illustrate this comparison. Statistical testing with the Mann-Withney test proved to be significant for some of these comparisons. This means that there are significant differences between the inter-level comparison of the two samples. In particular, Tables XLI, XLII, XLIII, XLV and XLVI show that Italian respondents have more extreme positions, in that half or more of the sample are positioned at the level of strong agreement. In the British case the distribution appears

to be more heterogeneous, with some peaks at the levels of slight agreement/moderate disagreement.

Table XLI: Psychiatric hospitals are the suitable place in which to cure mental illness.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	8.0(4)
Moderately A.	15.3(9)	8.0(4)
Slightly A.	33.9(20)	/
Slightly D.	6.8(4)	8.0(4)
Moderately D.	23.7(14)	24.0(12)
Strongly D.	10.2(6)	52.0(26)
No answer	5.1(3)	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XLII: Psychiatric hospital regulations aim at respecting clients' rights.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	13.6(8)	4.0(2)
Moderately A.	33.9(20)	8.0(4)
Slightly A.	22.0(13)	8.0(4)
Slightly D.	16.9(10)	2.0(1)
Moderately D.	10.2(6)	22.0(11)
Strongly D.	3.4(2)	56.0(28)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XLIII: Psychiatric hospitals provide the tranquillity needed to mentally distressed people.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	2.0(1)
Moderately A.	25.4(15)	8.0(4)
Slightly A.	49.1(29)	16.0(8)
Slightly D.	11.9(7)	8.0(4)
Moderately D.	8.5(5)	28.0(14)
Strongly D.	1.7(1)	38.0(19)
TOTAL	59(100%)	50(100%)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XLIV: In the psychiatric hospital mental illness can be controlled and studied.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	6.0(3)
Moderatley A.	15.3(9)	22.0(11)
Slightly A.	22.0(13)	6.0(3)
Slighlty D.	11.9(7)	16.0(8)
Moderately D.	30.5(18)	28.0(14)
Strongly D.	13.6(8)	22.0(11)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

Table XLV: The psychiatric hospital is a place for clients to freely express themselves.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	2.0(1)
Moderately A.	22.0(13)	6.0(3)
Slightly A.	22.0(13)	2.0(1)
Slighlty D.	20.3(12)	6.0(3)
Moderately D.	15.3(9)	22.0(11)
Strongly D.	15.3(9)	62.0(31)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table XLVI: ECT is a useful remedy for some kinds of illness.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	30.5(18)	2.0(1)
Moderately A.	33.9(20)	6.0(3)
Slightly A.	27.1(16)	/
Slightly D.	1.7(1)	6.0(3)
Moderately D.	5.1(3)	6.0(3)
Strongly D.	1.7(1)	80.0(40)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

In Italy the objection to ECT treatment is often identified with the psychiatric reform. Its abolition, together with the running down of asylums represented the end of a regime of violence based on the denial of individual freedom and dignity. ECT was strongly opposed even prior to the reform period, and nowadays it is believed to

be used only in private institutions. Among Italian professionals there is a generalised disbelief in the curative effects of ECT treatment, and it is mainly regarded as a violent method to control and sedate the person.

As shown in the table above, the position of British CPNs strongly opposes that of Italians. It is evident that neither ECT nor the psychiatric hospital represent violence and repression in Britain. Once again this comparison highlights perhaps one of the most important differences between Italian and British community care movements. In Britain community care is believed to be a better answer to mental illness, in Italy it is pursued as the only possible answer to mental illness. In Britain the psychiatric hospital is regarded as being potentially, if not actually, good for the care of mentally distressed people. In Italy there is a widespread belief in the opposite. Positively connotated answers from the British sample about community care should then always be interpreted as expressing an opinion about what is the best care option, which does not exclude a consideration of the hospital system as a good option. In contrast, Italian CPNs generally reinforce the connotation given to the positive elements attached to community care against hospital care.

The following table shows a low level of conformity from both samples towards the use of mechanical constraints for the care of mental illness. This confirms that ECT is not considered by British CPNs a mechanical constraint.

Table XLVII: Mechanical constraints are useful for some kinds of illnesses.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	1.7(1)	8.0(4)
Moderately A.	5.1(3)	6.0(3)
Slightly A.	8.5(5)	8.0(4)
Slightly D.	8.5(5)	6.0(3)
Moderately D.	10.2(6)	24.0(12)
Strongly D.	66.1(39)	48.0(24)
TOTAL	100%(59)	100%(50)

The next charts focus on the origins of mental distress. Both British and Italian nurses manifested a low grade of agreement with the statements, although this is more evident in the Italian than in the British sample. The interlevel comparisom shows that there are significant differences between groups which again indicate more moderate positions for the British sample.

Table XLVIII: Mental illness represents an impairment in the neurological system.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	1.7(1)	2.0(1)
Moderately A.	10.2(6)	16.0(8)
Slightly A.	25.4(15)	10.0(5)
Slightly D.	11.9(7)	8.0(4)
Moderately D.	35.6(21)	20.0(10)
Strongly D.	15.3(9)	44.0(22)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.041

Table XLIX: Schizophrenia is hereditary in character.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	4.0(2)
Moderately A.	13.6(8)	10.0(5)
Slightly A.	30.5(18)	6.0(3)
Slightly D.	13.6(8)	10.0(5)
Moderatelt D.	23.7(14)	26.0(13)
Strongly D.	13.6(8)	42.0(21)
No answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table L: Madness has got biochemical causes.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	/	/
Moderately A.	8.5(5)	6.0(3)
Slightly A.	33.9(20)	20.0(10)
Slightly D.	15.3(9)	12.0(6)
Moderately D.	22.0(13)	12.0(6)
Strongly D.	20.3(12)	46.0(23)
No answer	/	4.0(2)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.013

In all of the three tables presented above, Italian CPNs have shown a higher degree of strong disagreement with the statement than their British colleagues. Whilst a small minority of Italian nurses expressed levels of conformity to the statements, something less than half of British nurses agreed with them. Throughout the analysis of ideological approaches to mental illness, it emerges that whereas Italian nurses tend to be more keen on giving social and psychological explanations to mental illness, British nurses tend to consider any point of view as part of the overall explanation.

Yet there is an interesting similarity between the two groups about the statement 'Madness has biological causes'. Both British and Italian respondents scored quite high at the level of slight agreement/disagreement. Whilst this has been recurrent for the British sample, it looks like a new development for the Italian.

In the British case the higher propensity towards biological explanations of the phenomenon may be both due to the type of training undertaken, and to the general philosophy characterising psychiatric care in Britain. Such philosophy tends to value social, psychological as well as biological explanations of mental illness without particularly stressing one element against another. This consideration comes from my experience of British psychiatry as compared to the Italian, where opinions tend to polarise much more than in Britain. In a way, my personal feeling is that ideology is much more visible in Italy than in Britain, because it is identifiable in a dominant approach and belonging to a definite group i.e Psichiatria Democratica. That 32% Italian nurses expressed slight agreement/disagreement about the supposed biological

causes of mental illness surprises as not fitting within this permeating ideological framework. Above all, because significant levels of disagreement have been expressed for the two previous statements.

The hypothetical explanation might be that when it comes to be judgemental about causes, openly expressed and defined as such, Italian nurses feel less confident. When one's working experience cannot elucidate on the matter, then professional knowledge should provide the necessary information to support or to discard the issue. For instance, that schizophrenia is not hereditary might be experienced through practice, apart from being an ideological conviction. The issue might be that Italian nursing professional knowledge fails in providing the necessary information for being judgmental. If this hypothesis were to be true, this would highlight a break in nurses move towards professionalisation. It does not matter from which position, nurses should be able to justify their ideology by means of practice and theory. It would seem that British nurses are potentially better-equipped in this than their Italian colleagues.

The same hypothetical explanation cannot be applied to the following tables, which illustrate nurses attitudes towards drug administration. Interestingly, positions between samples are here inverted with Italian respondents expressing milder positions that the British.

Table LI: Psychiatric patients always need medication.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	/	2.0(1)
Moderately A.	1.7(1)	12.0(6)
Slightly A.	1.7(1)	22.0(11)
Slightly D.	8.5(5)	26.0(13)
Moderately D.	25.4(15)	20.0(10)
Strongly D.	62.7(37)	18.0(9)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Table LII: Patients should never take medication by themselves.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	1.7(1)	2.0(1)
Moderately A.	/	4.0(2)
Slightly A.	1.7(1)	12.0(6)
Slightly D.	5.1(3)	6.0(3)
Moderately D.	18.6(11)	40.0(20)
Strongly D.	72.9(43)	36.0(18)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

It is interesting to notice that in the above two tables Italian CPNs show a higher degree of agreement with the statements, although the majority disagrees with them, as in the British sample. This result may reflect the difference outlined in Table IVa about long term mentally ill clients on nurses' caseloads. It has been highlighted that the number of long term mentally ill clients accounts for 86% of the Italian CPNs caseload, against 51% of the British group. It can be assumed that the issue of medication will acquire a greater importance in the Italian case as compared to the British, since long term mentally ill clients do normally require more medication than 'worried well' clients.

The nurse distributing depot injections as his/her main role appears to be among the stereotypes on both British and Italian CPNs. There is indication in nursing literature (Davies,P. 1991; Crossfield,T. 1990) about CPNs' concern on long acting

medication, specifically used with continued care clients. It is highlighted that even the simple role of giving depot medication can be a tiresome and skilled job because of the clients to whom this is addressed. Long-term mentally ill clients are not always positive about their monthly injection. Thus CPNs have to go beyond being the deliverers of drugs to establish important therapeutic links with clients and families. It is therefore understandable that CPNs tend to implement clients' self-drug administration (with the client groups where this is feasible), because the stereotype of the nurse as a deliverer of medication is among the most symbolic of an executive rather than therapeutic nursing role, which is often attributed to nurses by their very same professional environment.

The following three charts show a significant similarity between British and Italian positions about the relationship between carers and mentally ill people. Levels of agreement are quite elevated for both groups, although there are high scores at the positions of slight agreement in tables LIII and LIV. This seems to express the experience of nurses in both countries, together with care towards the potential stigma that these statements could generate. Nurses express the possibility that mentally ill people may impair family life, and may be dangerous, but also that there is much more to being mentally ill to focus only on these possibilities.

Table LIII: Mentally ill people impair family life.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	6.8(4)	16.0(8)
Moderately A.	33.9(20)	30.0(15)
Slightly A.	30.5(18)	26.0(13)
Slightly D.	6.8(4)	14.0(7)
Moderately D.	11.9(7)	6.0(3)
Strongly D.	10.2(6)	8.0(4)
TOTAL	100%(59)	100%(50)

Table LIV: Mentally ill people can be dangerous.

Degree of Agr./Disag.	BRITAIN	ITALY
Strongly A.	6.8(4)	8.0(4)
Moderately A.	22.0(13)	32.0(16)
Slightly A.	44.1(26)	34.0(17)
Slightly D.	5.1(3)	8.0(4)
Moderately D.	11.9(7)	12.0(6)
Strongly D.	10.2(6)	6.0(3)
TOTAL	100%(59)	100%(50)

Table LV: Unskilled people, like friends and relatives, cannot properly cope with mentally distressed people.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	2.0(1)
Moderately A.	6.8(4)	14.0(7)
Slightly A.	1.6(1)	14.0(7)
Slightly D.	15.2(9)	14.0(7)
Moderately D.	30.4(18)	38.0(19)
Strongly D.	39.3(23)	18.0(9)
No answer	3.4(2)	/
TOTAL	100%(59)	100%(50)

Both British and Italian CPNs are concerned about the level of distress which can raise by living with mentally ill people. Nevertheless, they are positively convinced that friends and relatives can cope with mental illness. The underlining assumption seems to be that carers need to be trained to do so.

This is particularly interesting as the literature on CPNs often stresses the role of community psychiatric nurses in dealing with prevention. The relationship between CPNs, clients and carers indicates a role for CPNs in each of the three areas of prevention listed by Caplan. In this case, primary prevention, should aim at reducing the risk of impairing the client's family mental health, by adopting and teaching to relatives adequate coping strategies. Secondary prevention focuses on the prevention of long term problems for the at risk population. Tertiary prevention is the area where CPNs from both samples, and particularly Italian CPNs, are mostly involved. It is about reducing secondary impairments due to institutionalisation and about rehabilitation. It therefore includes the family environment and society at large.

The role of CPNs with carers has been analysed in the literature from different perspectives. Since the samples of this research include nurses working with all the range of client groups, it is worthwhile to briefly review the most significant contributions in the field. Simmons and Brooker (1986) analyse the potential of CPN intervention while acting as a link agent between the client and the family. By regarding the family as a systemic entity, a role for CPNs is identified in entering the system as an external unit thus modifying the actual pathologic mechanisms of interaction.

> '...if a CPN were to suggest family meetings he or she might find that these meetings were the only time that the family communicated together at all. At the other extreme, many CPNs will be familiar with families in which family members appear very involved with each other...in such enmeshed families the CPNs' work might aim to help reduce the family's over-involvement and allow individual members to become somewhat more separate.(Simmons and Brooker, 1986, 70)

It is also underlined that family burden is likely to be higher when a family member has had psychotic episodes or suffers from long-term mental health problems, rather than from milder illnesses. In the latter case, the role for CPN is focused on the adoption of counselling skills.

Pollock (1989) describes two approaches with respect to CPNs relationships with carers, which can be traced back as far as with the two first CPN units set up in the United Kingdom. At Warlingham Park Hospital CPNs were acting in close contact with the consultant psychiatrist, and they were not expected to undertake intervention which would take into account all aspects of care holistically. On the contrary, at Moorhaven Hospital the care approach acknowledged the CPNs' potential caring role in the family setting. According to Pollock, these two approaches

reflect the medical and the social models of care respectively. The relatives' active involvement in the therapeutic process is also more likely to develop after the transition of the care setting from the hospital to the community.

In this respect, it is important remember that the great majority of both British and Italian nurses practice home visiting, and that 'speaking with relatives' is the activity which scored the second highest modal value for both British and Italian CPNs after 'speaking with clients'.

Brooker and other contributors (Brooker 1990; Brooker and Butterworth 1991, Brooker et al. 1992) focus on the role of CPNs working with families caring for a relative with schizophrenia. An experimental group of CPNs was trained to act as health educators with families caring for schizophrenic relatives. The research assumption was that families with high levels of expressed emotion could be taught to understand and cope with the symptoms of schizophrenia, thus shifting the focus from the sufferer as the intelligent agent of the symptoms to the illness and its symptoms, typically beyond the sufferer's control. The results show that CPNs intervention succeded in lowering the level of expressed emotion, hence pointing out a role for CPNs' psycho-social interventions in health care.

Matthew (1990) analyses the potentiality for CPNs to work with families caring for relatives who suffer from dementia. Her survey highlights a lack of nursing support to carers, and calls for a better planning of CPNs interventions in accordance with both carers and clients. A need for moving away from medically centred approaches, typical of the nursing model, is stressed in order to develop strategies of care adequate to the community care setting. Matthew also accepts Pollock's remark (1989) about CPNs lack of support to carers, unless they consider it useful for clients or for their management. As already pointed out, Pollock assumes that CPNs still

work with a medically centred approach which often does not take into account the psychosocial level of intervention.

It is important to underline that the literature (apart from the articles on CPNs psychosocial intervention with carers of clients suffering from schizophrenia) focuses on what is thought to be the ideal CPN intervention with carers, and how this will need to differentiate according to different client groups. Emphasis is put on what is desiderable rather that on the present situation. The research presented by Brooker and other contributors points out positive results about CPNs intervention with a particular client group and their relatives. CPNs in this case had been trained to perform psychosocial intervention, and the research focused on the evaluation of training outcome. Yet, it is necessary to remember that the group of CPNs who successfully carried out the psychosocial intervention with carers, was dealing only with this aspect of care. One wonders what happens when CPNs deal with their daily caseloads and carers training is included as part of the care package. A reasonable answer to this question is that either CPNs' caseloads should be small, or it is not feasible to expect the carers needs to be taken into account as much as the clients' needs. This assumption does not deny the importance of a holistic care approach, where the client's family environment is considered as the locus of care. It rather points out a need for setting up priorities of care. Ideally, there should be provision for every aspect of care, from the carers' involvement to that of society's. From a practical point of view, CPNs deal with the daily needs of the person. It is therefore understandable that carers' needs are considered mainly when these are of concern for the client as well. Furthermore, I agree with the comment that the majority of CPNs - included those in my sample - have had a medically focused training and not a social one. Traditionally, the nurse is seen as the 'maid' of patients, and training programmes do not take into account the carers role. It is likely that this perception is partially retained within the CPN culture, and it appears to be confirmed by data from both the British and the Italian samples.

Some interesting data are illustrated in the two tables below. The results show that nurses from both samples acknowledge the psychiatrist's specific competence in diagnosing patients. Yet, they do not accept that nurses are not competent to carry out the same function. This is a paradox significant of the actual crisis in nursing identity after the shift to community care. Interlevel comparison indicates that there is a significant difference between the two groups. Italian CPNs appear less convinced of their diagnostic ability than their British colleagues. This is yet another example of differences between the self-perceived professional identity in the two samples.

Table LVI: Psychiatrists are appointed to diagnose patients.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	18.6(11)	24.0(12)
Moderately A.	37.3(22)	30.0(15)
Slightly A.	20.3(12)	22.0(11)
Slightly D.	6.8(4)	8.0(4)
Moderately D.	6.8(4)	8.0(4)
Strongly D.	10.2(6)	8.0(4)
TOTAL	100%(59)	100%(50)

Table LVII: Nurses are not competent to diagnose patients.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	14.0(7)
Moderately A.	6.8(4)	22.0(11)
Slightly A.	6.8(4)	8.0(4)
Slightly D.	3.4(2)	12.0(6)
Moderately D.	42.4(25)	34.0(17)
Strongly D.	35.6(21)	8.0(4)
No answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

The research hypothesis behind these statements was that the clearly defined division of roles within the hospital assigned the diagnostic function to the consultant psychiatrist, and executive duties related to diagnosis to nurses. Yet, due to the

amount of time spent by nurses with patients within the hospital premises, nurses were able to identify symptoms and related illness, and eventually to formulate a diagnosis themeselves.

This has been acknowledged by Italian nurses during informal interviews carried out in previous research (Savio 1988, 1989), and also during the development of this present research by British nurses. The move to community care is seen as increasing the nurses' ability to formulate diagnosis, due to the quantity and quality of time spent with clients. The setting where nursing practice takes place also allows a holistic view of the person. Especially in Britain, nurses have more chances than psychiatrists to see clients within their social and family environment, thus gathering more information for diagnosis and treatment.

As already pointed out, in Italy consultant psychiatrists perfome domiciliary visits as nurses do. This may partly explain the difference of attitudes between Italian and British CPNs, in that Italian nurses have less chances to prove and experience their ability in working as independent practitioners.

At the organisational level of analysis Menzies (1973) has demonstrated that nurses within the hospital environment adopt self-defense mechanisms, whose aim is that of coping with the anxiety produced by the overwhelming level of responsibility perceived in dealing with 'human material'. It might be that Italian nurses feel the need to hold on to the idea that psychiatrists and not nurses are in charge, and therefore responsible for diagnosing clients.

In terms of professional identity , this highlights the weight which the professional imagery of the traditional nursing role still places upon contemporary community psychiatric nurses. The consequences for professionalisation are significant. To acquire an autonomous and independent professional role, community nurses would need to be acknowledged as a profession separated from the medical class. Nurses need to modify their image- which still retains a strong weight in terms

of societal imagery- as the executive arm of doctors. The move towards becoming independent practitioners also implies undertaking more responsibility, possibly the whole responsibilty of the care process. Italian nurses appear as yet umprepared to take this step, while possibly having the practical requirements to do so. Perhaps adequate training and support could increase nurses'confidence in their skills. The lack of formalized training which affects Italian nurses appears to support the hypothesis that professional education is a key element in moving towards professionalism.

Furthermore, the organizational differences between Italy and Britain should not be neglected in the analysis of CPNs' chances of enhancing their professional status. In the British case there are indications about GPs and paramedical professions acquiring an increasingly important role in psychiatric community care (Wilkinson, 1989; White, 1986). Contrary to Italy, community care developed in Britain on the basis of two main organizational models:

a)primary health care teams to which different professions are attached, including the paramedical ones,; and

b)CPN teams, esclusively run by nurses who liaise with other community professionals. Community mental health centers are much less developed than in Italy, accounting for a minority of community care provision in the UK (Sayce and Field, 1990).In both these organizational models GPs perform an important role as referral agents. In consequence, psychiatrists appear to be losing ground in terms of status and prestige, while GPs tend to refer patients to paramedical professions rather than psychiatrists.

> 'The most commonly cited reason for GPs not referring appropriate patients to a psychiatrists remains the stigma of psychiatric care.'(Wilkinson, 1989, pg.72)

As pointed out by White (1986) the role of GPs in British psychiatry is crucial for an understanding of CPNs development and gaining of an autonomous role.

> 'Unlike social workers and health visitors, nurses -including the community psychiatric nurses of the present study-have their access to patients controlled by a medical practitioner. Thus the medical profession has a great influence over nurses' performance and development.'(White, 1986, pg.224)

Whereas CPNs role in Italy is still subjected to the psychiatrists influence, and nurses have little by means of training to fight for an independent position, British CPNs are moving from the psychiatrist's control to the General Practitioner's. The greater amount of training received, and the further development in community specialisation, should place British nurses in a better position than their Italian colleagues. It remains to be seen whether GPs' power in the community can be as strong as that of psychiatrists within the hospital. This would entail an important change: that from a psychiatric oriented approach to a broader medical/social oriented model of primary health care. As a matter of fact, the prospect of GPs becoming budget holders according to the prescriptions of the 1990 NHS and Community Care Act, might modify the relationships of professional power within the triangle GPs-psychiatrists-CPNs.

6.5. The psychological ideology of mental health.

Under the heading of 'psychological ideology of mental health' a number of statements have been listed which describe the origins and treatment of mental illness from a psychological perspective. Yet the psychological ideology is thought to be the least representative among all the ideologies of mental illness described in the questionnaire. A methodological problem arises when it comes to the stage of elaborating an ideal type of psychological approach. From an epistemological perspective it is not possible to identify one psychology, as there are in fact many psychologies, each of them addressing the issue from different angles. The psychodynamic approach, cognitive psychology, behavioural psychology, psychoanalysis, the theory of personal constructs - all refer to different, and at times contrasting, scientific paradigms.

In the comparison between Britain and Italy there are also differences concerning the type of psychology prevailing in psychiatric community care. For instance behavioural therapy is much more used in Britain than in Italy. Morover within the same country there may be heterogeneous psychological approaches according to the organization which is appointed to provide community care. In Britain social work is thought to be more psychoanalytically or psychotherapeutically oriented than CPN.

The elaboration of an ideal type would need to take into account such differences which on the other hand may be quite irreconciliable. As a consequence, an attempt has been made to develop an uncommitted model of psychological approach where possible diverging perspectives are not considered.

It is important to underline that psychotherapy and counselling are usually activities performed by psychologists and psychiatrists in Italy, their largest client group being the 'worried well' clients. Nurses are more likely to work with continued care clients with whom psychotherapy is much more difficult to undertake, and whose

rehabilitation needs demand a broader social perspective of care. However, for the British sample the typical clientele tends to be more heteregeneous, and nursing training does provide nurses with counselling concepts which are actually applied into practice.

Overall results from the two samples tend to be quite homogeneous, although there are some significant differences between interlevel comparisons.

Both nursing groups are concerned with psychological causes of mental illness, thus displaying an approach to mental illness as a multi-casual phenomenon where psychological as well as social, political, and biological factors can play a role. The following two tables illustrate the similarity between Italian and British nurses' positions about the relevance of psychological elements which can impinge on mental health.

Table LVIII: Mental illness is the result of a psycholgical distortion in experiencing reality.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	10.2(6)	18.0(9)
Moderately A.	44.1(26)	48.0(24)
Slightly A.	20.3(12)	16.0(8)
Slightly D.	8.5(5)	6.0(3)
Moderately D.	10.2(6)	10.0(5)
Strongly D.	6.8(4)	2.0(1)
TOTAL	100%(59)	100%(50)

Table LIX: A wrong way to cope with environmental stimuli can cause mental illness.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	5.1(3)	12.0(6)
Moderately A.	35.6(21)	52.0(26)
Slightly A.	32.2(19)	26.0(13)
Slightly D.	11.9(7)	2.0(1)
Moderately D.	11.9(7)	6.0(3)
Strongly D.	3.4(2)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.007

Statistical testing proves that there is a significant difference at the interlevel comparison in table LIX. Italian nurses appear to conform to the psychological causes of mental illness even more than their British colleagues, despite the lack of training in the sector. This result should not be generalised to all categories of psychiatric nursing in Italy. Coincidentally, nearly all the centres where nurses interviewed work have developed a particular attention to psychodynamic care approaches.[8] Although these are not always suitable and sufficient for continued care

[8] In one of the health districts where most of the nurses from the Italian sample were interviewed (in the province of Pordenone) a four-year course in psychotherapy is run under the auspices of the community mental health centres. The course director organizes seminars open to multidisciplinary participation, although the diploma in psychotherapy cannot be achieved by nurses because of lack of original training qualifications. Other two centres in Piedmont have experienced a particular situation with respect to psychological approaches to mental health. A centre in Grugliasco is coordinated by a cognitive psychologist, whose charismatic leadership has greatly influenced nurses professional culture. The second centre in Santhia', has had among its team members a psychologist whose ability to apply psychological models to nurses' every day experiences is still looked back with regret by nurses.

clients, nurses working in the centres have broadened their knowledge about psychological issues. Nevertheless, Italian nurses express a lower degree of conformity than their British colleagues towards two statements which are typical of the psychological /psychoanalitycal setting: the right of clients to choose their own therapist, and the issue of confidentiality which should be respected within the therapeutic setting.

Table LX: In psychiatric community care clients should be free to choose their own therapist.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	27.1(16)	20.0(10)
Moderately A.	37.3(22)	26.0(13)
Slighlty A.	18.6(11)	20.0(10)
Slightly D.	8.5(5)	12.0(6)
Moderately D.	6.8(4)	16.0(8)
Strongly D.	1.7(1)	6.0(3)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.04

Table LXI: Professional relationships with clients should not be discussed during team meeting.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	3.4(2)	/
Moderately A.	13.6(8)	2.0(1)
Slightly A.	10.2(6)	2.0(1)
Slightly D.	13.6(8)	6.0(3)
Moderately D.	25.4(15)	12.0(6)
Strongly D.	32.2(19)	78.0(39)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Answers to these two statements show that in both cases, but especially in the Italian case, it is not part of the nursing culture to adopt an exclusively psychological approach with clients. Table LXI indicates that although both groups do not agree with the statement the Italian opposition is stronger than the British. The important

function acquired by team meetings within the Italian organization of work has been previously outlined. Because of the lack of individual supervision, team meetings represent an opportunity to carry out collective supervision during which cases are discussed. Nurses disagreement to the statement is then understandable in the light of these consideration.

However, the fact that both sample groups express a high level of dissent may be due to the nursing culture and education which give relatively little time to the psychological perspective in favour of either medical or social orientations. Furthermore, the type of client group targetted by CPN in both countries, and especially in Italy, certainly requires the development of socially oriented practices which allow a holistic view of the case. Psychological insights may play a part in this prospective, but not an exclusive one.

The fact that both Italian and British nurses agree that professional relationships with clients should be discussed during team meetings, should not be regarded as lack of consideration towards clients' privacy. In fact, both samples agree with the need to respect clients' right to privacy. The table below illustrates the issue. The statistical difference detected by the test cannot but be due to the British tendency to choose moderate rather than extreme positions. However the concept of privacy certainly assumes different connotation in the two countries. In this sense statistical testing may indicate different cultural interpretation of the word rather than actual differences in practice.

Table LXII: Clients' right to privacy must be respected.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	57.6(34)	74.0(37)
Moderately A.	15.3(9)	14.0(7)
Slightly A.	3.4(2)	4.0(2)
Slightly D.	11.9(7)	6.0(3)
Moderately D.	3.4(2)	/
Strongly D.	6.8(4)	/
No answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.03

Psychotherapeutic practices are considered by nurses as specialised intervention. The majority of both British and Italian nurses pointed out their insufficient specialisation in the field which makes them feel less confident in practice. This seems to be an indicator of the distance which nurses perceive between their profession and psychologically oriented practices.

Table LXIII: Psychotherapy can be practiced only by persons who have been specifically trained for it.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	44.1(26)	28.0(14)
Moderately A.	22.0(13)	32.0(16)
Slightly A.	13.6(8)	16.0(8)
Slightly D.	8.5(5)	12.0(6)
Moderately D.	10.2(6)	4.0(2)
Strongly D.	1.7(1)	8.0(4)
TOTAL	100%(59)	100%(50)

The comparison between the two following tables indicate yet again the difference between British and Italian nurses' positions towards the psychiatric hospital. British nurses, although agreeing (as their Italian colleagues do) with the therapeutic potential of community care, do not exclude the possibility of similar development for the psychiatric hospital.

Table LXIV: Community care offers the best opportunity to develop therapeutic relationships with clients based on confidence and empathy.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	50.8(30)	50.0(25)
Moderately A.	39.0(23)	50.0(25)
Slightly A.	5.1(3)	/
Slightly D.	1.7(1)	/
Moderately D.	1.7(1)	/
Strongly D.	1.7(1)	/
TOTAL	100%(59)	100%(50)

Table LXV: The psychiatric hospital is not the right place for the development of therapeutic relationships.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	6.8(4)	44.0(22)
Moderately A.	22.0(13)	30.0(15)
Slightly A.	16.9(10)	6.0(3)
Slightly D.	23.7(14)	6.0(3)
Moderately D.	25.4(15)	4.0(2)
Strongly D.	5.2(3)	10.0(5)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

These findings outline neatly the ambiguity of the British attitude towards psychiatric hospitals. The community is acknowledged as the best place for the development of therapeutic relationships, the degree of agreement is nearly total. At the same time 45.8% of British respondents attribute a similar role to psychiatric hospitals, possibly attaching positive functions or potentiality to institutional care. From an ideological point of view this reluctance to radically discard institutional care is certainly linked to British nurses professional identity, which has been shaped and reinforced through hospital based care models. A denial of the hospital therapeutic functions might carry a negative weight on the self perceived professional identity too.

On the other hand, British pragmatism may play a part in this view as well. It could for instance be argued that an underfinanced community care sets the conditions for which occasionally hospital care may become a better option.

In both cases (hospital or community care) a role for British nurses professional contribution would be provided. The same is not true for Italian nurses, who feel that they have acquired a role and identity only since community care came into being.

6.6. The critical ideology of mental health.

The critical approach to mental health aims at representing the views of those professionals who, although ideologically supporting deinstitutionalisation, have developed a critical attitude towards some of the organizational aspects of community care. The conceptualisation of this ideology stems from the hypothesis that an original idealistic committment to the issues of dehospitalisation might have been modified through the strains of professional practice. Initial enthusiasm may become critical pragmatism, as often happens when a theory is applied in pratice. Hence committment to the critical approach does not exclude the idea that professionals can be partisans of other ideologies of mental illness as well.

Findings show that to a great extent both British and Italian nurses conform to most of the critical statements listed under this approach. Nevertheless there are comparative differences which highlight cultural and organizational diversities in the two countries. Overall, organizational issues are at stake for both British and Italian CPNs. They share the same concern about the implementation of community care, and agree on structural and corrective measures to be adopted.

The following five tables indicate that both groups have about the same levels of total agreement on the statements. Yet the interlevel comparison shows that a different concern is expressed about the organizational issues displayed by the statements. Italian nurses are less worried about the pace of deinstitutionalisation than their British colleagues, possibly because they are experiencing a further stage in the implementation process. Nurses interviewed are not attached to any project of hospital closure, which instead developed on a large scale at the time of the psychiatric reform. On the contrary, in Britain de-hospitalisation acquired importance during recent times highlighting that community care is due to become the backbone of the psychiatric system. It is becoming clear that community and hospital care can

no longer be two parallel organizations within the psychiatric scene. Not to be forgotten either, that two out of the three CPN teams interviewed are hospital based. Although CPNs work is mostly organized outside the hospital, it may be reasonable to assume that respondents are concerned about the future of the hospitals they work with.

A reflection of nurses' experiences is also evident in Tables LXVII and LXVIII. Both British and Italian nurses agree that community care requires a flexible organization and that its coordination is complex. Nevertheless Italian respondents seem to think that the community has to be comparatively better planned than the hospital, probably because in Italy the hospital organizational structure used to be much more rigid and less complex than it is presently in Britain.

It is also important to note that in Italy there is comparatively little attention to organizational issues than in Britain. Italian practice is often more a result of individual improvisation than of planned interventions and care programmes. Loosely defined organizational boundaries generate anxiety among professionals, together with the awareness of a need for developing better organizational tools.

Table LXVI: Deinstitutionalisation must be implemented gradually.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	78.0(46)	50.0(25)
Moderately A.	15.3(9)	40.0(20)
Slightly A.	5.1(3)	4.0(2)
Slightly D.	1.7(1)	2.0(1)
Moderately D.	/	4.0(2)
Strongly D.	/	/
TOTAL	100%(59)	100%(50)

Corrected for ties Mann-Whitney 2 tailed p=.003

Table LXVII: Community care requires a more complex organization than hospital care.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	55.9(33)	84.0(42)
Moderately A.	30.5(18)	14.0(7)
Slightly A.	3.4(2)	/
Slightly D.	6.8(4)	2.0(1)
Moderately D.	3.4(2)	/
Strongly D.	/	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.001

Table LXVIII: Planning and evaluating psychiatric work requires more flexibility in the community than in the hospital.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	55.9(33)	78.0(39)
Moderately A.	30.5(18)	20.0(10)
Slightly A.	5.1(3)	2.0(1)
Slightly D.	3.4(2)	/
Moderately D.	1.7(1)	/
Strongly D.	3.4(2)	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.008

An interesting difference between British and Italian views is shown in the table below (Table LXIX). Italian respondents are less concerned than the British about the economic costs of community care. It is important to remember that in Italy community care is not better financed than in Britain. In both countries only a fraction of the mental health budget is directed to community structures (see Chapter 2).

Partly due to the shortage of financial support, a different community care philosophy developed in Italy whose focus is on the use and involvement of social resources. Rehabilitation activities are in fact organized by means of involving users social networks, and participation is enlarged through social events which are of collective interest. For instance a user's interest or versatility to act would be

channelled and organized towards theatrical performances. Eventually more users with similar interests might join the individual project and a theatre group is formed as a creative expression of clients experiences and dreams. A room to perform can then be easily found either through the local church or by converting an ex hospital ward into a theatre. The social event is advertised in the community and participation is promoted by free access to the performance.

This kind of activity has virtually no economic costs. Instead it requires human resources which are usually recruited among mental health professionals and volunteers. To the writer's knowledge, users' theatre groups have developed in Trieste, Pordenone and Torino. There are certainly many more spread all over Italy. Following similar paths carpenters shops have been established and run by users, as well as greengrocers', bars etc. The philosophy which lies behind these projects not only tackles the need for overcoming financial shortages, but especially aims at shifting the focus of care from the individual to the social disability. Most of the professionals interviewed in Italy are involved in similar activities. It is most likely therefore that their concern is primarily about identifying social resources through which to convey normalising practices. Indirectly, this may also be a means of facing the frustration which arises when activities are constantly underfinanced.

Table LXIX:The economic costs of community care are often undervalued.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	69.5(41)	22.0(11)
Moderately A.	25.4(15)	32.0(16)
Slightly A.	3.4(2)	12.0(6)
Slightly D.	/	8.0(4)
Moderately D.	1.7(1)	12.0(6)
Strongly D.	/	10.0(5)
No answer	/	4.0(2)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Tables LXX, LXXI, LXXIII, and LXXIV indicate that both groups agree on some of the structural and organizational needs of community care. There is no significant statistical difference between British and Italian positions.

Table LXX: Community care must ensure housing and maintenance as it was in the hospital.

Degree of Agr./Disagr.	**BRITAIN**	**ITALY**
Strongly A.	30.6(18)	12.0(6)
Moderately A.	20.4(12)	26.0(13)
Slightly A.	18.6(11)	22.0(11)
Slightly D.	6.8(4)	10.0(5)
Moderately D.	13.5(8)	12.0(6)
Strongly D.	8.4(5)	16.0(8)
No answer	1.7(1)	2.0(1)
TOTAL	100%(59)	100%(50)

Table LXXI: Comparatively, community care requires different levels of assistence than hospital care.

Degree of Agr./Disagr.	**BRITAIN**	**ITALY**
Strongly A.	54.2(32)	52.0(26)
Moderately A.	39.0(23)	40.0(20)
Slightly A.	6.8(4)	/
Slightly D.	/	2.0(1)
Moderately D.	/	2.0(1)
Strongly D.	/	2.0(1)
No answer	/	2.0(1)
TOTAL	100%(59)	100%(50)

Table LXXII: Good relationships with clients' families are a requirement of community care.

Degree of Agr./Disagr.	**BRITAIN**	**ITALY**
Strongly A.	61.0(36)	66.0(33)
Moderately A.	27.2(16)	28.0(14)
Slightly A.	6.8(4)	2.0(1)
Slightly D.	3.4(2)	/
Moderately D.	1.7(1)	4.0(2)
Strongly D.	/	/
TOTAL	100%(59)	100%(50)

Table LXXIII: Community care asks for a better cooperation between professionals and clients.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	71.1(42)	64.0(32)
Moderately A.	27.2(16)	26.0(13)
Slightly A.	1.7(1)	10.0(5)
Slightly D.	/	/
Moderately D.	/	/
Strongly D.	/	/
TOTAL	100%(59)	100%(50)

It is essential to remember that answers to these statements have been given by professionals working in the field. It is therefore most likely, that the concern shown by both British and Italian nurses about organizational issues for the implementation of community care reflects their practical experience, and the problems they are encountering. If this is so, it is interesting to discover that the points in question are the same for both countries, despite disparities in terms of structural contexts, cultures, and history of psychiatric care. Furthermore, the perspective under investigation is a specific professional one-psychiatric nursing. Regardless of differences in training, professional culture, and identity, both Italian and British nurses agree on the existence of some important organizational issues. This is particularly significant, as it seems to indicate the existence of universal elements at the macro structural level which need to be tackled when the implementation process is in progress. The importance of these issues should therefore be taken into account by social policy at a cross national level.

The three following charts indicate nurses' positions about their professional role and the corrections which need to be brought into being in order to allow a better organization of community work.

Table LXXIV: The shift to community care presents difficulties concerning the professional role and identity.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	16.9(10)	24.0(12)
moderately A.	33.9(20)	30.0(15)
Slightly A.	27.1(16)	18.0(9)
Slightly D.	1.7(1)	4.0(2)
Moderately D.	10.2(6)	10.0(5)
Strongly D.	8.5(5)	14.0(7)
No answer	1.7(1)	/
TOTAL	100%(59)	100%(50)

Table LXXV: More interdisciplinary work is required in community work as compared to the hospital.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	54.2(32)	78.0(39)
Moderately A.	16.9(10)	12.0(6)
Slightly A.	20.3(12)	4.0(2)
Slightly D.	3.4(2)	4.0(2)
Moderately D.	/	/
Strongly D.	5.1(3)	2.0(1)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2-Tailed p=.008

Table LXXVI: The lines of professional responsibility ought to be more clear in community care.

Degree of Agr./Disagr.	BRITAIN	ITALY
Strongly A.	32.2(19)	40.0(20)
Moderately A.	42.4(25)	30.0(15)
Slightly A.	8.5(5)	14.0(7)
Slightly D.	13.6(8)	4.0(2)
Moderately D.	1.7(1)	6.0(3)
Strongly D.	1.7(1)	2.0(1)
No Answer	/	4.0(2)
TOTAL	100%(59)	100%(50)

Results show that both British and Italian CPNs identify the passage to community care as professionally demanding. Research in the field indicated that Italian psychiatric nursing significantly changed as a consequence of deinstitutionalisation (Zani et al., 1984, Savio, 1991). The custodial role performed by nurses within the mental hospital has been replaced by new holistic and socially

oriented practices in the community. The passage was not problem-free for Italian nurses. With only limited training and support they had to learn how to cope with the clients' new community needs. It is interesting to see that, under different structural conditions, British nurses experience similar feelings to their Italian colleagues.

The fear of change and a condition of undeniable professional uncertainty are in fact linked to any process of relevant institutional transformation, as is the shift to community care. The conditions of professional practice are modified by any significant change at the organizational level. Hierarchical relationships are likely to be modified as well, as professional roles acquire new institutional configurations. Professionals lose control over specific areas of competence, often being replaced by emerging occupations. To hold knowledge on specific subjects means to control areas of uncertainty for other professions, which ultimately gives power. By losing control in their areas of competence, professionals may also lose power in their relationships with other professions. The Italian and British experience of deinstitutionalisation are two typical examples of this process, whose outcome in terms of professional re-organization is not as yet institutionally established.

It is significant that in Italy some of the psychiatric hospitals still existing are practically controlled by the nursing power within the asylum ('Italy Mad Law' 1984 video on BBC). Democratic psychiatrists complain about nurses' resistance to giving up the hospital structure for community care. Nurses can successfully activate this kind of resistance as they know how to control patients better than doctors, and how to prevent them from being dehospitalised. They also fear the loss of the institutional-like organization of work which they learned to adapt to during the asylum years. It has been indicated (J.Carson et al., 1990) that one of the latent functions of the organizational structure of large institutions is to protect staff against stress factors.

> ' For instance, the presence of large numbers of staff on one site offers oportunity for much social support. Additionally, other issues such as predictable routines, clear hierarchical structures and job security, also contributed to the mental hospital being a low stress environment for staff.'(Carson et al., 1990, 1)

Significantly, Italian nurses who transferred to community work from mental hospital, were hierarchically down-graded thus also losing economic adavantages.
The British situation is even more threatening from a professional viewpoint. Whilst no worker was made redundant in Italy, in Britain no post is assured in the mental health services. Understandably, professionals show resistance to the community move. Furthermore, findings from a research on CPNs working in four health districts (Carson et al., 1990) show that stress levels are higher in community work as compared to the hospital, although community nurses do not appear to have lost their ability to care for patients.

Both British and Italian nurses agree on the need for multidisciplinary work in community care, but also ask for clarity about the lines of professional responsibility. This means that nurses experience a situation in which professional boundaries are loosely defined, which may generate anxiety and lack of professional satisfaction.
There is a significant statistical difference between the two groups about the issue of multidisciplinarity. Although the total level of agreement for both British and Italian respondents is high, British nurses expressed a more moderate position in comparison with the Italians. Differences between the organization of nurses' community work in the two countries explain this diversity. British CPNs are mono-disciplinary based and contacts with the other psychiatric professions are ensured by the community network. The degree of professional autonomy experienced by British respondents is in this sense higher than that of Italian nurses who operate in multidisciplinary teams.

It may be inferred that British nurses are slightly afraid to lose some of their operational autonomy by opening to multidisciplinarity.

An interesting comparison is shown in Table LXXVIII. Both British and Italian CPNs agree that mental illness has periods in which hospital admission is necessary. Yet the interlevel comparison points out that Italian nurses express a stronger concern about the issue. The interpretation of this finding could be misleading if the context and conditions in which community care develops in the two countries is not carefully taken into account. In fact the most likely explanation for this diversity is due to the nature of Law 180 which in Italy sets strict rules for hospital admission, rendering it a very occasional occurance rather than an easily available option. As a consequence professionals often endure difficulties in dealing with clients' crisis on a community basis. The Italian nurses' response seems more a reflection of this condition than a belief in hospital practice which, at first sight, would seem stronger than that of their British colleagues. Such an interpretation appears to be confirmed by the findings illustrated in Table LXXIX. There is a statistically significant difference between the two groups, in that Italian nurses show a lower level of agreement than the British about the positive functions of psychiatric hospitals. Once again it emerges that British nurses seem to consider hospital care as a suitable option, possibly not better but alternative to community care.

Table LXXVII:Mental illness has phases when hospital admission is necessary.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	22.0(13)	38.0(19)
Moderately A.	33.9(20)	48.0(24)
Slightly A.	27.2(16)	10.0(5)
Slightly D.	6.8(4)	2.0(1)
Moderately D.	8.4(5)	2.0(1)
Strongly D.	1.7(1)	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.001

TableLXXVIII: The psychiatric hospital has positive functions which have been forgotten in community care.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	17.0(10)	4.0(2)
Moderately A.	42.4(25)	12.0(6)
Slightly A.	28.8(17)	36.0(18)
Slightly D.	5.0(3)	14.0(7)
Moderately D.	3.4(2)	12.0(6)
Strongly D.	3.4(2)	22.0(11)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.000

Different positions between the two sample are also indicated by Table LXXX. Italian CPNs are more concerned than the British about the need to protect clients in the community. Again the diverse community care organization in Italy and Britain seems to be an explanatory variable of differences between nurses' positions. The opportunity to provide clients with a protected environment is very reduced in Italy given the conditions explained above. It is part of the community care philosophy to expose clients, as much as possible, to both the good aspects and the strains of community life. It is believed that only by exacerbating social and individual 'contradictions' can a solution be found to mental distress. The radical character of this approach often generates anxiety among professionals, because of the need for facing and confronting at the same time the clients' needs, the requests of families, and

the social feedback which is not always of a positive nature. The feeling of needing to protect clients from the emotional strains which this process often produces is common among nurses .

A similar explanation can be proposed about findings shown in Table LXXXI in which it is said that the care of mental illness is a collective responsibility. The lower level of agreement from Italian nurses as compared to the British might be a reflection of their experience of the care approach stated above. In other words it could be an indication of their need for approaching the implementation of community care from a different and more individualised angle, possibly at a different pace.

Significantly, answers in Table LXXX seem to confirm this explanation. Both British and Italian CPNs agree on the need for protecting the community from the emotional distress which mental illness may generate.

TableLXXIX: Clients should be protected in the community as they used to be in the hospital.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	6.7(4)	16.0(8)
Moderately A.	17.0(10)	30.0(15)
Slightly A.	20.4(12)	22.0(11)
Slightly D.	18.7(11)	12.0(6)
Moderately D.	27.1(16)	10.0(5)
Strongly D.	10.1(6)	10.0(5)
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.01

TableLXXX: The protection of the community must be guaranteed.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	15.2(9)	26.0(13)
Moderately A.	30.5(18)	34.0(17)
Slightly A.	27.2(16)	14.0(7)
Slightly D.	15.2(9)	12.0(6)
Moderately D.	8.5(5)	10.0(5)
Strongly D.	3.4(2)	2.0(1)
No answer	/	2.0(1)
TOTAL	100%(59)	100%(50)

TableLXXXI: The care of mental illness is a collective responsibility.

Degree of agr./Disagr.	BRITAIN	ITALY
Strongly A.	78.0(46)	54.0(27)
Moderately A.	18.6(11)	28.0(14)
Slightly A.	3.4(2)	16.0(8)
Slightly D.	/	2.0(1)
Moderately D.	/	/
Strongly D.	/	/
TOTAL	100%(59)	100%(50)

Corrected for Ties Mann-Whitney 2 tailed p=.004

5.7. Conclusions

This chapter focused on the analysis of nursing ideologies of care, namely that set of professional beliefs and values which define a specific approach to mental health care. The results indicate that generally there is no prevalence of one ideological approach against another to distinguish British and Italian respondents. Rather, mental illness is considered a multicausal phenomenon whose care requires a combination of social, psychological, biological and political approaches.

The comparison of the two sample groups indicates two major differences between nurses' attitudes towards mental illness. 1) Italian nurses tend to view community care as the only suitable option for the care of mental illness. The psychiatric hospital is in fact considered detrimental to mental health due to its stigmatizing character, to its focus on illness rather than on health, and to the alienation of the mentally distressed perpetrated through institutional life. This view is a reflection of the ideology of psychiatric reform which in its pure form actually went further. It viewed the psychiatric hospital as a capitalist means of control against deviant members of society. It held a primary cause of chronicity to be institutionalisation rather than illness.

On the other hand, British CPNs tend to view both hospital and community care as alternative options for the treatment of mental illness. However, as far as their profession is concerned, they show preference towards the community setting which allows them professional independence and creativity. This view may be partially due to the climate of professional uncertainty experienced by mental health workers in Britain as a consequence of the move from the hospital to the community. Attitudes of resistance to change are in fact likely to emerge due to the substantial lack of professional involvement in government's decisions about planning the move to the community. This reflects an important difference between the experience of British

and Italian CPNs, and has certainly some consequences on the philosophies of care promoted by the two professional groups in their respective countries.

2) The second main difference emerging from findings can be identified in the nature of responses provided by the two sample groups. Whilst Italian CPNs tend to strongly support or oppose ideological statements, British respondents usually express moderate views both in the cases of agreement and disagreement. These different attitudes are of a cultural nature. There is generally an element of 'drama' in the Italian culture which, mixed with idealism, generates radical views whenever political or social issues are at stake. This does not seem to be the case in Britain, where pragmatism is the prevailing attitude in social and political life. In part this difference also explains the different character of the community care movements in the two countries.

An understanding of nursing ideologies of care is important for two reasons. 1) The development of community care promotes the coexistence of complementary philosophies of care which place the care of mental illness within a multicausal framework. Concerning this thesis, it is important to investigate CPNs' ideological positions towards these new developments. Professional nursing culture and identity are a means through which a dominant ideology of care is implemented, but also modified in its interaction with the every-day professional practice. In this sense, the analysis of nursing ideologies of care also provides an insight into the practice of community care, as it indicates the relationship between the rationale of treatment philosophies and nurses' operational choices. This remains true to the extent that nursing ideologies of care, just like any other ideology, are considered expressions of the interaction between theory and practice. The analysis of the findings tends to support this hypothesis. It would have in fact been difficult to understand nurses' support or rejection to ideological statements without continuously referring to nursing practice, and to the context of care in which this is carried out.

2) The emergence of a new psychiatric nursing professionalism is linked with nurses' ability to ideologically represent their profession within the community care scene. The change which has taken place in nursing practice and professional role needs to find acknowledgment in nurses' self-perceived professional image. It is only by being aware of their new identity that CPNs will be able to promote a new professionalism both within the psychiatric field and towards the general public.

Butterworth writes about the development of the nurse practitioner:

> 'We cannot go hand on heart to the public and ask for their endorsement of what nurses see as an important professional development unless and until our own professional house is in order and the right educational and ideological shifts have been made.'(Butterworth, 1990, 37)

Although this comment is not directly related to CPN developments, it represents the issue that is here debated very well. It also indicates that the emergence of a new professional role develops through a process where each stage deserves attention. Important changes in professional practice need to be mirrored in the training, in nurses' self-perceived identity, and in the professional image which is proposed to the public. Nursing ideologies of care play therefore an important role in this process, as they are the link between the subjective professional experience and outside professional image. Ideologies of care legitimise the profession and, if a new professionalism is in progress, an ideological shift is also necessary both as the basis of and for the promotion of this new development.

Both British and Italian CPNs appear to enjoy their community role and to support the development of community care as the basis for a new professionalism.

The new educational developments which are taking place in Britain with the implementation of Project 2000, and the introduction of short-university nursing courses in Italy will certainly have some impact on the future of community psychiatric nursing. The analysis carried out in this Chapter indicates that CPNs tend to have an holistic approach to the care of mental illness and that, therefore, the ideological framework of CPN cannot be limited to a medical-centred approach as it used to be for the past hospital role. Conversely, there is a need to enlarge the focus of training on social and psychological perspectives. It is important to train nurses to take an active part in policy matters, as only by so proceeding will they fully be protagonists of change (Butterworth, 1988). In the present thesis, the analysis of nursing ideologies of care also aims to provide a modest contribution in enlarging the knowledge and understanding of the CPNs' first-hand experiences and views. In particular, such views and experience ought to be taken into account whenever a major educational change is on the drawing board.

6.8. References

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CHAPTER 7: CONCLUSIONS

7.1 Retrospective methodology

The methodological approach used in the present research has proved to be reasonably successful in achieving the following objectives:

1. To provide a documented comparison between the professional experience of the British and Italian CPNs interviewed;

2. to analyse the main variables identified in the theoretical review (organizational contexts, ideologies of care, professional cultures) in their interaction re the professional experience of CPNs, and to place such variables into a coherent framework for analytical understanding;

3. to propose a tentative theory about the growth and development of CPN as a cross-national endevour.

The multiple case study research approach has therefore been useful in achieving one of its important purposes, that is to elaborate analytical generalizations whose content will be analysed in this conclusive chapter.

The study is indeed preliminary to further research, whose objective would be to test the reliability of the analytical generalizations into a survey's sampling logic. The subject of analysis has been particularly complex, due to the general paucity of studies on cross-national comparisons of CPNs. The present study is a first attempt to provide a systematic comparison of the professionall endevour in both countries by means of historical insights, theoretical, and empirical observations.

The selection of case-study units in England and Italy was not aimed at achieving statistical generalizations. This has been both a limit and an advantage of the study. On the one hand, the analysis of findings and the tentative theory which is drawn from them cannot be extended to all British and Italian CPNs. In fact, such theory would need to be further tested to check its reliability on statistically significant samples. On the other hand, the method has allowed the testing of the theoretical framework within a reasonably flexible research design, aimed at generating feedback between empirical and theoretical observations.

An aim which possibly the study has not fully achieved is that of providing a thorough account of the process of data collection. Whilst this has been illustrated in the methodology chapter, the analysis of findings has only partially accomplished the goal. The issue of matching results about the informal interviewing and the observation with data from the questionnaires has been central for the presentation of findings. Indeed, the issue has occured as a result of an insufficient standardization of the data collected through informal interviewing and the observation. As a consequence, the findings from the questionnaires have tended to over-shadow the information collected by means of non-structured tools, despite the fact that the latter have been fundamental in providing the background for contextualizing data. Yin (1984) warns the case-study researcher about the need to use pre-defined field work diaries, where each empirical information must be filled. This is particularly important when multiple sources of evidence are used, and data are of different nature. Although this may be limiting the creativity of the researcher, it does certainly appear useful retrospectively.

Apart from the reliability of findings, and their usefulness in generating a theoretical and practice-oriented debate within the field, the main result of this work is that of indicating the need for more investigation on the topic. As the study has

raised more questions than it has answered, it is therefore experienced as preliminary to further research.

These clarifications are intended to introduce the reader to the conclusions chapter of this thesis, in the hope that they will throw further light on the meanings of the analysis.

7.2 Conclusions

This thesis is aimed at analysing the growth and development of community psychiatric nursing on a comparative basis. The rationale for comparing British and Italian CPN stems from the consideration that in both countries the profession has acquired centrality in the implementation of community care. Such importance is expressed not only through the quantity of CPN work force employed in the community, but in particular by the quality of practice which CPNs perform within the community setting. The quality of service offered by community psychiatric nurses represents a break with psychiatric nursing hospital practices, and therefore indicates that on a cross-national basis the occupation is undergoing an important professional change.

The main task of the thesis was to understand whether this professional trasformation could aim at a new CPN professionalism. One that could set the basis for community psychiatric nursing becoming an independent profession with a unique body of knowledge to affirm the exclusiveness of the professional features, hence the complete autonomy of the occupation.

The research questions aimed at:

1) investigating whether differences in the history and education between British and Italian CPNs could result in different nursing practices, types of clientele,

organization of work, ideologies of care, and eventually in the individual experience of the professional role.

2) Identifying universal elements in psychiatric nursing that made it be central to the implementation of community care both in Britain and in Italy.

3) Analysing contextual factors which can promote or impinge upon the professionalisation of CPN in Britain and in Italy.

The literature review examined theoretical contributions from the sociology of knowledge, the sociology of professions, and organizational analysis.
The sociology of knowledge focuses on the study of ideology as that set of beliefs, values, and norms that provide meanings and explanations for social phenomena. The ideologies of mental health care have been defined as those views which historically provide a professional dominant interpretation of mental illness and of its treatment. In this respect, ideology bears neither affirmative nor negative value. Rather it supplies explanations, meanings, and legitimation to an historically determined view about mental illness.

In agreement with Habermas a crisis of legitimation is a result of an ideological crisis which occurs whenever ideology no longer has any reference to reality and knowledge, and therefore loses the rational consensus on which it is based. Eventually, an ideological crisis is a crisis in the paradigm of knowledge that supports a dominant interpretation of a social phenomenon. The progressive replacement of psychiatric hospital care with community-based structures represents a shift in the paradigm of knowledge of psychiatric care. Deinstitutionalisation and community care are a serious critique of what mental health professionals have done in the past. Therefore a crisis in the paradigm of knowledge and in the legitimation of professional activities in mental health care has taken place. An ideology based on

deinstitutionalisation and community care is being developed, one that provides professionals with new means of legitimation for their practice, as well as new interpretations and meaning for understanding mental illness.

The sociology of professions, and particularly the studies on professionalisation, focus on the emergence of professionalism and on the means used to support its development. When an occupation aims at becoming a profession, new means of legitimation need to be found in order to support and promote the new professional status. Therefore, a new professional ideology needs to be developed. The relationship of the occupation with the labour market also needs to be considered. It is important to find an occupational niche which can guarantee the profession against possible competitors. Training is fundamental to this process because it both provides the unique technical and cognitive skills to the profession, and promotes the emergence of group cohesion, therefore of a professional identity and culture.

The patterns of development of the medical profession have been used as a model of theoretical reference for two reasons:

a) the literature on professionalisation indicates that medicine and law were historically the first occupations to achieve a professional status. This made them the leading models for the development of the other professions in modern society.

b) Nursing has traditionally been linked with doctors. The very occupation emerged as an answer to the doctors' need to be relieved in a number of executive and assistance tasks which were time-consuming in relation to more responsible medical tasks.

A possible CPN development towards a new professionalism would therefore imply a revision of the nurse-doctor relationship, and to some extent might implicitly endanger medical dominance among the healing professions in psychiatry.

The organizational context where professional skills are put into practice is also relevant to professional development. Not only is organization the means by which professional practice can be planned and coordinated according to stated objectives, but organizations are also the expression of a dominant professional ideology. The process of de-hospitalization in psychiatric care has produced a transformation of the organizational structures for the care of mentally distressed people. Community care promotes a new philosophy whose focus is on solidarity, on inter-personal relationships, and on community support. This has consequences on the aims that the organization of psychiatric care pursues. On the one hand the organization has to guarantee a rational coordination of professional practices. On the other hand, the organization (the community mental health centre or the CPN team) can no longer be merely the expression of technicism and efficiency. It has instead to find ways to empathically liaise with people. It has to be care for the community and not simply care in the community. This requires a new professional approach, one that is able to combine technical abilities and competence with the focus on the person rather than on the task.

The analysis of the findings indicates that this very ideological shift has had a relevant impact on the organization of CPN as well as on the subjective professional experience of the nurses interviewed.

Organizational factors therefore also have an impact on professional identity and culture. Whilst in hospital environment organization is such as to avoid nurse emotional involvement with patients (Menzies), in community work organizational defence mechanisms against professional anxiety and stress diminish. Professional contact with clients becomes more direct, in that it is individualized and not task centred. This has consequences on both the management of stress factors in professional life, and on the self-perceived professional role in the community context. The CPNs interviewed fully perceive this change. They see themselves as protagonists of the care process rather than executors of the technical tasks of the process, as happens in the hospital context. On the one hand this promotes the emergence of a

self-confident professional identity. On the other hand, nurses are more exposed to stress factors, and new mechanism for the management of anxiety need to be established.

In order to analyse whether there is a common trend towards professionalisation in British and Italian community psychiatric nursing, it was necessary to analytically compare nursing organization of work, professional culture and identity, and ideologies of psychiatric care in the two countries. These three main variables led to an understanding of the professional experience both at the macro-structural level, and at the level of nurses subjective experiences.

The analysis of the organization of work described the nurses' practices within the structural contexts of psychiatric community care in Britain and Italy. Through the investigation of the professional identities and cultures, the self-perceived professional role and status became visible. This represented a key element in this research, as it indirectely illustrated CPN attitudes towards professionalisation. In fact, although the structural conditions for a new professionalism may exist, these need to meet nurses' expectations and wishes concerning their professional career. The external input needs to find a welcoming and fertile terrain in order to produce a real change.
The analysis of nursing ideologies of care added further knowledge of the phenomenon. It in fact pointed out the relationship between CPNs' philosophies of care and the general psychiatric contexts where they operate.

A new nursing approach to psychiatric care emerges from the findings, one that is more holistic than in the past and which tends to place the care of mental illness within a multicausal framework.

Methodologically, efforts have been directed at maintaining a balance between the need to understand CPN as it is professionally experienced by the nurses

interviewed, and the constant necessity to link the empirical observations to the national contexts which underly the experience of community care. The different lines along which community care developed in Britain and Italy in fact represent the fundamental references for understanding nursing practice, culture and ideology in the two countries.

It has often been difficult to preserve coherence in presenting findings which are sometimes contradictory not only between samples, but even within the same sample. Yet, it appeared that such incoherence, rather than being a failure in the analysis, is representative of the condition of contemporary community psychiatric nursing. The picture that emerges - and this is common to both British and Italian nurses - is of a profession in transition where new elements coexist with features typical of the past hospital role. Present and past often come into conflict, reflecting the image of a profession that is still trying to find a definite place in the community.

Parsons' study (in particular the interpretation of Parsons proposed by Gilli, see literature review) of social system and social action has helped in understanding and describing the development of CPN through a coherent framework. According to Parsons social change is expressed through the functional differentiation of parts of the social system (sub-systems). The sub-systems are differentiated by specialising in the attainment of specific goals of the general system . Each system is characterized by four functional needs which both pertain to the achievement of the goal that justifies the establishment of the system, and the maintenance of the system itself. The four functional needs are:

Adaptation: the need for the system to exchange resources with the external environment;

Goal attainment: the purpose for which the system has been established;

Integration: the maintenance of the order internal to the sub-system, i.e. the integration of its different parts;

Latency or pattern maintenance: the creation of sufficient motivation and legitimation useful for achieving the goal.

CPN is an example of functional differentiation. It is a specialised answer to the need of the psychiatric care system to provide new patterns of care in the community. The variables analysed (psychiatric nursing organization, practices, education, identity, culture, and ideology) represent the four functional needs of the sub-system of community psychiatric nursing. Therefore it follows that:

Adaptation=Training : the need for CPN to take resources from the environment under the form of information technologies,

Goal attainment=CPN practice ;

Integration= Professional nursing culture and identity, and organization: the need to integrate the different parts of the sub-system through means of identification and organizational stability.

Latency= Nursing ideologies of care: the need for providing the sub-system with legitimation both for the internal and the external.

This key of interpretation of the variables analysed is also useful at synthetically presenting the findings, as any of the four functional needs seem to lend themselves to a neat summary of the results from this study.

British CPN

Adaptation=Training	Goal attainment=CPNs practices
The nurses interviewed have attended the RMN training that specifically focuses on the mental health sector, and originates from the educational needs of hospital-based psychiatric nursing. Only a minority of CPNs attended the post-qualifying CPN course, which is not mandatory. Comparatively, British nurses spend more time in education than their Italian colleagues. The majority of nurses expressed the need to further their professional education.	In Britain CPNs practices tend to be specialised both in terms of intervention approaches, and as to the selection of specific client groups. There is a prevalence of intervention models which require a certain amount of information-technology. The individual caseload is quite high, but the care period is usually time-limited. Nurses' practice is characterized by a high degree of professional autonomy and responsibility. It tends to be client-centred rather than task-centred.
British nurses tend to see mental illness as a multicausal phenomenon whose explanation and care pertain to the psychological, social, biological, and political fields. Community and hospital care tend to be viewed as equivalent and alternative answers to mental distress. As a consequence, deinstitutionalisation is not always considered a positive solution to mental health needs. Yet, community care is viewed as the best opportunity for psychiatric nursing to acquire a therapeutic role. Community psychiatric nursing is perceived as a thinking job, stimulating individual contributions, indepedent and different from the hospital nursing role. It is also a caring job, allowing contact with people, and people to be the centre of intervention.	The professional culture of British nurses is to a large extent the result of structured training, through which messages of identification with the profession are conveyed. There is certainly among the British sample group the feeling of belonging to a specific profession. Yet, the development of specialisation in the community might threaten professional unity by causing interprofessional rivalry: i.e the opposition between acute and rehab. teams. There is an internal professional hierarchy, and there are career opportunities which may also be a source of motivation to the job. Work is organized according to structured activites like planning, coordination, and supervision.
Latency=Ideologies of care	Integration=Prof.culture/ident.

Italian CPNs

Adaptation=Training	Goal attainment=CPNs practices
Italian CPNs either receive a three year training course in general nursing, or are trained on an ad-hoc basis while already working in the community. Training often acquires the form of on-going professional education provided by mental health centres on the basis of local needs. The specific community training is not therefore institutionalised, nor can it be generalised as its content varies between and within regions. Italian community nurses are not qualified as psychiatric nurses, as such a qualification has been dropped within nursing.	Nurse practices have a holistic character that focuses on the rehabilitative needs of the majority of clients served by Italian CPNs. Specialisation is not developed as in the British sample , and in particular there are a number of practices that rank very low in the Italian sample group, like counselling, family and behaviour therapy. The number of clients on nurses individual caseloads is low compared to the British, but the care period tends to be indefinite.
To a large extent, CPN ideologies of care express the philosophy of psychiatric reform in Italy. In contrast to their British colleagues, Italian nurses do not view the psychiatric hospital and care in the community as alternative options. Rather they regard community care as the only feasible solution to the needs of mentally distressed people. In accordance with the principles of the psychiatric reform, the psychiatric hospital is viewed as a means of social control and stigmatization, where human dignity and individual rights are not respected. The process of deinstitutionalisation is ideologically supported, although it is clear to nurses that the implementation of community care is in many instances, defective and therefore in need of improvement. Because the hospital care model has been rejected, the presence of new and un-codified intervention models is justified as an answer to the need for establishing a new psychiatric epistemology. Psychiatric nursing is in this sense, a pioneering profession to which the responsibility for defining new care approaches is also delegated. The profession therefore allows individualised interventions, creativity, and independence.	In the Italian case it is more appropriate to speak about a group culture rather than a professional culture. Italian nurses in fact, do not feel they have a specific profession to identify with. The loosely-defined training does not provide CPNs with a specific set of customs and ways of professional behaviour, but a peer culture develops during practice (that almost has the character of an apprenticeship). Therefore Italian nurses tend to see themselves as the pioneers of a new profession that has little to share with the past hospital role. They actually feel they have a professional identity which is not legitimised or acknowledged at the institutional level. It is possibly due to this same feeling that group cohesion is generated among nurses. There is no internal hierarchy in the profession, therefore there are no career opportunities. As a consequence the job motivation is not provided through instrumental goals - like upgrading - but by means of affective activities. Nurses tend in fact to experience the job as a means to enhance their cognitive abilities in relating to people and in stimulating their individual (and not professional) self-growth. The scarcity of instrumental activities is also visible at the organizational level, where there are few codified and planned activities aimed at achieving the service's goals.
Latency=Ideologies of care	Integration=Prof.culture/ident.

As regards the research questions that this thesis aimed at investigating, the results lead to the following comments. The different historical and educational contexts in Britain and Italy produce some significant differences between CPNs practice, type of clientele, organization of work, ideologies, and professional culture and identity (question 1).

The comparison between the situations of British and Italian CPNs illustrated in the above tables, indicates that in Britain community psychiatric nursing possesses a specific professional identity. In Italy on the other hand the professional existence appears to be more indefinite, due to lack of institutional qualification and acknowledgment of the psychiatric nursing role in the community. Training is a key element in understanding this difference. Professional education is the means through which an occupation acquires the necessary intellectual resources to build expert knowledge and achieve the legitimacy of professional status and role. The more such resources have an indefinite character, the less social and professional legitimacy is conferred on the occupation. By the same means a specific professional culture and identity are conveyed, providing legitimacy from within the occupation: the feeling of belonging to a specific professional group.

The ways through which the situation of professional uncertainty is handled are also different in the comparison of Britain and Italy, and this indicates a further difference in the ways of experiencing the professional identity. British CPNs tend to use instrumental activities in the accomplishment of their professional goals. In contrast, Italian CPNs use affective activities, which accomplish the need to overcome the lack of legitimation at the professional level better. The reader will remember that there are few planned and organized activities in CPNs practice. Also the profession tends to be experienced as a means for personal growth rather than as a tool for instrumental objectives, like status and career. In general, it has also been observed that one of the most successful community care models in Italy is that based on a charismatic leadership, which again implies that action is undertaken for affective

rather than only instrumental reasons. This seems to confirm Parsons' observation on the need, during the process of differentiation, for a sub-system to spend some energy on internal integration. In small sub-systems, like CPN teams, the pattern variable likely to be used is that of affective neutrality/affectivity (see literature review).

It is clear that during institutional changes an occupation also needs to concentrate its efforts on consolidating the bulk of information technologies which better represent the new professional role and status. This may also imply a change or transformation of the professional knowledge forwarded through training. The risk in promoting such necessary change is always that of weakening professional certainties which are not immediately replaced by new means of identification. This latter appears to be the case in Italy, where the psychiatric reform promoted a radical transformation of psychiatric nursing whose practice, culture, and ideology have now little in common with the custodial role of the past. Yet the lack of consolidation and therefore legimitation of the new nursing role at the educational level have produced a crisis in the professional identity whereby nurses feel, and are, different from the past, but have no means of testifying such difference. In the British case the danger of professional uncertainty is being controlled by an educational structure which was also in the past stronger than that of Italian nurses. Yet a hidden risk to be detected here that is that of relying on educational messages which are no longer representative of the new nursing role in the community. This occurance might actually work against the emergence of a new professionalism. Although nursing practice is significantly changed (to the extent that British nurses find it completely different from the hospital nursing role) the unchanged ideological and cultural messages conveyed through training may impinge upon the opportunity for nurses to realise their new professionalism.

The operational message in the Italian case is therefore to concentrate professional effort on codifying, at the educational level the new content of nursing practice. This may in fact be a means of achieving institutional acknowledgements and the legitimation of the new professional status.

In the British case the first step appears to be that of making the CPN post-qualifying one year course mandatory. Both Italian and British CPNs, however, need to realise that the advent of community care has offered them the opportunity to promote a significant change in the epistemological basis of psychiatry.

The development of community care is detrimental to the status of psychiatry as a medical discipline, as the progressive replacement of hospital care with community based structure implicitly indicates that for over a century mentally ill people have been treated in a place - the psychiatric hospital - that did not represent the ideal conditions for care. The thesis that community care became a feasible option only following the advent of psychotropic drugs is unsustainable. There are in fact many practical and theoretical contributions to demonstrate that mentally distressed people can live in the community without the support of neuroleptics, and that the 'deviant' behaviour of those with mental illness becomes more 'normal' or acceptable outside the hospital.

Community care also implies the development of social and psychological intervention models which tend now to be seen as complementary, and not subordinated, to specifically psychiatric oriented practices. Both in Italy and in Britain community psychiatric nursing appears to be paradigmatic of such developments, and nursing practice in the community seems to synthetise both the crisis of hospital psychiatry and the future of community care.

An answer to the second reasearch question that aimed at identifying universal element which can explain the centrality of CPN both in Britain and in Italy, could therefore be the following. According to Parsons, it is possible that the

development of community psychiatric nursing enabled the system of psychiatric care both to evolve towards community based cared models, and to control the potential threat that social and psychological approaches represent to the medical basis of psychiatry. Psychiatric nursing could adequately answer this need because the occupation has traditionally been subordinated to medical directives, and is therefore more controllable than , for example, social work. The easiest way to activate such control appears to be through the adaptive function of the professional sub-system, namely the part which has the task of taking from the environment the technological resources for the maintanance of the system , i.e. training.

According to this hypothesis, the analysis of the contextual factors which can impinge or promote the development of a new CPN professionalism (research question 3) entails the following.

In Italy the content of training has informally changed towards providing nurses with the necessary skills to carry out the community job; it is therefore mainly socially and psychologically oriented. Control is activated through the lack of institutional acknowledgement of this professional change. The lack of acknowledgement was possible because even in the past nurses had a weak professional identity whose image referred to the custodial and subordinated hospital role.

In the British case training appears to be used as a means of conveying ideological messages which tend to reinforce the role of medicine within psychiatric care. Findings indicate that British CPNs, although supporters and promoters of community care, also identify a function for the psychiatric hospital within the care system. The RMN training seems to play a part in this- it was in fact structured to accomplish the educational needs of hospital psychiatric nursing, although it remains to be seen whether it is still pertinent to the new nursing developments in the community. Project 2000 does not seem either to accomplish the need of community psychiatric nursing, as the first period of nursing shared training actually assimilates

those who will decide to be CPNs into other nursing areas whose clinical basis belongs specifically within hospital medicine and not within community care.

The pathway to professionalisation implies differentiation, namely the identification of expert knowledge which is not shared by other occupations. If on the one hand this is already happening in CPN practice, on the other hand it needs to be promoted and acknowledged at the educational level. It might in fact be that the productive need and the need for control, which according to the intepretation of the Parsonian model generated the development of CPN, are not sinergic but in conflict with each other. In terms of production, in fact, the orientation of community psychiatric nursing practice is increasingly social and psychological. Rather than accomplishing the function of safeguarding and controlling the medical basis of psychiatry, such practice appears to be the basis for the emergence of a new profession.

CPN is in this sense paradigmatic of both the crisis endemic in hospital-based psychiatric care, and of the new community care developments. The origins of the profession belong to hospital psychiatry, whereas its future depends on community care. CPN is therefore fully involved in the crisis of legitimation that pertains the past care system, as well as in the promotion of a new community-based ideology of care. The crisis in the paradigm of knowledge of the old psychiatric system is therefore also a crisis of the psychiatric nursing paradigm, to the extent that a new comunity care philosophy has not yet been completely achieved. Whilst this is common to both British and Italian CPNs, the ways through which the crisis becomes manifest are different.

For Italian psychiatric nursing the crisis in the professional paradigm is visible in the lack of institutionalised professional knowledge and skills. This is necessary to formally acknowledge the new nursing role in the community, and to provide the occupation with new means of legitimation and hence the emergence of a new professional identity. In the British case there is the need to focus on the elaboration

of a new CPN ideology, one that acknowledges and promotes in full the nursing role in the community rather than in the hospital. The lack of mandatory CPN training for nurses working in the community is an example of this unmet need. Also, the development of nursing specialism does not answer the need for creating a community practitioner whose skills can be holistically applied to the situation of care. On the one hand this could avoid fragmentation of care. On the other hand it would favour the growth of professional unity, hence the strength of the profession within the labour market.

The opportunity of challenging the medical establishment is certainly one that both British and Italian CPNs need to confront. Yet, it is important to remember that opposition to the medical system implies a high risk for failure. According to Parsons, the fight between a sub-system (community psychiatric nursing) and the system it was generated from (psychiatric care), has little chance of success. This is because the general system has many ways of boycotting the sub-system, starting with the control of resources which are vital to the sub-system's maintenance. Additionally, CPNs also need to consider the risk of overlap with other socially and psychologically oriented professions, like social work. It is possible that the pathway for a new professionalism lies between the two. This entails the need to preserve that amount of medical knowledge and practice which is necessary to distinguish CPN from social work, and at the same time to improve the performance of those psychological and social practices which appear to be a specialised feature of CPN today. The ever-increasing number of mentally ill people who are being re-located into the community have normalisation needs which may find an answer in community psychiatric nursing holistic approach.

The most important step remains that of acknowledging, from within the profession, the independence achieved by community pyschiatric nursing that makes of it a complementary and not subordinate profession among the other professions in psychiatry.

Finally, there are some structural factors which need to be considered in the development of a new CPN professionalism. These are given by the shift, currently in process both in Britain and in Italy, of the welfare care policies towards market economy, and to the combination of private and voluntary sectors. It is forseeable that state-based and supported health care strategies will be replaced, if not in toto, then partially, by mechanisms typical of the competitive labour market. It is possible that mental health professionals will no longer have the certainty of a life-time job. On the one hand this may lead individuals and not institutions, to invest more in their training., because professional education might be a means to be competitive on the market. On the other hand, individual emotional involvement and identification with a specific professional group may become less important. Identification with the profession could instead perform an instrumental function in the achievement of a post and in keeping it. Those who wish to remain in the profession will presumably be motivated more by market forces than affective issues. To some extent this is already so in Britain, where the move towards a market economy in welfare services is more advanced than in Italy. That the process of hospital closure in Britain does not guarantee against redundancy may also promote the rational action of individuals towards goal-oriented rather than value-laden objectives (Weber). However, mental health care is a field where the rules of a competitive market need to combine with human-centred activities. The focus on the individual, the client, as the receiving end of the care process does not allow the exclusive adoption of enterprenurial means, typical of a liberal economy. This is perhaps the next challenge which CPNs need to consider in their move towards a new professionalism.

Lastly, the development of case management deserves consideration for the future of CPN. It seems encouraging that community psychiatric nurses and social workers are in Britain among the preferred professional groups for recruiting case managers. Although there are many ways to implement case management, it is certainly a role with high levels of decisional power as to the choices of care and its

means. It may therefore confer more prestige and status to the profession, as well as provide the tools for actively contributing to the direction of community care strategies. Yet it is important to remember that the acquisition of a case manager position does not itself guarantee the achievement of these objectives. Community mental health centres in Italy operate according to a key worker system which to some extent reproduces some of the features of case management. CPNs are involved in this practice like any other mental health professionals. Their relationship with clients entails all the aspects of care, including the decision whether to ask for the psychiatrist's, social worker's, or occupational therapist's professional assistance. CPNs deal with all aspects of care, because they also tackle family issues, as well as job and housing needs. This is also a good reason for their dealing with a smaller case-load than their British colleagues.[9] As the findings indicate, the key worker role did not help Italian CPNs in reinforcing their professional status and power within the organization of psychiatric care. This is because in Italy , the adequate educational and institutional conditions do not exist, nor has the profession overcome the internal self-perception of subordination to the medical field, or the fear for an indepent professional role. Moreover, Italian CPNs do not have responsibilities as to the budget and purchasing of care packages. This represents indeed an important difference with British CPNs who are offered, by means of case management, the opportunity to achieve control on the use of resources. However, the Italian

[9] Thornicroft in an WHO publication about case management (see ref.chapter 5), describes the mental health centre of South Verona, in Italy, as an example of case management. What possibly Thornicroft does not know is that his description applies to any of the community mental health centre that, at least, the writer has visited and researched. What strikes in the comparison between the example of South Verona case management and other American or British examples of case management, is the lack of formalisation of the Italian structure. It is not in fact possible to define for the Italian case, individual case-load, type of professional interventions, length of the interventions, and so forth. This also confirms the difficulties encountered in this thesis at codifying and categorising the activities of Italian CPNs, which were instead clearly identifyable for British nurses. Furthermore the Italian system, although making use of key workers, is oriented towards the sharing of responsibilities at the collective-team level. In the British case, on the other hand, responsibility tends to lie on individual key workers. As indicated by Onyett (1993), the British system has a number of case management schemes, some with direct budgetary responsibilities and some without. This, however, represents an important difference with Italy, where neither CPNs nor other mental health professionals have budgetary or purchasing responsibilities. It is therefore possible that the comparison proposed by Thornicroft only illustrates one of the case management schemes which for some features recalls the Italian model.

experience should be a warning for British CPNs to concentrate on the legitimation of their profession and on the educational changes necessary to support the community role, in order to make the better use that the introduction of case management can bring to CPN.

If anything, this study provided an insight into the professional nursing experience during an important phase of institutional change. Professional needs, wishes, and suggestions are very often neglected at the policy level. In psychiatry, on the other hand, users and professionals ought to be the primary advisers during the implementation of a large scale project such as community care. Although it is certainly a modest contribution, this thesis is - to the writer's knowledge - the first European comparative study on CPNs.

The comparative perspective offered in this study indicates that there are many ways of learning from each other's experiences, starting from the shared point - underlined by both British and Italian CPNs - that contemporary community psychiatric nursing is a client-centred profession, and in this reversing the past task-centred hospital role. Indirectly the comparison between Britain and Italy also pointed out the relevance of cultural and historical differences between the two countries, which should be considered as a warning against any thoughtless attempt to export organizational or care models cross-nationally.

The room for further research is immense compared to the little which has so far been produced in the analysis of nursing as a professional endeavour. In particular, there is a need to closely monitor CPN practice, in order to elaborate and propose educational models which represent and support at best nurses' professional needs in the community. In the Italian case, it is also important to promote nursing research from within the professional field. Italian CPNs need to be more actively involved in planning and developing social research in their professional field, as this is also a more direct way of expressing professional needs and wishes, and of increasing the

status of CPN. British nurses are far better represented in social research,and they deserve to be encouraged towards this direction. The study of inter-professional relationships is another important research area, as the rapidly changing care policies are likely to affect the hierarchical structure of mental health professions.

The implementation of community care in many European countries is producing innumerable changes at the professional level which need to be studied and understood. Community psychiatric nursing is today one of the most interesting innovations of new psychiatric developments. It is by studying the vanguard of a phenomenon that the most hidden mechanisms of social change can be tackled and addressed. I also consider this to be one of the most important tasks of a social researcher.

7.3. References

Habermas J., 1975, see ref. chapter 3.

Gilli G.A., 1975, see ref. chapter 3.

Onyett S., 1992, *Case management in Mental Health*, Chapman & Hall, London.

Thornicroft A. , 1992, see ref. chapter 3.

Yin R., 1984, see ref. chapter 4.

APPENDIX A

QUESTIONNAIRE A

This research has been designed to investigate psychiatric nurses' professional experience of the process of deinstitutionalisation. The questions are aimed at finding out about nurses experience, opinions, and feelings about the move of psychiatric care into the community. It is the researcher's opinion that psychiatric nursing performs a key role in the implementation of psychiatric community care. The present questionnaire attempts to modestly compensate for the shortage of research on psychiatric nurses' opinions, proposals, and professional needs concerning community care. You will be asked several questions, so I would be grateful for your patience and collaboration.

Please attempt to answer all the following questions. A space for comments is left and the end of the questionnaire. If you find that any question is irrelevant or incorrectly specified, please note it down.

May I thank you in advance for your cooperation.

SECTION 1

Professional qualification :_____

Sex:
- ☐ F
- ☐ M

Age (please tick)
- ☐ 20-30 years old
- ☐ 31-40 years old
- ☐ 41-50 years old
- ☐ 51-60 years old

Place of work: please indicate the type of psychiatric team in which you work (i.e: CPN, resettlement team, community resource team, primary health care team etc.) and where the base is (health centre, psychiatric hospital etc.)

_____
_____
_____

Previous employment(s) if any: please list your previous employment(s).

_____
_____
_____

SECTION 2

1. Which kind of professional courses did you attend ?
Please, indicate the kind of professional education undertaken (including academic qualifications or degrees); the qualification obtained; and the length of the course.

Course	Qualification	Length

2. Are you satisfied with your training ?
Please, tick.

- ☐ Very satisfied
- ☐ Quite satisfied
- ☐ Little satisfied
- ☐ Not satisfied

3. Do you think your professional training suits the work you are presently doing?

- ☐ Yes
- ☐ No

4. Do you feel the need to extend your training?

- ☐ Yes
- ☐ No

5. If so, in which of the following sector you wish to undertake further training?
Please tick.

- ☐ Medical
- ☐ Psychological
- ☐ Psychiatric
- ☐ Social

6. Which one among the above sectors do you consider most suitable to your work?

- ☐ Medical
- ☐ Psychological
- ☐ Psychiatric
- ☐ Social

7. Did you specialised in any of the following approaches ?
(tick all those that apply)

- ☐ Family therapy
- ☐ Behaviour therapy
- ☐ Counselling
- ☐ Cognitive therapy
- ☐ No specialization
- ☐ Other (specify)

8. Do you think that professional specialization in psychiatry is:

- ☐ Fundamental
- ☐ Important in some cases
- ☐ Useless

9. Did you specialize in any particular client group?

- ☐ Yes
- ☐ No

10. If so, would you please indicate which one(s)?

- ☐ Elderly
- ☐ Drug/alcohol
- ☐ Rehabilitation/resettlement
- ☐ Children/adolescents
- ☐ Aids/Hiv

11. If you did not specialize in any particular client group or therapeutic approach, would you like to?

- ☐ Yes
- ☐ No

Would you please indicate the reasons for your answer?

_____

_____

SECTION 3

12. How many clients are presently on your caseload?

Please give an estimated number:_____

13. How many of your clients are long term mentally ill?

- ☐ None
- ☐ Less than half
- ☐ More than half
- ☐ All of them

14. How many of your clients have had a previous hospital admission?

- ☐ None
- ☐ Less than half
- ☐ More than half
- ☐ All of them

15. From which of the following sources do you get your referrals?

- ☐ Psychiatrist
- ☐ GP
- ☐ SW
- ☐ Health visitor
- ☐ Clients
- ☐ Family
- ☐ Other (specify)

16. How many of your clients have had a medical diagnosis of psychosis ?

- ☐ None
- ☐ Less than half
- ☐ More than half
- ☐ All of them

17. How many of your clients have had a medical diagnosis of neurosis ("worried well" or mild ilnesses) ?

- ☐ None
- ☐ Less than half
- ☐ More than half
- ☐ All of them

SECTION 4

18. On average, for how long would a client remain on your caseload ?

- ☐ 1 month
- ☐ from 1 to 2 months
- ☐ more than 2 months
- ☐ 6 months
- ☐ between 6 months and 1 year
- ☐ more than 1 year
- ☐ other (specify)

19. Does the time on individual caseload vary according to the clients' diagnosis?

- ☐ Yes
- ☐ No

If Yes, please specify_____

20. Do you visit your clients at home ?

- ☐ Yes
- ☐ No

21. Would you please specify which kind of activities you usually carry out during such visits or in your community work ?
(Please rank order by frequency)

- ☐ Speaking with clients
- ☐ Speaking with relatives
- ☐ Helping with the house work
- ☐ Having leisure activities with clients
- ☐ Shopping with clients
- ☐ Monitor medication
- ☐ Give medication
- ☐ Counselling
- ☐ Family therapy
- ☐ Behaviour therapy

22. How often do you spend time with clients' relatives ?

☐ Almost never ☐ Frequently ☐ Once in a while

23. How often do you do the following activities during your community job ?

	DAILY	WEEKLY	MONTHLY	NEVER
Planning	☐	☐	☐	☐
Evaluating	☐	☐	☐	☐
Having supervision	☐	☐	☐	☐
Giving supervision	☐	☐	☐	☐
Coordinating other serv.	☐	☐	☐	☐
Administrative work	☐	☐	☐	☐

24. Where do you spend your working time ?

- ☐ In the community mental health centre
- ☐ In the community
- ☐ Clients' houses
- ☐ In the hospital

25. How often do you have team meetings ?

- ☐ Monthly
- ☐ Weekly
- ☐ More than once a week
- ☐ Daily

26. Would you like to have team meetings :

- ☐ More often than now
- ☐ Less often than now
- ☐ With the same frequency as now

27. Do you happen to have one-to-one meetings with the members of your team?

- ☐ Yes
- ☐ No

28. If so, whom do you see more frequently ?
(Please rank order by frequency)

- ☐ Psychiatrist
- ☐ Psychologist
- ☐ GP
- ☐ SW
- ☐ Occ.Therapist
- ☐ Nurses

SECTION 5

29. What do you think of the career system in your profession ?

_____
_____
_____

30. Have you got any career objectives ?

- ☐ Yes
- ☐ No

Would you please specify ?

_____
_____
_____

31. Do you think that the process of deinstitutionalisation has somehow affected your professional career ?

- ☐ Yes
- ☐ No

Would you please indicate the reasons for your answer ?

_____
_____
_____

SECTION 6

32. What made you choose the psychiatric specialty?
Please tick.

- ☐ Absence of alternatives
- ☐ More chances to get a job
- ☐ Example from relatives
- ☐ Example from friends
- ☐ Willingness to help mentally distressed people
- ☐ Casual choice
- ☐ Personal history
- ☐ Vocation
- ☐ Other (specify)

33. If you had the chance, would you like to change your job ?

- ☐ Yes
- ☐ No

If yes, why?

_____
_____

34. Which features do you see as the advantages of your profession ?

_____
_____
_____

35. Which features do you see as the disadvantages of your profession ?

_____
_____
_____

36. In your opinion, what is unique about psychiatric nursing ?

_____
_____
_____

37. Where do you think your professional capacity is better used ?

- ☐ Community
- ☐ Hospital
- ☐ Both

38. If somebody tells you s/he would like to become a psychiatric nurse, would you :

- ☐ Congratulate and encourage the person
- ☐ Advise the person not to do it
- ☐ Tell the person about the difficulties entailed

39. Do you think that psychiatric nursing is a job with :

- ☐ A high degree of responsibility
- ☐ A normal degree of responsibility (as any other
- ☐ profession in psychiatry)
- ☐ A low degree of responsibility (less than other
- ☐ profession in psychiatry)

40. In your work would you like to have :

- ☐ Less responsibility
- ☐ More responsibility
- ☐ The same responsibility

41. Do you feel that you can share responsibility concerning your clients with other professional disciplines within your team ?

- ☐ Yes
- ☐ No

42. If no, would you like this to change ?

- ☐ Yes
- ☐ No

43. If yes, would you please indicate which disciplines ?

_____

_____

44. According to your experience, is there a professional role more important than others in mental health care ?

- ☐ Yes
- ☐ No

If yes, please indicate which and the reason for this choice.

_____
_____
_____

45. Do you think that the patterns of your work are :

- ☐ The same of other professionals
- ☐ Individualised
- ☐ Typical of my specialty

SECTION 7

46. If a friend or one of your relatives needed psychiatric care, would you contact :

- ☐ Community mental health centre
- ☐ A private clinic
- ☐ Hospital
- ☐ depends on the nature of the need

47. Do you think that deinstitutionalization is mainly :

- ☐ Political issue
- ☐ Economic issue
- ☐ Social issue
- ☐ Health issue
- ☐ Other (specify)

48. Do you think that the process of deinstitutionalization has brought :

- ☐ Positive and important innovations
- ☐ Nothing new
- ☐ A worse situation in psychiatric care

APPENDIX B

QUESTIONNARE B

This questionnaire contains statements about mental illness and therapeutic practices about which I would like to have your considered opinion.

Please, read each of the statement carefully, in the order in which it appears, and for each one indicate frankly to what extent you personally agree or disagree with it. Do this by circling next to each statement the one of the six symbols which best represents your own feelings about the statement.

Circle AAA if you strongly agree
Circle AA if you moderately agree
Circle A if you slightly agree

Circle DDD if you strongly disagree
Circle DD if you moderately disagree
Circle D if you slightly disagree

	Strongly agree	Moderately agree	Slightly agree	Slightly disagree	Moderately disagree	Strongly disagree
The psychiatric hospital does not have a curative function	AAA	AA	A	D	DD	DDD
Psychiatric hospitals are the suitable place in which to curemental illness	AAA	AA	A	D	DD	DDD
Deinstitutionalisation must be implemented gradually	AAA	AA	A	D	DD	DDD
Mental illness is the result of a psychological distortion in experiencing reality	AAA	AA	A	D	DD	DDD
The psychiatric hospital has the function of controlling deviance	AAA	AA	A	D	DD	DDD
Mental illness has social origins	AAA	AA	A	D	DD	DDD
The regulations of psychiatric hospitals aim at respecting the rights of patients	AAA	AA	A	D	DD	DDD
Community care offers the best opportunity to develop relationships with clients that are based on confidence and empathy	AAA	AA	A	D	DD	DDD
Mental illness presents periods in which hospital admission is necessary	AAA	AA	A	D	DD	DDD
Psychiatric hospitals are total institutions	AAA	AA	A	D	DD	DDD
People who are mentally ill are not dangerous for the community	AAA	AA	A	D	DD	DDD

Psychiatrists are appointed to diagnose patients	AAA	AA	A	D	DD	DDD
The psychiatric hospital is not the right place for the development of therapeutic relationships	AAA	AA	A	D	DD	DDD
Community care must ensure housing and maintenance, as they were provided in the hospital	AAA	AA	A	D	DD	DDD
Psychiatric hospitals deny human dignity and individual rights	AAA	AA	A	D	DD	DDD
The community is in itself therapeutic	AAA	AA	A	D	DD	DDD
Nursing staff has the duty to prevent patients from harming themselves	AAA	AA	A	D	DD	DDD
In psychiatric community care clients should be free to choose their own therapist	AAA	AA	A	D	DD	DDD
Community care requires a more complex organization than the hospital	AAA	AA	A	D	DD	DDD
Psychiatry medicalizes problems which are social in nature	AAA	AA	A	D	DD	DDD
The psychiatric hospital impairs mental health	AAA	AA	A	D	DD	DDD
Psychiatric patients always need medication	AAA	AA	A	D	DD	DDD
Patients must agree on their therapeutic treatment	AAA	AA	A	D	DD	DDD
The psychiatric hospital has positive functions which have been forgotten in the implementation of community care	AAA	AA	A	D	DD	DDD
Psychiatric diagnoses are a label that tends to produce a self-fullfilling prophecy	AAA	AA	A	D	DD	DDD
Mental illness is a social matter	AAA	AA	A	D	DD	DDD
Patients should never take medication by themselves	AAA	AA	A	D	DD	DDD
Community care should allow both professionals and users to choose each others	AAA	AA	A	D	DD	DDD
Planning and evaluating psychiatric work requires more flexibility in the community than in the hospital	AAA	AA	A	D	DD	DDD

The traditional professional hierarchy in psychiatry is a consequence of the mistification perpetrated through the psychiatric hospital	AAA	AA	A	D	DD	DDD
Psychiatric hospitals must shut down	AAA	AA	A	D	DD	DDD
A mentally disturbed person impairs the life of her/his relatives	AAA	AA	A	D	DD	DDD
Professional relationships with clients must not be discussed during team meetings	AAA	AA	A	D	DD	DDD
Good relationships and collaboration with clients' families are a fundamental requirement of community care	AAA	AA	A	D	DD	DDD
Mental illness represents a contradiction of the capitalist system	AAA	AA	A	D	DD	DDD
Everybody can learn how to cope with mentally distressed people, without the support of professional training	AAA	AA	A	D	DD	DDD
Psychiatric hospitals provide the tranquillity and the protection needed to mentally distressed people	AAA	AA	A	D	DD	DDD
Clients' right to privacy has always to be respected	AAA	AA	A	D	DD	DDD
Too often the economic costs of community care are under-evaluated	AAA	AA	A	D	DD	DDD
Mental illness is generated from social and political contradictions	AAA	AA	A	D	DD	DDD
Preventive psychiatry is a social duty	AAA	AA	A	D	DD	DDD
Mental illness indicates an impairment in the neurological system	AAA	AA	A	D	DD	DDD
Psychotherapy can be practised only by persons who have been specifically trained for it	AAA	AA	A	D	DD	DDD
The shift to the community presents difficulties as regard to the professional role and identity	AAA	AA	A	D	DD	DDD
A commonsense approach is one of the best answers to mental distress	AAA	AA	A	D	DD	DDD
It is scientifically demonstrated that schizophrenia is hereditary in character	AAA	AA	A	D	DD	DDD
The wrong way to cope with environmental stimula can cause mental illness	AAA	AA	A	D	DD	DDD

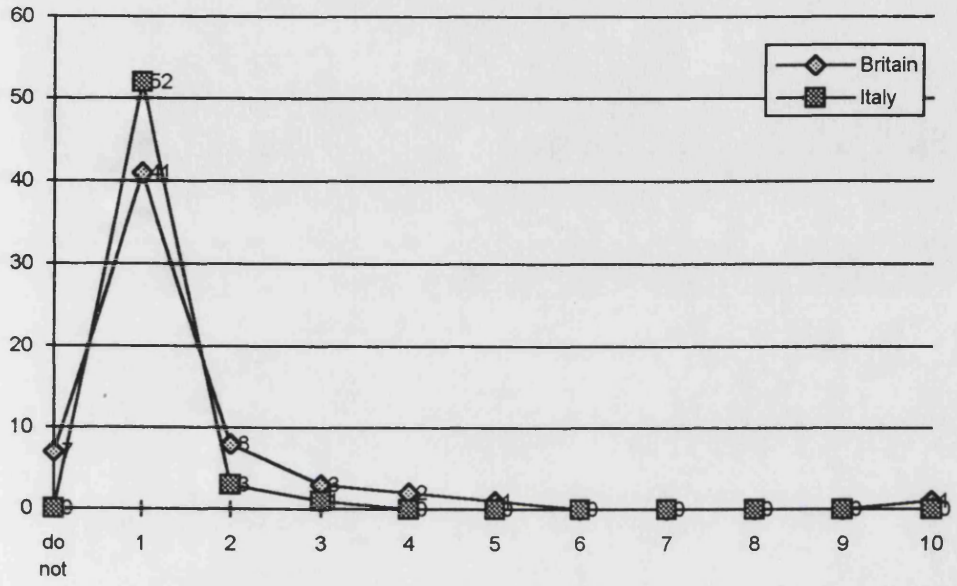
Community care, as compared to the hospital, requires different levels of assistance	AAA	AA	A	D	DD	DDD
Community care demands cooperation between professionals and clients in order to set up new patterns of care	AAA	AA	A	D	DD	DDD
ECT is a useful remedy for some kind of patients	AAA	AA	A	D	DD	DDD
More interdisciplinary work is needed in community work than in the hospital	AAA	AA	A	D	DD	DDD
Professionals in the community must reject their traditional roles	AAA	AA	A	D	DD	DDD
Madness is a disease whose causes are biochemical	AAA	AA	A	D	DD	DDD
Clients must be protected in the community as they used to be in hospital	AAA	AA	A	D	DD	DDD
Professionals in the community must be on the same footing as clients	AAA	AA	A	D	DD	DDD
Mentally distressed people can be dangerous	AAA	AA	A	D	DD	DDD
The protection of the community must be guaranteed	AAA	AA	A	D	DD	DDD
Multidisciplinary work is the basis of community work	AAA	AA	A	D	DD	DDD
Chronicity is the consequence of some kind of mental disease	AAA	AA	A	D	DD	DDD
The lines of professional responsibility ought to be more clear in community work	AAA	AA	A	D	DD	DDD
Psychiatric nursing in the hospital has a custodial functional	AAA	AA	A	D	DD	DDD
The psychiatric hospital is the place where patients can freely express themselves	AAA	AA	A	D	DD	DDD
Traditional professional competences are useless in the community	AAA	AA	A	D	DD	DDD
Nurses are not competent to diagnose patients	AAA	AA	A	D	DD	DDD
The only function of psychiatric hospitals is custodial	AAA	AA	A	D	DD	DDD
Unskilled people, like friends and relatives, cannot						

properly cope with mentally ill people	AAA	AA	A	D	DD	DDD
Chronicity is a consequence of the hospital system	AAA	AA	A	D	DD	DDD
Psychiatric nursing in the community has the opportunity to become an eminently social and therapeutic professional role	AAA	AA	A	D	DD	DDD
The psychiatric hospital is the place where mental disease can be controlled and studied	AAA	AA	A	D	DD	DDD
Psychiatrists' specific competences are useless in the community	AAA	AA	A	D	DD	DDD
Chemical constrains are a useful remedy for some kind of patients	AAA	AA	A	D	DD	DDD
Psychiatric nursing in the hospital has a clinical function	AAA	AA	A	D	DD	DDD
The care of mental illness is a collective responsibility	AAA	AA	A	D	DD	DDD
Mechanical constraints are useful for some kind of patients	AAA	AA	A	D	DD	DDD

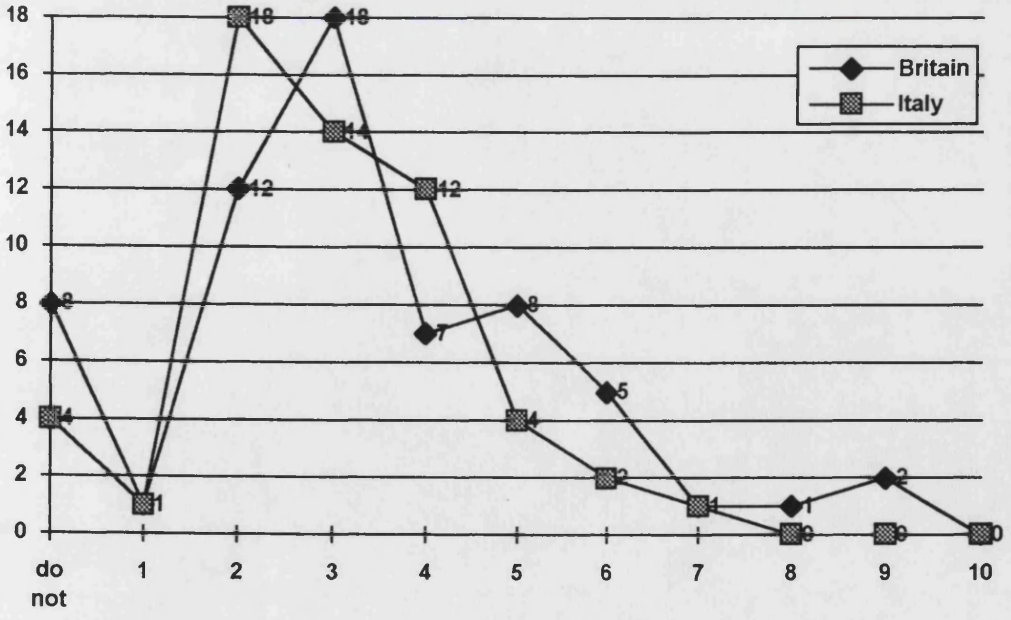
APPENDIX C

The following tables indicate nurses ranking about ten work practices according to frequency order 10

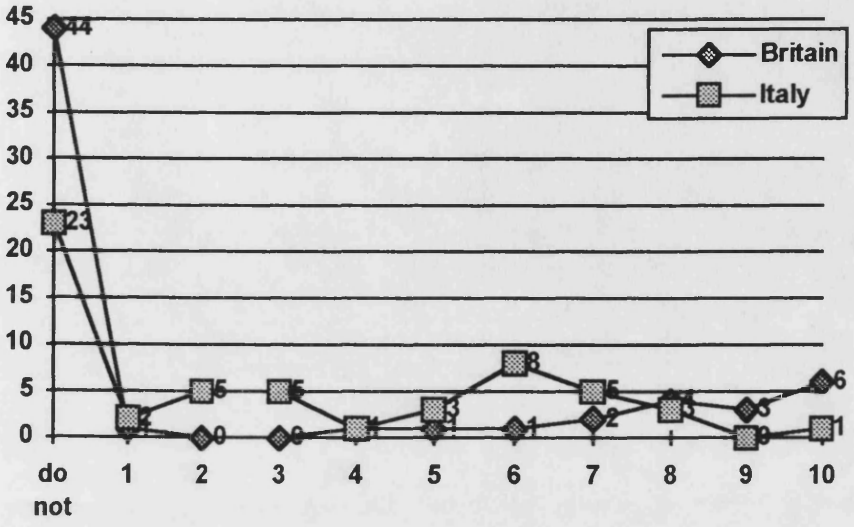
Graphic 1 : CPNs work practices : speaking with clients



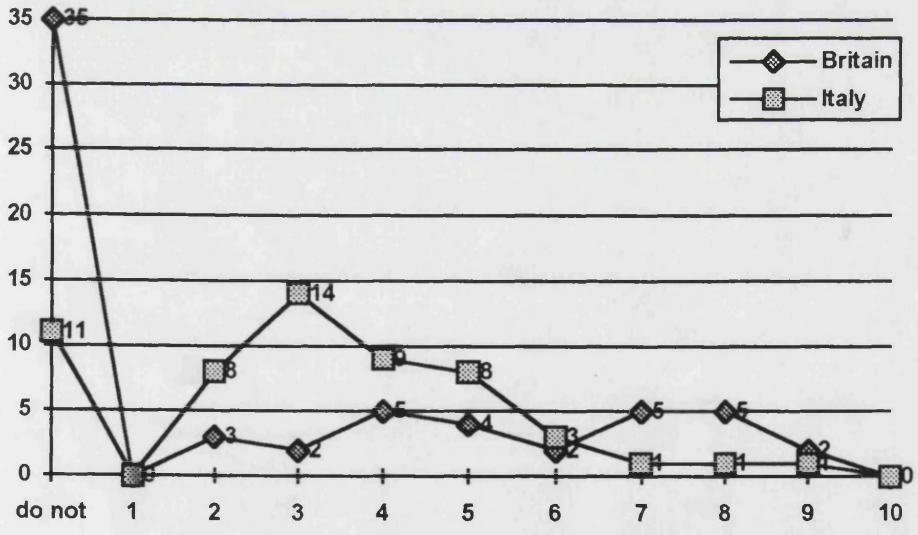
Graphic 2 : CPNs work practices : speaking with relatives



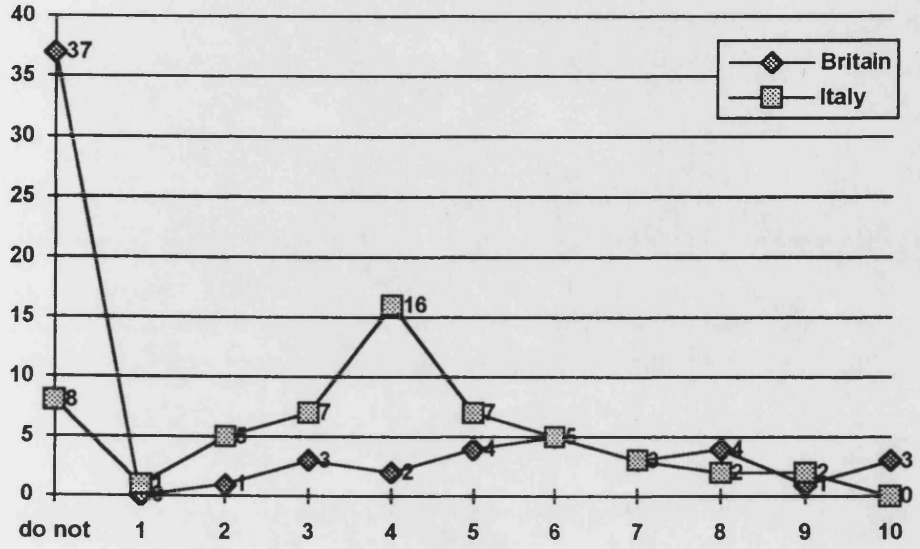
Graphic 3 : CPNs work practices : helping with the housework



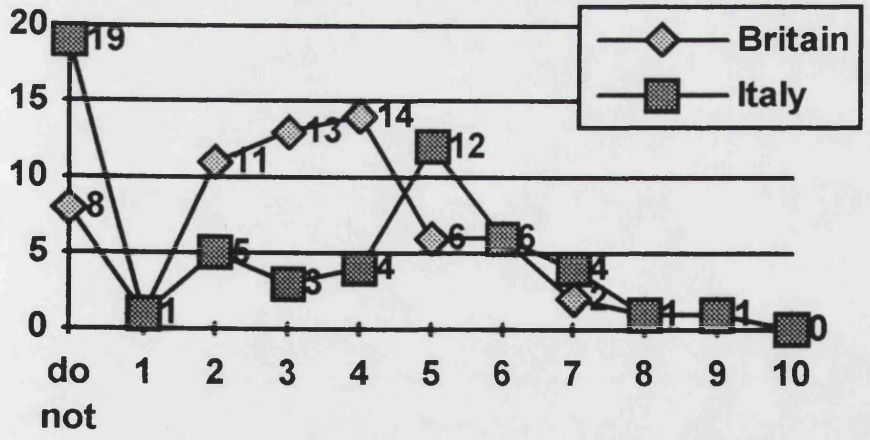
Graphic 4 : CPNs work practices : having leisure activities with clients



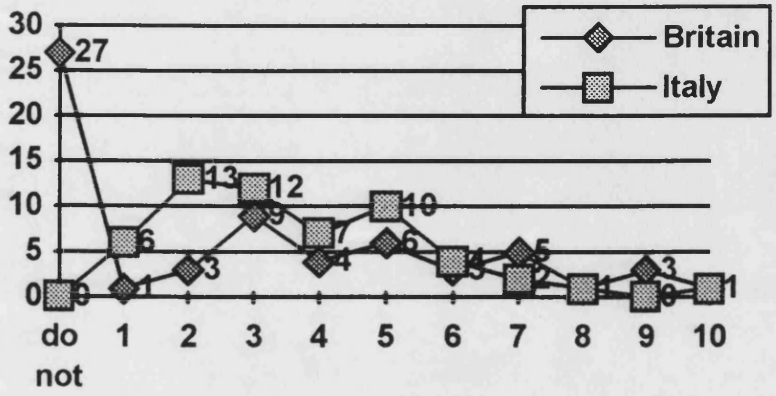
Graphic 5 : CPNs work practices : shopping with clients



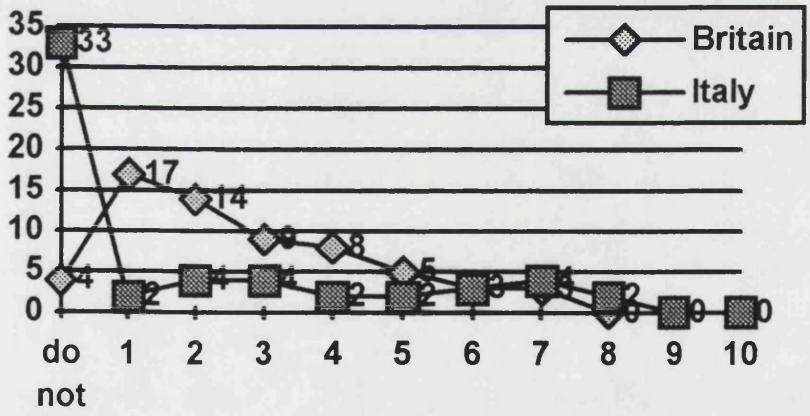
Graphic 6 : CPNs work practices : to monitor medication



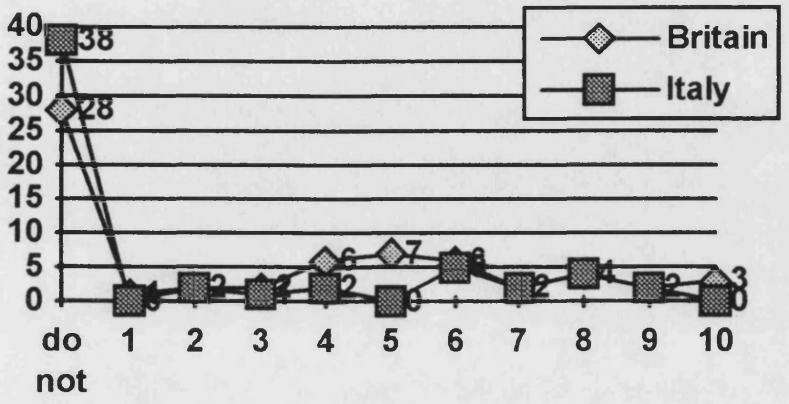
Graphic 7 : CPNs work practices : to give medication



Graphic 8 : CPNs work practices : counselling



Graphic 9 : CPNs work practices : family therapy



Graphic 10 : CPNs work practices . behaviour therapy