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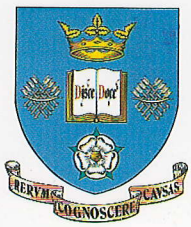

University of Sheffield

for Health Services Research

Evaluation of two Pharmaceutical Care Programmes for People with Mental Health Problems Living in the Community

A. Aldridge, R. Dingwall, P. Watson

DISCUSSION PAPER No.96/03

1996

EVALUATION OF TWO PHARMACEUTICAL CARE PROGRAMMES FOR PEOPLE WITH MENTAL HEALTH PROBLEMS LIVING IN THE COMMUNITY

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Alan Aldridge
Robert Dingwall
Pamela Watson

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EXECUTIVE SUMMARY

This report describes the qualitative evaluation of the Liverpool and Nottinghamshire pharmaceutical care programmes. Data were collected over a 30 month period by means of observation, interview, examination of documents and postal questionnaire.

The programmes showed marked divergences indicating the influence of different priorities and strategies. Where a specialist psychiatric hospital existed the developments reflected processes of service transfer and substitution. Hospital pharmacists have been involved in these plans and their contributions have led to projects focusing on the problems of dual prescribing sources, including the inadequacy of customary recording mechanisms. To pharmacists these issues are important: however projects of this type do not appear to have attracted any significant support from other health care personnel or patients unless they were coincident with other changes taking place. Attempts to provide clinical services by community pharmacists in conjunction with GPs have also met with limited success. On the other hand, advisory services offered directly to clients by community pharmacists in social care settings have been widely welcomed by users, their representatives and care providers.

FHSA project facilitators have accomplished a wide variety of tasks and assumed many responsibilities outwith the original objectives in order to meet other needs, either identified directly as a result of the project work or by their FHSA managers. These activities may have been important in demonstrating the value of a development worker for pharmaceutical services. The projects have also demonstrated how services developed in primary care settings can affect aspects of practice in the secondary sector and re-emphasised the importance of effective communication between the two.

The facilitators have also come to be an important resource for local pharmacists. In evaluating this it is essential to recognise the way in which the funding attached to the facilitators has allowed them to take initiatives without becoming embroiled in the disputes about payment which may otherwise arise when independent contractors are asked to expand their roles.

This evaluation has also confirmed the findings of other work on the problems associated with health service innovations in terms of understanding the implications of change for others and the resistance that is likely to be encountered.

1 BACKGROUND

..an integrated approach to the treatment of the psychiatric patient living in the community .. requires that topics as diverse as pharmacokinetics, community organisation and psychotherapy be appropriately co-ordinated.

Preface to The chronic psychiatric patient in the community (1983) I Barofsky and R Budson (eds.) MTP Press Ltd, Lancaster

As a generalisation it can be said that anyone who is chronically sick or mentally handicapped, and who has to rely on a continuous drug regime, should be a candidate for additional support and help from the (community) pharmacist. ... The long term treatment of schizophrenics is an example of a new development in what is largely uncharted territory. (para. 3.55)

Pharmacy: A report to the Nuffield Foundation, (1986) Nuffield Foundation, London

1.1 It is well established that medication plays a pivotal role in maintaining the stability of the mentally ill[1], particularly those diagnosed as schizophrenic (1). Within a hospital environment there are, at least theoretically, reliable and carefully monitored systems to cover all aspects of prescribing, drug supply, usage and response. Although there are now a large number of initiatives concerned with planned discharge and aftercare, medication is only one of the many factors to be considered. In most community settings there are a number of points at which the parallel systems may be disrupted. Patients have far more opportunities to fail to take their medication, whether intentionally or otherwise. It is, however, reasonable to assume that the majority of prescriptions for such medication written by general practitioners will eventually be presented to, and dispensed by, community pharmacists who share

[1]The precise words used to describe phenomena are frequently taken as indicating some particular professional, moral or political stance. Mental illness, mental health/problems, mental distress have been used almost interchangeably during the evaluation as have patient, client, resident, service user, user, member and (occasionally) customer. Within the report usage tends to reflect the terminology adopted by the source.

responsibility with prescribers (and others) in helping people to take their medicines appropriately.

1.2 The Pharmaceutical Division of the Department of Health proposed the pharmaceutical care programmes with the objective of promoting integrated and responsive pharmaceutical services for the mentally ill returning from hospital to the community. More specifically it aimed to promote service developments which could include the provision of special dispensing services and professional advice by community pharmacists for this particular client group. The department also wished to encourage the involvement of such pharmacists in multidisciplinary teamwork in order that pharmaceutical care[2] should, as far as possible, be integrated with the wider care programme approach[3].

1.3 The Department's proposed strategy was to set up a number of pilot schemes, or demonstration programmes, to show some of the various ways in which this could be achieved using specially appointed pharmaceutical facilitators. The facilitators would 'act as a resource for community pharmacists, enable them to make contact with key workers and primary healthcare teams, examine with them the problems faced by this group of patients with regard to medicines and establish sensible solutions to those problems'.

1.4 A number of FHSA general managers were contacted to assess interest in the proposed programmes and eventually the choice was narrowed down to four areas. All had psychiatric hospitals that had recently closed or were in the process of closure. For both financial and logistic reasons it became apparent that only two sites could be included in the scheme. Liverpool and Nottinghamshire were said to have shown the most interest over some period of time and eventually these were the two FHSAs selected. Pharmaceutical facilitators for mental health were appointed by these FHSAs in the summer of 1991 on two year fixed term contracts.

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[2]Pharmaceutical care is defined by its major proponents as 'the responsible provision of drug therapy for the purpose of achieving outcomes that improve a patient's quality of life' (2). The resulting approach to providing patient services focuses on individualisation of care and 'outcomes' that are negotiated with patients. Within this study informants have also used the term as a more general description of the various healthcare activities in which pharmacists are, or could be, involved.

[3]The Department of Health issued the joint Health/Social Services Circular HC(90) 23/LASSL(90)11 in September 1990. By April 1st 1991 DHAs and SHAs were to implement 'local care programme policies' which were to 'apply to all in-patients considered for discharge, and all new patients accepted by the specialist psychiatric services.

1.5 The outlines given to both sites made it clear that the Department would not be prescriptive about how services were developed or what was to be developed. Part of the key to success was seen to be the local knowledge and ingenuity residing in the FHSAs.

1.6 In January 1992 a contract for the evaluation of both programmes extending over 30 months was awarded to the School of Social Studies at the University of Nottingham. The evaluation began in February 1992, six months after the appointment of the facilitators.

2 EVALUATION METHODOLOGY

2.1 The aim of the evaluation project was to monitor and assess the impact of the pharmaceutical care programmes. Recent writers on the methodology of programme evaluation have stressed the need to adopt multi-method approaches in response to the numerous problems associated with the evaluation of human services (3,4,5). Traditionally evaluations have been synonymous with measuring goal attainment but it is now recognised that service goals are normally multiple, conflicting and subject to change over time and between contexts. Conventional input/output and outcome evaluation methodologies are ill-suited to handling such complexity.

2.2 Any evaluation is context-specific - it addresses particular questions being asked in particular circumstances for particular individuals. These individuals can be referred to as 'stakeholders'. Guba and Lincoln (4) have identified three broad classes each with some subtypes:

- the agents, those people involved in producing, using and implementing the programme - these would include developers, funders, decision makers and providers;
- the beneficiaries, those who profit in some way from the use of the programme - target groups, indirect beneficiaries;
- the victims, those people negatively affected by the use of the programme - groups systematically excluded, those suffering loss in power, influence or prestige.

2.3 The proposed research design consisted of four overlapping phases:

- identification of major stakeholders in the community care networks for discharged patients in which the programmes were embedded. They would be interviewed in order to elicit their objectives and criteria for assessing the scheme;
- a description of the work of the facilitators and of the community pharmacists they have involved in the programmes;
- data analysis;

- more closely focused interviews with key stakeholders to assess whether their expectations of the schemes had been met.

2.4 Because there are invariably difficulties in assessing the extent to which any service innovation is responsible for the outcomes achieved - a problem compounded in this case by the organisational turbulence being experienced at the time by both health services and local authority social services departments - a 'control' site was included in the study. Relevant criteria related to city status, population size, ethnic diversity, geographical accessibility and situation within a third region. Our initial approach to Coventry FHSA's general manager elicited an encouraging response and this city was selected as our control site.

2.5 Evaluations are however tailored to programmes and not *vice versa*. The rapid progress in both Liverpool and Nottinghamshire before the evaluation began, coupled with the distinctive patterns emerging in each site, led to various modifications in the research design.

2.6 Some stakeholders who should, in theory, have been important did not always know enough about the pharmaceutical care programmes to have developed any criteria at all for assessing the schemes. Others were aware of the schemes but were reluctant to participate in the evaluation. Yet others (for example, the early 'beneficiaries') did not see any need for evaluation. In consequence we concentrated on stakeholders more directly involved with the programmes themselves and then followed identified lines of influence where this seemed appropriate.

2.7 In both Liverpool and Nottinghamshire data have been collected in a variety of ways. A part time research assistant was employed in Nottinghamshire (May to November 1992) to assist with a literature search. A Liverpool based research assistant was appointed later (January to November 1993) to supplement the work of the main researcher.

2.8 An indispensable part of the study of any social organisation is systematic direct observation. Pharmacists and facilitators were observed in a wide variety of situations and interacting with clients and members of other occupational groups.

2.9 Approximately 90 interviews were carried out in Liverpool and over 70 in Nottinghamshire. The people interviewed included FHSA and project managers, steering group members, LPC members/officers, hospital pharmacists, community services pharmacists, Centre for Pharmacy Postgraduate Education (CPPE) tutors, LPC members/officers, community pharmacists, psychiatrists, general practitioners, nurse managers, day hospital staff, social workers from local authorities and the voluntary sector, day centre managers, nursing and residential home managers, housing association personnel, representatives of voluntary organisations (e.g. Age Concern, NSF, MIND), community health council officer and service users themselves. Seven interviews were carried out in Coventry and there were other telephone contacts.

The interviews varied in the extent to which they could be characterised as formal or informal but in all cases the major questions and areas to be covered were planned in advance. Most interviews were tape recorded and (selectively) transcribed. Notes were made in all cases. In some instances interview summaries were provided for informants/respondents.

There have also been numerous informal contacts and telephone calls with pharmacists and facilitators. Contemporaneous notes were made of most of these encounters.

2.10 Regular written reports for the Department of Health were prepared by the facilitators. Together with other documentation these were made available for analysis. Records designed by the Liverpool facilitator for the pharmacists in that project were also reviewed.

2.11 Suitable textual data from all sources was coded and analysed using the HyperRESEARCH text management package.

2.12 A very short questionnaire was sent to 29 Liverpool GPs relating to one specific part of the programme; 16 were eventually returned.

3 PROJECT LOCATIONS

3.1 **LIVERPOOL:** the population is presently estimated at about 460,000. During the period 1981 to 1987 the population loss was about 40,000 and this decline continues with consequential effects on both the human and financial resources available for community care. DHA, FHSA and local authority boundaries are coterminous.

3.2 The FHSA holds contracts with 242 GPs (41 single handed) in 106 practices. There are 123 pharmacist contractors although the total number of pharmacists regularly working in the community is unknown.

3.3 Rainhill Hospital, the main psychiatric hospital serving the Liverpool District Health Authority, finally closed shortly before the project began. Long term patients had been discharged to a variety of community settings throughout the city. The phased closure of this hospital over a seven year period has been described as 'a model of care in the community' (6) although the future provision of pharmacy services to its former residents was said to be:

> *"a very secondary matter"* (Regional Pharmaceutical Officer)

3.4 Acute psychiatric services in the city are provided by a number of units in district general hospitals. A comprehensive (and critical) review of general psychiatric services was conducted in 1992 (7).

3.5 There are no specialist psychiatric pharmacists: clinical pharmacy specialisms have developed in other fields and there have been both financial and time constraints on expanding psychiatric services.

3.6 Among the services for the 'mentally distressed' are those provided by day centres. The city describes itself as having been 'particularly innovative in creating community day centres provided by the local authority and voluntary sector - About 300 places a day are available' (8). These are linked by a group known as the Joint Forum, bringing providers and users together.

3.7 **NOTTINGHAMSHIRE:** has a population of 970,969, slightly more than a quarter of this total residing in the city district of Nottingham. The area is covered by two district health authorities. (Bassetlaw and Central Nottinghamshire merged in 1992 to form North Nottinghamshire Health Authority.) Nottingham Health Authority serves approximately two thirds of the county's total population.

3.8 Primary medical care workers include 505 GPs working in 189 medical practices (53 single handed). Twenty one of these practices do their own dispensing. There are 187 pharmacist contractors.

3.9 The former County Asylum (Saxondale Hospital) closed in 1988, its patients returning to the parts of the county from which they came. Mapperley Hospital, the only remaining psychiatric hospital within the city, is scheduled to close by 1995. Psychiatric care in Nottingham is almost invariably associated with services provided by the sector teams.[4] Acute psychiatric services have been fully sectorised since 1985; each sector is served by a community mental health team, hospital acute ward (at Mapperley or in a district general hospital psychiatric unit) and day hospital situated either in hospital or community. Although there are links with GPs most of the activity is not in the primary care sector. Nottingham Rehabilitation and Community Care Services (RCCS), established in 1982, act as the long-term division of the mental health unit.

3.10 Rebuilding of some psychiatric facilities is taking place on a part of the Mapperley site, and will include a new pharmacy. The hospital pharmacy has always been particularly active and provides services to a large number of offsite facilities including those run by RCCS.

3.11 Although there is an active user movement in Nottingham (Patients Council, Advocacy Group) this has largely been linked with services provided by sector teams.

[4]Bean and Mounser (9) have argued that sectorisation in this form is a community care model.

3.12 Acute psychiatric facilities in North Nottinghamshire are situated on district general hospital sites although in the former Central Nottinghamshire area they form part of the NHS Trust providing priority care services.

3.13 **COVENTRY:** (population 304,000). Primary medical care services are provided by 165 GPs working in 66 practices. There are 80 pharmacist contractors, mainly working for large companies.

3.14 An acute psychiatric unit is located on a district general hospital site but now forms part of a separate Trust. This has approximately 200 beds some of which were reported to be for longer stay patients. Pharmacy services have been provided by a specialist pharmacist working closely with the general hospital pharmacy.

3.15 Approximately 12 registered nursing/residential homes provide care for patients with long term mental illness.

4 FHSA STRATEGIES AND OBJECTIVES FOR THE PROJECT

4.1 Managerial objectives

In spite of the very different locations and starting points for the two programmes FHSA managers, in their initial interviews, made similar points about community pharmacy and its likely future development, its position in regard to the organisation itself and interprofessional relationships between their various contractors.

4.2 Many FHSA, and previously FPC, developments had concentrated on their 'other contractors' (primarily GPs) and there was a recognition that pharmacy had been neglected. The FHSA were keen for pharmacists to be involved in a broader role and for this to be proactive rather than reactive - the projects been instrumental in giving specific and achievable examples of role development. They were also keen to see more integration of community pharmacists into the primary health care team.

4.3 The different emphases of the two programmes were apparent at this stage with consequences for both stakeholder networks and intended outcomes. In Nottinghamshire concern was expressed over pharmacists' perceived lack of knowledge and understanding about community care - the planned programme training was intended to address this. There were no overt references to mental illness. Problems associated with medication compliance, the potential for pharmacist intervention and hospital re-admissions (*'the revolving door syndrome'*) were only mentioned in Liverpool.

4.4 One manager compared the posts with those of nurse facilitators, who had had to work over lengthy periods to establish *'credibility and trust'*. As this programme was time limited it was possible that the term 'facilitator' was misleading and that 'project worker' may have been more appropriate.

4.5 The time scale and the pilot project status were problematic. Where services had been planned or were in the process of implementation it was quite clear that there should be mechanisms to allow them to continue and:

"a major task is to explore ways of carrying on -- but if we are unable to find ways to measure improvements in care it will not mean that the project has been a failure" (FHSA manager)

4.6 Steering groups

Nottinghamshire FHSA established a steering group for the programme which first met before the facilitator took up her post: there were representatives of hospital pharmacy/community services pharmacy from all health authorities within the FHSA area, of Mapperley Hospital pharmacy (specialist psychiatric pharmacy) and community pharmacy (LPC secretary). It also included the two FHSA managers. The group defined six individual projects each with its own specific objectives and timescale. Liverpool FHSA decided not to form a steering group. Professional and managerial support were available within the organisation, key people in other agencies were already known and the facilitator was well established in local community pharmacy networks.

4.7 Initial interviews with Nottinghamshire steering group members did not elicit a homogeneous definition of what they would regard as successful outcomes. Indeed most of the informants had difficulty in specifying any expected outcome for the programme as a whole. Members were mainly concerned with the particular project or projects which touched on their individual spheres of interest. Comments were made about the lack of community pharmacy representation in the steering group but there were difficulties in identifying legitimate representatives of this group and in ensuring their availability during normal working hours.

4.8 Hospital pharmacists acknowledged the difficulties in liaison between different branches of pharmacy but thought that projects of mutual interest (such as these) were useful in improving understanding and establishing new links. The purpose of four of the projects was to make a smooth transition from hospital to community based services and to tailor the amount of support needed in the longer term - for both individuals and organisations. They also stressed the importance of using the projects to learn how things worked in the community - it was unlikely that there would always be a facilitator in post to assist with similar developments.

4.9 Nottinghamshire LPC was reported to have been deliberately provocative to the facilitator over the financial aspects of the programme, in part as a consequence of previous dealings between the profession and the Department of Health. It was also thought that there was some anxiety about a change of role, particularly among older pharmacists who had never been involved in 'Community Care'.[5]

4.10 **Pharmaceutical facilitators**

A large number of FHSAs now employ pharmacists variously described as advisers or facilitators. There would appear to be no clear linkage between the title and the particular job description but the majority were originally employed to work on issues related to prescribing. Before the beginning of this project Liverpool employed a full time pharmaceutical adviser (clinical pharmacy adviser) and Nottinghamshire a part time prescribing adviser. Coventry FHSA had a local community pharmacist (and LPC member) employed as pharmaceutical adviser on a part time basis. He also acted as community services pharmacist.

4.11 The mental health pharmaceutical facilitators appointed to the project had very different professional backgrounds. Liverpool selected a community pharmacist who was active in both local and national pharmaceutical organisations. He was managerially accountable to the FHSA's pharmaceutical adviser. In Nottinghamshire the successful candidate was a hospital pharmacist from another area who had previously worked at Mapperley Hospital. She was managerially accountable to the FHSA's Director of Planning and Service Development through the Joint Steering Group.

4.12 Each had funds allocated to cover the community pharmacy services they wished to develop. This was reported to be about £40,000 in Liverpool for the two year period. There was presumably a similar amount in Nottinghamshire but no figures were ever quoted.

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5 Other pharmacists may have interpreted the terminology of community care differently. One was particularly emphatic that this was what he had been doing for the last 35 years.

5 PHARMACEUTICAL CARE PROGRAMMES: DESIGN, IMPLEMENTATION AND RESPONSE

LIVERPOOL

5.1 The Liverpool facilitator recognised from the outset that the population for which he aimed to create innovative pharmaceutical services were not necessarily those people who had been discharged from Rainhill. There were no centrally held data which would allow this group to be identified but it was assumed that the service developments would include at least some of them.

After *'wide consultations'* which resulted in a mass of conflicting information he adopted a dual approach:

- the use of data obtained from the Prescription Pricing Authority to locate within the city those postal districts where the highest proportion of antipsychotic drugs (BNF Chapter 4.2) were dispensed and then to find suitable pharmacists in those localities to take part in his planned programme of training and service provision;
- administering a specially designed questionnaire to gain information relating to attitudes to drug therapy and other aspects of drug usage among a number of clients currently using mental health services. The services could then be planned to respond to the concerns expressed by the particular client group.

5.2 Fourteen pharmacists were originally 'recruited' to the programme, reportedly with some difficulty. This lack of enthusiasm was contrasted with other local initiatives which attracted greater interest - however it did free the facilitator from having to make potentially difficult decisions about which pharmacists to include. Two others wished to join but were unable to obtain permission from their employers. The pharmacists came from a variety of business situations with different professional orientations and experience. Half of the group were said to have been known to the facilitator previously. Most pharmacists reported that they joined the project as a result of a direct approach, some admitting that the training course, held over two days and four evenings, was the main attraction.

5.3 The course, focusing particularly on the care of the patient with psychotic illness, was planned in conjunction with the School of Pharmacy at Liverpool John Moores University and was advertised using regional RPSGB lists. Contractors wishing to participate in the pharmacy mental health programme were required to attend all the sessions.

5.4 Subsequently each pharmacist was to offer four services which were planned to be implemented in stages from March to June 1992. Contracts were issued referring to the specific services, the hours of service and remuneration and the logging of pharmacists' activities.

> *"All activities related to the provision of extended mental health services should be recorded in the log book provided by the FHSA"*

5.5 **Community Mental Health Resource Pharmacies ('In shop' services)**

> *"Regardless of whether non-compliance is considered a patient or a practitioner problem all health providers have a professional responsibility to offer services that adequately meet the needs of their patients including those that promote safe and appropriate drug use. ... the literature strongly suggests that certain basic, routine services which are considered a minimal part of any good pharmacy practice can have a dramatic impact on preventing a compliance problem.*
>
> *The clinical pharmacy and compliance, JM McKenney in Compliance and Health Care (1979) RB Haynes, DW Taylor and DL Sackett (eds.), Johns Hopkins University Press, Baltimore"*

Additional services within the pharmacy were to include:

- increased stock holding of relevant drugs;

- provision of individualised information leaflets (a computer programme had been specially commissioned);
- maintenance of patient medication records;
- instalment dispensing or dispensing into medication aids of various designs.

5.6 The pharmaceutical care programme and participating pharmacies were publicised in a leaflet designed by the local branch of MIND.[6] These were circulated among relevant organisations and displayed in a range of locations. Leaflets were also given to patients being discharged from psychiatric units at two local hospitals. A hospital pharmacist described this as not in any way directing subsequent prescriptions but giving patients the option to speak to *'interested pharmacists'*.

5.7 When initially interviewed in September 1992 most pharmacists considered that there had been no great uptake of this service although pointed out that they do not necessarily know about the origins of all their customers. Professionals (community psychiatric nurses and social workers were cited as examples) as well as clients had also approached pharmacists for additional information.

Pharmacists were interviewed for the second time a year later when some of the same examples relating to patients/care providers were given suggesting that the leaflets had the most impact soon after the initial distribution.

There were some suggestions that existing customers then known better from pharmacists' work in other locations (hostels/day centres) were using the pharmacies in a different way - for instance they would stay longer and were more likely to ask for advice.

Records kept by six pharmacists over a total of 131 weeks show 954 project related activities taking place within their pharmacies (approximately seven each per week) ranging from the provision of leaflets to contacts with prescribers and key workers.

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6 Despite the implication that only listed pharmacists were able to answer 'questions about the tablets you or a relative or friend were taking' (for mental distress) no critical comments about 'unethical advertising' were received from other pharmacists. However a Cantonese speaking pharmacist translated the leaflet for use at a Chinese community centre but omitted pharmacists' addresses as another pharmacist worked in the vicinity and he was anxious to avoid problems.

5.8 A number of pharmacists had bought 'compliance aids' but there seemed to be relatively little demand from customers for drugs to be dispensed in such devices. The information leaflets designed for the project were difficult to produce at the time of dispensing without a second computer although they were being used both in the pharmacy and in other locations.

Some pharmacists had independently developed instalment dispensing systems which continued throughout their participation in the scheme. (Only for this period were their costs covered.)

5.9 Although 'in pharmacy' work was initially described by the facilitator as the 'backbone' of the proposed new services it is not clear that project pharmacists have seen it in this light. Few have mentioned it in terms of 'work they were still doing for the project' and only one as the area in which they thought they had had most impact. But others have commented on the extent to which their knowledge and counselling skills had improved both as a result of the training programme and subsequent experience so it seems likely that this is reflected in their daily activities without prompting specific comment or record.

5.10 **Advisory and Counselling Services in Day Centres**

> *"Insofar as HCPs adopt an open, honest, supportive style, demonstrate respect, praise the patient, and provide clear explanations, treatment adherence will increase.*
>
> *Facilitating treatment adherence: a practitioner's guidebook (1987) D Meichenbaum and DC Turk, Plenum, NY*
>
> *When (facilitator's) project was first talked about it was described as a medication compliance project and I was quite horrified by what this might mean -- it was pleasant to discover it was about helping people manage and make choices about their medication."*
>
> (Mental Health Charity Worker)

The aims as originally defined were the provision of information to both staff and day centre members with respect to psychotropic medicines as well as the provision of informal and confidential counselling to members, again regarding the use of psychotropic drugs.

Of the 13 day centre managers interviewed not all were initially in favour of the proposed service though for different reasons:

> *"I was sceptical because we're dealing with mentally ill people and at first I thought of it as not being advantageous to know a lot about their medication*
>
> *I interrogated (facilitator) when he first came because I wondered if there was a hidden agenda going on about medication and why people were checking up"*

However all mentioned the extent to which issues to do with medication affected both their work and their members' well-being and how ill equipped they were to deal with these problems. Various strategies had been used previously (for example contacting GPs or CPNs) but frequently with little success.

Members of day centres had been consulted by staff about the introduction of the proposed services either informally or through organisational committee structures.

5.11 Most pharmacists instituted a regular programme weekly of visits as planned. This was thought important mainly in terms of *'building relationships'* and *'establishing trust'* even though the number of members wishing to consult the pharmacist on any one occasion might be small. A day centre dealing with homeless people, some of whom were not registered with a GP, stressed the importance of a weekly visiting schedule for another reason:

> *"We've got a number of people who decide they don't need to go (for injections). So if you can get people quite early on in that cycle and say (member) will talk to (pharmacist) about the*

effects on Thursday - that often persuades people back onto injections." (Manager)

5.12 It very quickly became clear (verbal and written comments) that this was a service valued by centre managers and members and was also one about which the majority of pharmacists were enthusiastic. These positive reactions have been sustained over time. An initial response came from various contributors to the Joyce report (7) in June 1992. The facilitator circulated a questionnaire towards the end of 1992, interviews with several social workers and CHC officers in January 1993 and the main interviews with day centre staff/members in the summer of 1993 have all provided similar evidence. Even where services had lapsed (or had never been completely implemented) staff still saw the **potential** for a pharmacy service of this type.

Any dissatisfaction expressed related to the failure to establish a predictable pattern of visits and a lack of liaison with staff.

5.13 Pharmacists were involved in both individual counselling initiated by staff or member and in group work. Managers provided a number of examples where their members had been helped but also made more general points.

There was a widespread belief that members should be given sufficient information to be able to participate in decisions about their treatments:

"people are disempowered by a lack of information. It helps us to promote self advocacy - the pharmacy service does help them to realise that they're not just there for needles to be jabbed in"

Further, it was thought that this advice and information should be independent and not given by professionals making other judgements and controlling access to other

resources. It was also important that the service was available in familiar and *'non threatening'* locations where their more vulnerable members felt secure.[7]

The geographical and professional 'distance' from the psychiatric services was important for those members who were actively being encouraged to reintegrate into the community. Services provided to the day centres by local pharmacists were particularly welcomed.

5.14 Staff from two day centres have also reported that the individual and confidential sessions have allowed pharmacists to counsel members on illicit drug use:

> *"they tell us things which they know are breaking the law and they couldn't tell the social worker and the last person to hear about that would be their consultant. (Pharmacist) comes across in much the same manner. Members will talk to him about their misuse of amphetamines.*
>
> *he's not judgmental either so that people feel that if they are doing something that is wrong they can actually go and talk to him about that"*

The pharmacists' friendliness, their willingness to allow users to approach them as equals:

> *"there's none of this twopenny ha'penny snobbery which you get with GPs "*

and their ability to explain things simply were widely commented on as was their patience and persistence in following up problems.

5.15 Some managers referred to the project pharmacists as 'specialists' although another spoke as though their knowledge were common to all members of the profession:

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7 Many of the points made in these interviews have echoed the findings of a much larger study of mental health service users (10,11) particularly in respect of the failure to provide adequate information, problems with drug side effects and the preferred siting of services.

"we weren't really aware that pharmacists knew so much about mental health problems. Also because they deal in medication we were quite surprised that they were trying to come up with alternatives to medication. "

Pharmacists themselves reported that their advice had been sought on a wide variety of problems related to both physical and mental health of members and occasionally on behalf of others for whom members acted as carers:

"I've been used as an information resource on anything from cardiac drugs to eye drops."

5.16 Twenty members from eight day centres were interviewed. These were not randomly selected from the whole membership but were people available - and willing to talk - in the centres when managers were interviewed.

Only one had not spoken to the pharmacist saying that there had been *'no need'*.

The others had asked the pharmacist about a variety of health related problems but chiefly about their psychotropic drugs. Side effects and interactions with other drugs (including alcohol) were the main concerns. In several cases the same form of words was used:

"he put my mind at ease"
"she's given me the information to put my mind at ease"

Although some of those interviewed did make use of other pharmacies there was general agreement about the value of the day centre service. Not only was there a lack of privacy in the shop setting:

"I panic when I'm in there, there's too many people"

but pharmacists were usually described as *'too busy'* with their other activities.

The only negative comment from this group related to one pharmacist who had allowed himself to be monopolised by the more vociferous members so that it had been difficult to find the opportunity to talk to him. This, presumably, is the downside of the more informal setting where a professional may find it hard to impose closure on a conversation in order to ration access to his or her time.

5.17 Services to some day centres lapsed as pharmacists moved away from the area or been diverted by the other business interests. But only one pharmacist gave any indication that this aspect of the work was not worthwhile:

> *"you'd be talking to a group and someone would just stand up and say 'I'm not *** staying to listen to this' and walk out -I was using my time that could be properly used somewhere else."*

5.18 **GP Services**

Here the aim was to link a pharmacy with a nearby medical practice and, within the field of mental health, to find an area of mutual interest where a pharmaceutical input would be valued.

Some practices suitable in geographical terms did not wish to take part and as a result GPs and the pharmacists with whom they were linked were neither in the same neighbourhood nor shared a common clientele.

5.19 By September 1992 all the pharmacists had contacted the designated general practice and half had agreed an appropriate area of activity. These included the review of medication at nursing or residential homes where the GPs had patients, domiciliary visits for suspected 'compliance' problems and participation in benzodiazepine withdrawal schemes one of which was run as a health promotion clinic on practice premises.

5.20 Towards the end of 1992 the facilitator decided to refocus this part of the programme to link with the national Defeat Depression campaign. Further training was organised for the pharmacists concentrating on antidepressant drugs and PACT analysis.

A four stage plan was proposed:

- Level 3 PACT analysis;
- Pharmacist review of records belonging to patients currently being treated with antidepressants;
- Pharmacist/GP discussion of treatment. Possible recommendation for change;
- GP review of patients. Pharmacist counselling of patient with regard to medication use.

However both the LMC and at least one local practice raised questions about the issue of confidentiality and access to medical records so this scheme (at least in the manner outlined) was not adopted to any great extent. Four practices were said to have expressed an interest but when all GPs were interviewed in June 1993 only two made specific mention of combined work in the area of antidepressant therapy.

5.21 By this time there was little evidence of continuing joint activity: these collaborative ventures had seemed to be low on the list of GP priorities:

> *"GPs have noticed quite an increase in their workload, between 10 and 20 percent, not only as a result of the changes in the contract - this is dealing with illness as opposed to health promotion - you've got to prioritise the work you're doing* (LMC member)
>
> *our problem is that there are so many people coming at you with other things to do, both management ones and clinical*
>
> *we're tied up in so many other things, we're up to our eyeballs in other problems."*

The GPs also commented on their relative lack of involvement in the care of some of their mentally ill patients and decisions about prescribing[8]:

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8 Other work has pointed to the lack of specific practice policies for the care of long term mentally ill patients and their continuation of psychiatrist initiated drug regimens (12,13).

"the schizophrenics, we don't have much dealing with those people - the CPNs deal with them when they're unstable or they go to hospital - when they're stable the CPNs see them - it's as though they're out of our care to a certain extent

in terms of the injectables we're guided by the hospital because it's a specialist field

with mental health it's the specialist that prescribes."

Some queried the need for a service concentrating on advice:

"if I'm doing my job properly then there shouldn't be a need - it should be about explaining side-effects and possible problems with treatment."

There was also a suggestion that if interest in the project were to be maintained the practice should take the lead:

"it takes somebody with a particular interest to keep pushing it on the doctors' side - I suppose the pharmacist could keep checking and reminding - but it's better coming from a partner."

and that it would have been preferable for GP/pharmacist linkages to based on geographical proximity (as the facilitator originally planned).

5.22 Examples were given of project work the pharmacists had done which was considered valuable - domiciliary visiting relating to non-compliance and supportive work with patients taking antidepressant drugs.

The two GPs who had requested pharmacists to undertake medication reviews for their patients in nursing homes appeared very satisfied with the results and reported adopting a number of the suggestions that had been made. One however appeared

to be more interested in medication review as a process of cost control rather than as directed towards the identification and monitoring of drug related problems.

5.23 This part of the project has not seemed to be a priority for GPs: neither has it been for all the pharmacists. This was not entirely due to the lack of receptivity of the doctors. They have seen the purpose of the programme as helping patients rather than doctors, have been well aware of the contributions they have made in other areas and preferred to concentrate on these. Some expressed doubts about the uses of PACT data analysis within the programme. Ultimately this could be used as a cost containment exercise and there was as yet no evidence to suggest that savings were used to improve the quality of patient care.

5.24 There are few indications of the development of 'teamwork' arising from the project although most GPs defined areas where thought there was scope for further work with pharmacists. These broadly fell into two groups: patient compliance and cost effective prescribing. There was no mention of other clinical involvement. Some GPs considered they had very good relationships with local pharmacists but these were not always the pharmacists in the project. Further, good relationships as expressed in other ways (frequent contacts, other joint enterprises), had not necessarily developed to include the mental health project work.

5.25 **Services to nursing/residential homes and hostels**

> *"At a minimum, we must aspire to improve adherence only with those treatments or actions for which we have reasonable evidence of efficacy, and we must maintain constant vigilance for any harmful results of our interventions, however well-intentioned.*
>
> *A compliance practicum for the busy practitioner, DL Sackett in Compliance in Health Care (1979) RB Haynes, DW Taylor and DL Sackett (eds.), Johns Hopkins University Press, Baltimore."*

"(Nurse) told (pharmacist) that (patient) was refusing to take her Seroxat. She found that it was making her sleep constantly and so decided not to take it. It turned out that (patient) was 100 years old." (Field notes March'93)

These were facilities selected to have a substantial proportion of residents with a history of psychiatric illness. The aim was to act as a resource for care staff and residents with regard to the administration and use of medicines, to liaise with staff in identification of possible adverse drug reactions and, in collaboration with GPs, to perform regular medication reviews. All GPs with patients in selected homes were contacted by letter informing them of this initiative as were supplying pharmacists.

The accompanying protocol suggested that three outcomes were to be recorded:

- pharmacists' written recommendations;
- number of hospital admissions;
- periodic assessment of patients' well-being by means of questionnaire.

5.26 A key issue here was the separation of 'supply' and 'advisory' functions and frequent references were made to the US system of consultant pharmacists. Within the existing system of remuneration there is an incentive to maintain current levels of prescribing -an interest not entirely consistent with the aim of medication review. The facilitator also wished to ensure that if changes to medication usage were thought to be necessary this should not jeopardise the relationship between supplier and home managers.

5.27 Within the first few months of the project most pharmacists instituted a programme of regular visits to their designated homes. In an attempt to achieve parity of client numbers some were allocated more than one facility. Two pharmacists reported that the homes were so 'well organised' that they discontinued this element of the project work. The pharmacists' activities varied according to the type of establishment, the dependency level of the residents and the expectations of the staff. There were no reports of medication reviews carried out with GPs although there were reviews with nursing/care staff and occasionally with community psychiatric nurses.

5.28 It is possible that the term 'medication review' has been used to describe different levels of activity carried out for a number of purposes and with different significance for the participants involved. As the work with the GPs showed it can be used in the process of reducing drug costs although this was not the intention in this case. Doctors have described it as a form of professional audit. Supplying pharmacists may also have considered that it could be used to identify any inadequacies on their part. One pharmacist contrasted the medication reviews within this project with the full drug regimen reviews performed elsewhere. Some nursing homes were said to have been concerned about the regulatory implications.

Medication review as part of the pharmaceutical care programme could thus have been considered threatening for a number of reasons. In at least one case this led to a pre-emptive review by pharmacist supplier and GP. At another home the manager, appreciating some of these problems, arranged medication reviews with both project and supplying pharmacists.

5.29 There is a considerable body of evidence pointing to the inadequacy of some prescribing practices for elderly patients, particularly those in residential care (14,15). It might be assumed that the same applied to patients with mental health problems living in similar facilities. Project pharmacists have, however, reported - or recorded - relatively few interventions. It is unclear whether problems do not exist on this scale, whether they have not been identified or whether they have been recognised but not pursued. Most pharmacists considered that reporting a problem to a GP was of limited value since decisions about prescribing were made by the psychiatric team.

5.30 In order to explore this further 29 GPs with patients in project residential/nursing homes were asked to complete a very short questionnaire which had three main and two supplementary questions:

- 16 forms were returned but not all questions were answered in each case;
- 12 GPs have said they were interested in setting up systems of medication review and 6 had already instituted such a programme;
- 6 (not entirely the same 6) had had contacts with project pharmacists, 9 had not. (There were requests to know who was involved in 2 cases);
- 4 had adopted suggestions made by project pharmacists;

- 10 thought it unlikely that they would make 'significant alterations to a medication regime without first conferring with a consultant', although 5 respondents thought they would.

> *"such patients that I have with mental problems living in 'residential care' are under surveillance of psychiatric OPD and CPN."*

These responses largely confirm the information from the GP interviews. (5.21)

5.31 Records of interventions which have been seen relate mainly to drug interactions. Not all pharmacists have had access to medical records which is an obvious limiting factor on their potential to intervene. Other problems have been identified with drug formulation, presentation and packaging - particularly in the inappropriate use of monitored dosage systems. The implications seem to be:

- supplying pharmacists should be able to solve some of these problems;
- review does not necessarily lead to a reduction in number of prescription items.

A further complication was that some project pharmacists seemed to be as reluctant to confer with supplying pharmacists as they were to make recommendations to GPs.

5.32 Proposed changes were usually agreed or discussed with nursing/care staff who relayed them to prescribers. Not all nursing staff appreciated this strategy:

> *it was as if we were telling (GP) what not to prescribe and what he should alter - it was like someone coming in from another department and saying this care plan needs to be altered but not actually dealing with the nurse who wrote it*

Contacts with key nursing staff (primary nurses for example) had not always been established.

5.33 Most staff have given examples of recommendations made by pharmacists and have particularly remembered those with a distinctly clinical focus. Some of the tests suggested had unintended but equally desirable consequences:

> *we've got one gentleman who is on aminophylline and it didn't seem to be helping and (pharmacist) suggested a blood test. Now this is regular and we've been able to increase the dose (enough to help). As a consequence his mental state has improved - he was skipping his Stelazine and dropping them down the sink - so if he's taking the aminophylline and his levels are up it's an indicator he's taking all his tablets - and now he does*

5.34 Care staff have almost invariably reported visits as helpful and informative but it is unclear how much of the more general advice would overlap with that routinely provided by a community services pharmacist or a supplying pharmacist with a residential home contract. (There would be no equivalent for the hostels.)

Although the facilitator wished to separate supply from advice this was neither possible to enforce or sustain. Pharmacists unable to gain co-operation from project allocated homes instead extended their services to homes where they acted as suppliers. Another home, dissatisfied with a former supplier, requested the advisory pharmacist to take over. Contacts with GPs and voluntary sector representatives made for other purposes have indicated that some of the more enthusiastic responses about work in residential facilities relate to those where the functions are combined. This was an extremely limited sample and may refer to the practices of a few particularly energetic individuals.

5.35 **Domiciliary visiting scheme for the elderly mentally ill**

This was an additional service initially reported in January 1993 and offered in its 'pilot' stage by one pharmacist who was to cover the eastern area of the city. It was hoped to recruit about 50 patients to whom weekly deliveries of specially packaged medication would be made. This would enable safer medicine management and closer patient monitoring. Nine months later 10 patients were involved, most of the

referrals coming from the elderly mentally ill unit, although the facilitator had advertised the service 'widely'.

There may be a number of reasons for this limited uptake. There is for example no evidence of demand from proposed 'beneficiaries'. One GP approached had an existing 'provider arrangement'. The LMC also had *'problems with this initiative'* on the grounds that issuing a weekly prescription went against general principles *'on prescribing medication as to the increased cost of dispensing'*. The pharmacist involved reported her only difficulty as obtaining the necessary prescriptions.

5.36 Unlike the advisory and other more diffuse services some stakeholders ('agents') thought that this initiative might lead to the specification of quantifiable outcomes. However, given the small numbers involved significant results could not be achieved therefore it was decided that this would not be pursued. In any case pharmacists' domiciliary visiting schemes are being evaluated elsewhere.

5.37 **Facilitator's other work**

Much of the investigatory and development work took place during the earlier part of the project. After the community pharmacists took over service delivery the facilitator's role changed its focus and he became involved in a variety of other activities. Some were directly related to the programme - for instance he set up a liaison group comprising two pharmacists and a consultant from the rehabilitation service, and worked with hospital pharmacists on issues related to discharge and shared care arrangements - but others were developments outwith the original objectives. They were predominantly in the field of mental health and many involved co-operation with social services departments in several local authorities. He also represented the FHSA on a number of mental health committees/groups.

NOTTINGHAMSHIRE

5.38 **Residential scheme A (RCCS)**

This project was to concentrate on the resettlement of all 12 elderly patients from a ward at Mapperley Hospital into a bungalow complex designed by and managed by a local housing association and registered as a residential home. The officially stated

aims were to ensure a smooth transition from a hospital based pharmaceutical supply service to a community based supply service. Hospital pharmacists however consider that their contribution is something rather more than a 'pharmaceutical supply service'. Drawing on her hospital experience the facilitator wished to encourage a community pharmacist to provide a clinical pharmacy service.

5.39 Before discharge, medication regimens were simplified wherever possible. The facilitator and a hospital pharmacist worked together on this. Discussions with the nursing staff (who were moving from the hospital to the bungalows with the patients) led to the organisation of three separate training sessions which involved a community services pharmacist as well as hospital pharmacist and facilitator.

5.40 The facilitator was responsible for producing a drug custody and administration policy for the bungalows which was acceptable to all interested parties.

There were lengthy and apparently difficult discussions relating to drug policy which:

forced us to confront issues that otherwise we would have avoided
(health authority management committee member).

A housing association representative summarised the achievements of the facilitator as: producing a document which, after consultation with numerous interested persons, took into consideration:

- the concerns of care staff most of whom operated with a distinctly nursing perspective;
- former drug practices at Mapperley Hospital;
- the rights of residents as expressed by housing association and advocacy group members of their management committee (relating to ability to exert maximum control over their own lives, use of GP and other members of the primary health care team rather than mental health unit services);
- the requirements of the Service Standards Unit;
- the practicality of running a residential home where staff qualifications and skill mix may vary both in the long and short term.

5.41 Another task was to locate, along with the home manager, a community pharmacist who would not only supply prescription medicines (all to be prescribed by the GP) but would also become part of the 'team' working with the residents. The residents were unable to select their GP in the first instance - this was decided by the hospital consultant. However, an important facet of the pharmacy project was that 'choice' should be actively encouraged. This was seen as impractical at the level of individual residents and the home manager made the selection of a local community pharmacist.

A payment system was devised to take into account the contract between the home and the business but recognised the extra time and additional requirements of the project. The pharmacist was able to attend review and report sessions which coincided with her 'half day'. This involvement continued for eight months until she moved to a new post but the work was taken over by a pharmacist (one of 'Caring for People' group (5.64)) who had recently moved into a new pharmacy in the same development as the GP's surgery. More frequent interprofessional contacts do not necessarily lead to improvements in patient (resident) care but these arrangements were seen as most satisfactory by the pharmacist and home staff.

5.42 Few medication changes seem to have been thought necessary for the original group of residents although it is probable that future incoming residents will require more active psychiatric/ pharmaceutical management. The (second) pharmacist also acknowledged the extent to which some staff were already knowledgeable about psychotropic drugs. Their awareness of physical problems was less well developed:

> *there was one lady who'd got progressively more breathless and I thought it sounded like a cardiac problem - I asked when the doctor was coming - he put her on diuretics - they hadn't picked that up*

Pharmacists have been given access to medical records at this home.

5.43 There is no doubt that this project has worked well. Stakeholders consider that important factors are:

- new routines and working practices were inevitable as a result of moving out of the hospital. The facilitator was involved in the process of defining some of these together with the home staff and was available throughout the period of maximum instability/uncertainty;
- home staff were allowed to exercise choice in the selection of a pharmacist - the facilitator was determined not to exert any influence on their decision. The home manager also appeared to want to create a team involving other professionals working in the community (the first pharmacist remarked how staff had wanted her to become part of a team before she felt ready for this);
- psychiatrists still visit the home but all prescribing is done by the GP and all prescriptions dispensed by the same pharmacist. The medication records are up to date, complete and can be supplemented by relevant clinical data;
- there seems to be a mutual acknowledgement and acceptance of the respective roles of GP, staff and pharmacist. Both GP and pharmacist have described the latter's activities more in reactive terms but this does not seem to be problematic for either. The home are interested in an efficient supply service as well as additional advisory or training functions. This too is acceptable to the pharmacist involved:

they want their drugs on time and correctly distributed -
that's the most important thing to them

5.44 Residential scheme B (RCCS)

This is another residential scheme run in conjunction with a housing association operating with a different philosophy. It opened six years ago, with 15 residents coming from a range of hospital and community placements. They continue to need a high level of medical and social support but most problems have been contained within the home and there has only been one re-admission to hospital during this period.

The aims were to research and identify the benefits and disadvantages to the clients of a hospital based service compared with a community based pharmaceutical service. The implications for the staff were also to be considered.

5.45 The home and housing association managers were jointly responsible for setting up the existing arrangements, describing the first few weeks of chaos when residents had come with standard 'TTOs'. At this point they met with RCCS medical staff who allocated them the specialised psychiatric input requested and this had continued. The hospital pharmacy were closely involved at that stage and had continued to be so:

they were an indispensable part of the feed back loop

One manager also contrasted the quality of care and high level of staff morale at this home compared with another (in an adjacent county) where all the medical care was given by GPs.

5.46 In theory drugs for non-psychiatric conditions were prescribed by GPs and dispensed by community pharmacists who previously had no means of knowing the full range of drugs being taken by residents. However, the visiting RCCS consultant or SHO often prescribed for a range of 'physical' ailments and the drugs were supplied by the hospital pharmacy.

5.47 A local community pharmacist, a prospective member of the Caring for People group (5.64) independently made contact with the home and did some voluntary work there. This connection was maintained when this project began. After consultation between facilitator, home and psychiatric staff it was decided that the first changes to the system would focus on the three residents who were in charge of their own oral medication (all had depot injections too).

Instead of prescriptions being written on a 'community card' they were issued on FP10(HP) forms and dispensed by the community pharmacist. The pharmacist delivered them directly to the residents on a weekly basis, checking for residual supplies at the same time. At the pharmacist's suggestion a fourth resident became a 'self-medicator' and was included in the scheme. The pharmacist was said to have established good relationships with these and other residents who sought his help with a variety of health problems.

5.48 Initially the main concerns of the consultant were with the 'practicalities' of the scheme which should be closely monitored. He expressed some reservations about increasing the size of the team, particularly in relation to issues of confidentiality although the pharmacist did attend case reviews and

> *suggested ways of rationalising drug therapy and warned of drug interactions*
>
> (home manager)

5.49 After the first 12 months of this scheme the consultant requested a return to the previous arrangements - prescribing on community cards for all residents - as there were few advantages for either residents or staff, *'although equally there were few disadvantages'*. The facilitator's response was to remind the psychiatrist of the purpose and time scale of the project and to suggest ways in which some of the problems associated with the use of FP10(HP) prescriptions could be tackled (a monthly prescription dispensed in weekly instalments). In spring 1994 there was a reversion to hospital drug supply for all residents.

5.50 The residential home manager saw advantages in having a community pharmacist working with the home, essentially with the 'service' element (Saturday opening, longer hours, delivery service) and acknowledged the necessity for the community pharmacist to keep complete medication records if they were to dispense prescriptions coming from the GP. A staff training session arranged by the pharmacist together with the local CPPE tutor was also appreciated. Further joint training sessions were developed with a Mapperley Hospital pharmacist and there were some suggestions that this 'package' could be used in other homes run by the housing association.

5.51 Unlike the first scheme (5.38) this has had a number of problems of which the main ones were considered to be:

- it involved changes to routines and established working practices which had been set up (not inherited) by major stakeholders;
- a main concern was to maintain the level of psychiatric support and the community pharmacy scheme might have been interpreted as a signal that this was under

review. It is unclear whether there had been prior consultation with home managers before this was nominated for inclusion in the pharmaceutical care programme. There was no long term aim to further involve GPs in the care of residents;
the pharmacist had no access to medical records or results of laboratory tests and the confidentiality issue was not resolved, although information about medication change was passed on so that the computerised medication records kept for all residents could be updated;

- the scheme was said to have created a layer of unnecessary administration which was inconvenient for medical staff and had implications for the time that could be spent on direct patient contact. A succession of SHOs as well as the consultant provided psychiatric services and it was never made clear what information the former had had about the project or who had given it;
- community cards were seen as infinitely preferable to FP10s - there was said to be less scope for error and they were able to function as a proxy medical record. The use of FP10(HP) prescription forms also had cost implications for the hospital pharmacy;
- the project was meant to explore the implications for staff and it has been their views that have prevailed. The 'beneficiaries' (the four self medicators) are unlikely to have had any collective voice in the organisation;
- there were clear differences in perception between home manager and pharmacist about the professional status of (community) pharmacy and the development of 'an extended role'.

The pharmacist remains enthusiastic and considered that the knowledge gained from participation in the project could be used in other ways and other locations.

5.52 Dispersed Intensively Supported Housing Scheme (DISH) (RCCS)

This scheme oversaw the care of many patients who would otherwise be long term inpatients but who, with intensive multidisciplinary support, were living in their own homes. All psychotropic medication was dispensed by Mapperley Hospital in appropriate amounts (determined by team workers) and subsequently delivered to the home by the key worker. The aim was to research and identify how the medication needs of these patients could be met by the community services.

5.53 Progress on this project was delayed but reported by the DISH manager to be their 'fault' and they appreciated the background work that the facilitator had done. All clients were contacted through team members and asked to complete a short questionnaire relating to registration with GP, frequency of consultation, use of other medication and of community pharmacy services. The facilitator liaised closely with team members and clients, identifying two who were willing (and suitable) to take part in the scheme. Meetings were arranged with their GPs who agreed to prescribe and with (client specified) community pharmacists.

5.54 The consultant was fully informed of these developments but made no response until prompted to do so by unease expressed by a clinical assistant who was concerned about the transfer of clinical responsibility and in particular the administration of depot injections by practice staff (neither were envisaged). The facilitator responded by making further explanations. The use of an FP10(HP) prescription was, in this case, not seen as a suitable long-term option but the overall advantages were that GPs and pharmacists were fully informed about psychotropic medication for their patients and both would be able to hold complete medication records with presumed benefits for patient care. It was also thought important that suitable clients should be encouraged to take more responsibility for their own medication.

5.55 No further problems have been reported and the DISH team workers themselves were very satisfied with the arrangements. However, they have seen the advantages predominantly in terms of increased GP contact (one of the clients was described as *'increasingly frail'*) rather than anything specifically related to medication or to pharmacy. They were said to be to have been interested in extending the scheme to include more of their clients although a year later only one other obtained her medication via a GP's prescription. This had not resulted from deliberate transfer - she had come into the care of the team on that basis.

5.56 This scheme has had limited success:

- DISH teams were being expanded and reorganised on a large scale and this scheme was only of peripheral importance;

- the psychiatrist's interest in the project has been nominal. It is possible that issues to do with clinical responsibility were involved, although concerns were not raised directly with the facilitator at an appropriate point in the developments.

5.57 **Central Nottinghamshire Bungalows**

These were health authority owned and staffed residential complexes situated on two urban sites with approximately 50 residents, mostly former patients from Saxondale Hospital. The pattern of prescribing was complex. Theoretically 'new' medication (anything commenced since the residents had moved in) for non psychiatric conditions was prescribed by GPs and dispensed in any one of a number of local community pharmacies. Everything else was supplied by a hospital pharmacy. A psychiatrist and psychiatric pharmacist visited weekly to undertake case reviews with staff. The convenience of this weekly contact and a perceived reluctance of GPs to become fully involved in care meant that some of these 'rules' were ignored.

The intention was to rationalise the system and to raise the intervention potential for selected community pharmacists to that of the hospital pharmacist.

5.58 Independently of the pharmaceutical care programme moves had been made to transfer more of the (non psychiatric) prescribing to the GP and systematic patient reviews had been arranged. One manager claimed these changes had been made to confirm the community status of the residents although this was disputed by a second who thought they had been introduced primarily for budgetary reasons. The facilitator encouraged restriction to one pharmacy so that full medication records could be kept. Psychotropic prescriptions for 'self medicators' were subsequently issued on FP10(HP) forms and were also dispensed by the community pharmacist.

5.59 The intermingling of the community pharmacy project, GP prescribing and self medication schemes has made it difficult for staff to discuss the advantages/disadvantages of the former without continued reference to the latter factors.

The provision of a prescription collection and delivery service was much appreciated. For residents who were preparing to move on to more independent living conditions the ability to use a pharmacy was seen as an important skill:

> *it's been better for the residents and it's better for us, in that we're able to progress further with rehabilitation than we have been in the past*

5.60 The aim was to raise the intervention potential for community pharmacists to that of hospital pharmacists. The community pharmacists hold computerised medication records for all residents and the psychiatric pharmacist informs them of any changes made by psychiatrist prescribers. For the community pharmacists there was little opportunity either for direct, regular contact with prescribers or for a monitoring of patient response. Neither of the pharmacists expressed a wish to extend their services in this way. Neither had claimed any payment under the scheme.

5.61 For local stakeholders this initiative was successful:

- it supported changes already being made in the bungalows with little disturbance in the structure of the team caring for residents;
- it encouraged further rehabilitation of residents;
- staff appreciated the personal contact and service received from community pharmacists;
- there was no evidence that community pharmacists themselves were frustrated by any lack of 'clinical' involvement although other stakeholders may have wished to see this.

5.62 This project had consequences elsewhere in the county. One staff member left to work in the voluntary sector in another area and was keen to adopt a similar model. A community pharmacist was involved in a pre-discharge planning meeting for a resident moving to a newly built facility and later took on the supply of all medication to all its residents. He became involved in assessment meetings as did his successor in the business. Payment was made on the same basis as the other pharmacists involved in the various projects.

5.63 Training materials and information were provided by the facilitator although the second pharmacist thought that *'any pharmacy should be able to do this'*. He had worked in a hospital and contrasted the meetings with clinical reviews:

> *in hospital everyone is very clear about their respective roles - you know which is your bit - if it's not yours it's someone else's. It's not like that at (residential facility) - and sometimes I'm not sure when to contribute*

He pointed out that assessments are very wide ranging. For example they would cover the level of benefits and the ability to handle finances, as well as social functioning and integration. Medication might only be mentioned very briefly. There had been occasions when his pharmacological knowledge was used but he was also a reporter of social skills:

> *as far I can see if I can contribute not just from a clinical point of view, that I've seen an improvement in a particular tenant because they are now better at taking their medicines, better at collecting them, more open when they come in, or whatever - then that's fine*

This pharmacist saw potential in this involvement but there were aspects about which he was uncertain:

> *it really could go further - but I don't know where*

5.64 **Caring for People 1992 and Beyond**

Twelve community pharmacists selected largely because of the interest they had shown at two evening meetings organised by the facilitator took part in this training initiative. The pharmacist originally providing services to one of the residential schemes (5.38) also took part as did the local CPPE tutor who attended as both learner and speaker at one of the sessions. Most pharmacists worked in Nottingham and its surrounding suburbs. Like the Liverpool group they came from a variety of professional situations.

5.65 This initiative was based on the assumption that there was considerable scope for developing the role of the community pharmacists in the provision of 'total pharmaceutical care' for the mentally ill living in the community - reflecting the objectives of the overall project. The aim of the training programme (five full days over a five month period) was as much to acquaint participants with community care and care management issues as to develop clinical expertise in the relevant area.

At the end of the course each participant was asked to suggest some particular service development in which they would be interested. Subsequently the facilitator made a series of individual arrangements linking pharmacists with organisations and groups interested in using their skills.

5.66 Nottinghamshire Social Services Department run four mental health day centres in the county. Each was introduced to a pharmacist but the particular arrangements for the frequency and type of involvement was left for managers and pharmacists to arrange between themselves. Staff were quite clear that there was a need for this type of service - previously they would have struggled to make sense of reference books or referred a client to a GP. One had always thought they needed a pharmacist at the centre:

and then it was wonderful - we had

The pattern that emerged in most centres was of a semi-formal referral system with pharmacists coming in at approximately monthly intervals. Pharmacists worked with groups but mostly were involved in individual 'counselling'. The latter was thought to be particularly valuable by staff. It was said that some members would probably need to be on medication for the rest of their lives and needed help to cope with that. Others had been given far too much medication and if this was to be reduced would also need help but that:

people have had their feelings recognised

Some of the descriptions also confirmed the Liverpool responses in terms of the information being impartial or 'neutral':

neutral because nobody's going to make a clinical judgement that they're paranoid because they're worried about the effects of their medication

5.67 In the county, there was one local authority-run residential hostel for people with mental health problems. The manager met the facilitator through the 'day centre network' and thought they had:

a lot of needs that could be addressed by the scheme

The community pharmacist introduced to the hostel spent several hours there every four-six weeks. The visits were said to be *'totally beneficial'* for both staff and residents. Known problems relating to drug administration were investigated and there had also been staff training sessions. These were important in terms of the knowledge gained by the care workers and the implications for their *'autonomy'*.

Medication for the residents was reported to be *'always changing'*. GPs varied in the extent to which they made explanations but the pharmacist had *'expanded'* them. Examples were also given of changes suggested by the pharmacist (but passed on by staff) which had been adopted at case reviews.

5.68 Pharmacists also worked with voluntary organisations such as local NSF and MIND. The former recognised the community pharmacist as a source of helpful and friendly advice - something especially of value to carers. A community pharmacist subsequently volunteered to act as source of pharmaceutical advice to their Nottingham group.

There were a number of active MIND groups in the county. The manager of one group had previously enlisted the help of a pharmacist from another area to assist with the numerous medication related problems with which they had to deal so was particularly pleased to find a local source of help. She pointed out how much pharmacists and the organisation had in common - referring to similar difficulties in access to GPs.

Newark MIND organised an open access group whose function was mainly social support and for some time a pharmacist visited monthly - this service was said to be:

one more arrow to the quiver

The pharmacist brought in printed information for the group and also took MIND leaflets to display in his shop. Members of the group reported how useful it was to have a pharmacist in their group discussions which were wide ranging and not always confined to mental health.
Plans were being made to start another group in another locality. If this met with a favourable response it was hoped that a pharmacist there could be approached to provide a similar service.

A third MIND group held 'Drop In' sessions which the pharmacist attended on several occasions but these had not been well attended. Nevertheless the local manager was keen to maintain links with the pharmacist and saw particular potential for a training role at another facility.

5.69 Training sessions for staff at a nursing home where his company supplied medication were organised by another pharmacist. He considered that he would never previously have had the confidence - or knowledge - to do this.

5.70 The facilitator was slightly uncertain of her relationship to sector teams (their links were with the hospital pharmacy) but contacted community link workers at two bases who saw particular value in using local rather than hospital resources. Three pharmacists were involved in various group activities. All reported these more in terms of 'explaining the role of the pharmacist' and encouraging the use of any pharmacy rather than as an opportunity to demonstrate specific clinical knowledge.

5.71 Several members of the group met with the facilitator, the FHSA's Community Care Co-ordinator and two local authority social workers. A series of meetings followed which led to the production of an information leaflet aimed at community care assistants. The longer term aim was to introduce the concept of 'pharmaceutical need' into community care planning. The group now includes a pharmacist who was not involved in the original initiative and is considering how its activities can be

expanded or its meetings relocated so as to include more pharmacists from other parts of the county.

5.72 **Bassetlaw Day Hospitals**

The sixth project was to identify and develop the pharmaceutical services offered to elderly patients in the two day hospitals - one acute psychiatry and the other 'care of the elderly'. In the period between defining the projects and starting the work there were staff changes in the elderly day hospital which might have made some of the proposed work less essential. Patients attending this unit in the 'target' group (those suffering from a variety of dementias) had few medication related problems and the sister in charge had already made links with GPs and community pharmacists where necessary. The facilitator contacted carers to find details of the services they already received and concluded that there was little scope for further development. The sister would have been pleased to co-operate with a pharmacy led project - in particular she was concerned by the extent to which hospital discharge prescriptions were discontinued or inappropriately combined with earlier prescriptions - but these were not within the rubric of 'mental health'.

5.73 Within the acute psychiatric hospital all patients were self medicating. Drugs for psychiatric conditions were dispensed in weekly quantities by the hospital pharmacy. Any other drugs were obtained via community sources. There were 18 elderly patients and in the few cases where there was a real cause for concern about the patient's use of medication the hospital would take over the whole supply and monitor usage. The medication system was said not to present any problems and the charge nurse had continued to develop and improve the system he had inherited:

the way we operate suits us and our clients

He acknowledged that there was a possibility of *'double dispensing'* and *'conflict'* between drugs and although willing to co-operate with the proposed developments (or *'research'*) commented on the lack of *'a hypothesis'*.

5.74 The psychogeriatrician recognised the extent of polypharmacy among her patients but this was justifiable in terms of the conditions from which they were suffering. She

was well aware of discrepancies between theoretical and actual drug use partly as a result of her domiciliary work.

5.75 After conferring with hospital pharmacists the facilitator suggested the development of a client held co-operation card on which prescribers and pharmacists could enter details of drugs prescribed and dispensed. The latter discussions took place shortly before the original facilitator left and the detailed design of the card and arrangements for its trial usage were left with the hospital pharmacy. Further progress on this was slow but by the summer of 1994 the cards had been printed and preliminary contacts made with local GPs and community pharmacists.

5.76 It is difficult to say at this stage whether this project has been successful. Certainly it has not been approached with any degree of urgency:

- the day hospital was busy, understaffed and the project was seen as of only marginal importance;
- staff were satisfied with the familiar routine and may have been sceptical of the value of shared care in potentially difficult cases;
- the scale of the problem (inadequate records in both primary and secondary care sites, possibility of drug interaction) was not demonstrated;
- the hospital pharmacists were in the process of moving to new premises - presumably it was not a priority for them either.

5.77 **Facilitator's other work**

As in Liverpool the facilitator became involved in numerous other activities. She co-operated with community services pharmacists in writing a leaflet encouraging the registration of residential homes with pharmacists. The number did increase over the two year period although no one suggested that there was a causal relationship. She also acted as the FHSA's representative on the Registered Homes Interagency Group.

Meetings were held with hospital and other pharmacists relating to discharge medication practices and the consequential bid for a research grant met with partial success.

A further session for all 'Caring for People' pharmacists was organised and run by the facilitator and local CPPE tutor. This was to increase skill and confidence in their capacity as trainers for staff of residential care facilities. Training for staff working with the homeless mentally ill was also provided.
Finally a Mental Health Resource Pack was written/assembled and distributed to all pharmacies in the county.

5.78 **COVENTRY - Developments**

The use of a 'control' site became more questionable as it became apparent that the evaluation was focused on a series of specific projects rather than the overall programmes. The individual projects had fairly self contained objectives but for the latter no stakeholders could suggest operationalisable outcomes. This was primarily an evaluation of **process** rather than **outcome**. A further complication was that the considerable publicity attracted to the developments (predominantly those in Liverpool) was likely to have biased some of the responses. Nevertheless the interviews and discussions were useful in illuminating the data being assembled from the other sites.

5.79 Coventry LPC undertook some 'educative' activity not reported elsewhere including sessions on domiciliary visiting. Social issues (child protection was given as an example) had also been discussed. The committee had met with mental health unit managers/personnel and officers made contact with social services managers regarding pharmaceutical services to residential homes. The number of homes registered with pharmacists had increased between the initial and final interviews.

5.80 A recent FHSA/hospital pharmacy initiative there (still at a pilot stage) involved the supply of fax machines to four 'geographically' selected community pharmacies. Complex or potentially problematic prescriptions for patients with GPs in those areas were to be faxed before discharge. All GPs have been informed. Records were to be kept in both hospital and community pharmacies using a form adapted from one designed by the CPPE. This scheme, however, will not include discharges from the psychiatric unit which is part of a different Trust.

6 PHARMACEUTICAL CARE PROGRAMMES - STAKEHOLDERS' CLAIMS, CONCERNS AND ISSUES

6.1 Department of Health

Departmental representatives met with facilitators and managers at intervals (initially three monthly) throughout the project. From the outset the latter expressed concern about continued funding. It was always intended that the programmes should eventually be self financing (and self supporting) but to bring their centrally funded completion date into line with existing planning and financial cycles the department awarded additional sums to fund extension until March 31st, 1994. During this final period facilitators were expected to work on a part time basis.

6.2 FHSA Managers

By the summer of 1993 the all managers reported the facilitators' success at getting different professionals to work together even though this may have been more limited than their initial hopes. Pharmacists continued to be committed to the projects which had given them a different view of their role. Liverpool commented on the number of drug usage issues highlighted during the project on which work would continue. Nottinghamshire said the project had given them the opportunity to look at other services that needed to be developed and had challenged some of their thinking - including that on the standards of care being provided by GPs.

6.3 In Liverpool mental health was still a district and organisational priority but all budgets had to be scrutinised closely - £12 million was to be 'lost from contracts' during the next three years. It was therefore important that there should be some **quantitative** measures relating to the scheme and an attempt to show *'where the savings are'*.

6.4 Nottinghamshire considered that pharmaceutical issues were now *'firmly on the FHSA's agenda'*. They were an important part of their primary care strategies and the facilitator's work had been an important foundation. They intended to supplement the programme's central funding to maintain a full time facilitator post but work on

the mental health scheme was to be combined with other community pharmacy developments.

6.5 Steering Group

In the final interviews concerns - and judgements - still related largely to the individual projects although the general consensus was:

> *that (facilitator) had done a good job*

Few members had independently followed up the specific developments and their reports were mainly reliant on information provided by the facilitator.

Hospital pharmacists had been prompted to think more of issues relating to discharge and to reconsider the services that they themselves were providing. All appreciated the new links and different networks that had been established.

6.6 Facilitators

The facilitators' roles changed significantly over the two year period as did their views about the title and position:

> *I thought I would be more personally involved in things - some of the time I've been frustrated - now I view the facilitator's role as really one of the door-opener - really you are there to allow someone else to do a particular job*

> *I felt (in this project) my job would be help the community pharmacist do what the hospital pharmacist had done in the past - I now feel there is much more to the role than that. There's a lot that community pharmacists can do - not enormous things but they can make changes based on having more awareness of what mental health is - part of being a facilitator is about raising awareness*

6.7 Community pharmacists have regarded them as trainers, teachers, enablers, motivators, managers, administrators, agents, co-ordinators and negotiators. The latter role was particularly important in setting up payment systems. In the absence of any clear national guidance on the issue rates of pay had to negotiated locally. Originally the levels were set at £12 per hour in Liverpool and £14 per hour in Nottinghamshire - both slightly more than current locum rates. This was thought acceptable for a pilot scheme if not in the longer term. Latterly Liverpool increased the rate to £20 per hour.

6.8 The limited time scale of the programmes and the uncertainty surrounding their future had a distinct effect on both facilitators. By December 1992 the Liverpool programme was said to be 'winding down' and the Nottinghamshire facilitator was reluctant to take on new commitments. Although they had attempted to set up schemes that were self sustaining, as participating pharmacists left or lost interest it became difficult to provide equivalent training for any newcomers or even to persuade others that, in the longer term, this might be a worthwhile enterprise.

Facilitators and pharmacists were also interacting with other groups/organisations working with similar constraints of time with the consequence that some of the potential for co-operative work was unrealised.

6.9 Nottinghamshire's original facilitator left at the end of the original two year period and (after a short gap) was replaced by a former community services pharmacist. Liverpool's facilitator continued to do part-time work for the FHSA. This may not be an entirely satisfactory arrangement particularly in the absence of clerical support dedicated to this task. Although some elements of the programme (essentially those where the facilitator had acted as an agent) required minimal additional input, community pharmacists considered that its overall continuation and direction was dependent on a facilitator's co-ordination and support.

6.10 **Community Pharmacists**

In both project locations pharmacists taking part have worked in a variety of business situations (contractor, full time/part time employee, locum) and have had diverse professional backgrounds. Successful implementation of the Liverpool programme

required a weekly time commitment of 3-4 hours which for many was impossible to achieve. Satisfactory locum arrangements were only possible if the various parts of the programme could be scheduled for the same session. Two pharmacists were able to streamline their programme commitments in this way, the remainder made alternative plans including working during lunch hours or other personal time. Some pharmacists provided the services in sequence, for example working with GPs for a short period and then moving on to work in a day centre or nursing home, rather than attempting to provide all services at the same time. Nottinghamshire pharmacists also reported problems with finding locum cover for the necessary hours. There were occasions when locum arrangements had been made and expected case reviews or appointments cancelled at short notice. This is clearly a problem when care providers who are paid on very different bases and with different priorities for ordering their time are expected to work together.

6.11 Record keeping by Liverpool pharmacists has been patchy. Most self reporting schemes have problems and this was no exception. People interpret instructions in different ways, normal work patterns are disrupted and the input may be affected by the degree of commitment. The most complete set of records was prefaced by a warning not to take the data literally, listing several reasons for the request. Continuous minimal records may have been kept to justify claims for payment rather than to describe activities and interventions. Referral/request forms for proposed prescription changes (a copy of which should have been returned to the facilitator) were little used although interview data suggests that changes were made on a number of sites. It may be that these changes were negotiated in a way that renders them less clearly an 'intervention'. There was also some evidence to suggest that non usage was a deliberate decision and that information about 'inappropriate prescribing' should remain with prescriber, pharmacist and possibly the residential establishment involved.

Nottinghamshire pharmacists with service agreements were asked to log their activities but no formal recording forms were provided. Evaluator and facilitator discussed what might be required in the case of one specific project. (5.44) This was beset with other difficulties and records did not emerge here either.

6.12 By the end of the first two years of the programme approximately half the Liverpool pharmacists had dropped out. One received a Department of Health grant and was intent on doing his own research, three had left the area, one was involved in business relocation and another moved to a different position in his company. Nottinghamshire's programme (particularly Caring for People 5.64), with its somewhat looser framework, was not quite so dependent on the continued presence and interest of its original pharmacists. However there were problems in the more rural parts of the county which had only sparse representation in the group to start with. Not all pharmacists leaving the programmes officially informed the facilitators of these movements.

6.13 Most pharmacists considered that they had gained from their involvement in the project both professionally and personally. The initial training had been worthwhile in itself and some of the Liverpool group had subsequently attended Psychiatric Pharmacy Group conferences and training events. They welcomed the opportunity to practice their profession in other locations and made interesting comparisons between counselling activities in their pharmacies and those in other situations - particularly in respect of the expectations of clients and the negotiation of conversational rights. Some of the problems that they encountered - for example, personal safety, fear of sexual harassment, accepting confidential information about illegal activities - rarely surface in accounts of pharmacists' work.

6.14 **Local Pharmaceutical Committees**

There were dissimilar levels of support from the respective LPCs. Key participants in the Liverpool scheme, including the facilitator, were members. The LPC had prior knowledge of the project and were fully informed throughout. Their reservations about the initial level of payment were made clear. It was acceptable only because this was a pilot scheme.

Nottinghamshire's LPC were more suspicious about the development and (much later) acknowledged how negative their attitudes had been. The facilitator attended most of their meetings as well as hospital/community pharmacist liaison meetings. The production of the leaflet relating to residential home services was said to be one

of the most useful things to have emerged from the programme. This was reported to have been sent to national pharmaceutical organisations for wider distribution.

6.15 Local Medical Committees

In Liverpool protocols relating to medication review in nursing homes and work on the Defeat Depression campaign were submitted for approval. Neither was wholly acceptable although the first approved with minor amendments.

There was some concern that consultation had been inadequate in relationship to the programme as a whole. Factors contributing to difficulties in relationships between GPs and pharmacists (in the context of this project) included their different financial priorities and the propensity of pharmacists to warn patients of particular drug interactions without first checking their clinical significance with the prescriber.

Few of the developments in Nottinghamshire had significant professional or financial implications for GPs. The LMC were only involved at the stage of an exchange of letters about the DISH scheme (5.52).

6.16 Community Psychiatric Nurses

CPN managers in Liverpool described the scheme as 'supportive' although it was known that all their staff did not share this view. Textbooks for CPNs make it clear that monitoring the effects of medication is an important part of their job so quite clearly this was an area with possibility for interprofessional tension:

> *they (the CPNs) would probably be the first to say our work is not just about medication, which it isn't. But at the same time if someone is going to attack that, or seem to, then it is our business*

The problems were reported to relate mainly to the CPNs' fear that providing too much information to patients (particularly about drug side effects) would affect compliance. In contrast the whole stance of the pharmaceutical care programme was that people not only have a right to that information but that prior knowledge of side

effects helped people to cope with them better (and that these effects could be minimised by careful prescribing). In fact there were more examples given of pharmacist/CPN collaboration in relation to particular clients than there were of conflict - but few of either description.

One manager would have welcomed additional pharmacological training for his CPNs and had approached the hospital pharmacy but this had only been offered at *'an exorbitant price'*.

In Nottinghamshire interprofessional relationships with this group were limited by the nature of the projects.

6.17 Psychiatrists

In Nottinghamshire support for the programme was not wholly enthusiastic and psychiatric teams were not been always made fully aware of developments.

Reported antipathy from one Liverpool consultant seemed to be related to the rhetoric surrounding the project rather than subsequent practice. Concern was expressed about decisions and activities made in isolation, which had the potential to undermine the work of the multidisciplinary team in relation to the treatment of schizophrenics. It was considered that community pharmacists could make a substantial contribution in the treatment of depression.

6.18 Social Workers

The views of the Liverpool social workers interviewed were largely informed by the developments in the day centres and the local authority run residential homes. The scheme was said to be successful because it had not adopted *'a medical model'* - it had made people question their treatment and given them access to the information necessary for them to be able to make their own judgements. It was entirely congruent with their aims of *'partnership'* and *'user empowerment'*. This was *'an idea that had never entered anyone's head before'* but it was thought that schemes like this should be expanded.

Unlike some other respondents they discussed the problems associated with obtaining outcome measures. Day centres kept minimal records and some of the services were deliberately unstructured *'because that is what the members want'* (particularly those in a younger age group). Even if data on hospital admissions, for instance, were available it would be extremely unlikely that a single triggering factor could be identified.

Social work staff interviewed in Nottinghamshire were those directly involved with services to day centres and the residential hostel and their responses are reported elsewhere. The facilitator reported her other contacts as being *'on a trial and error basis'*. She was aware of tensions between social services and health authority personnel even within supposedly well integrated teams and the implications this may have for pharmacists' involvement:

> *I went to speak to (team) and they were talking about how pharmacists could help them. In the end I said 'Pharmacists aren't here to give you ammunition to fight against the psychiatrist' - to some degree that's what they were looking for - they said 'Well that's what our job is - to challenge the psychiatrist'*

6.19 Voluntary Organisations

A number of links were made on both sites and the projects welcomed as useful for both clients and carers. In Liverpool there was unconditional support for the programme as indicated in their evidence to the Joyce Report (7). A local survey of people attending psychiatric outpatient departments had pointed to the demand for much more information about medication and the scheme had begun to address this.

There were, however, some indications from other sources that problems may arise if pharmacists, hoping to influence prescribing or to be part of a multidisciplinary team, associate themselves too closely with campaigning organisations which have frequently challenged areas of psychiatric practice.

6.20 User Groups/Representatives

The developments in Liverpool were backed enthusiastically by members of the joint forum, the local mental health stakeholders group (set up as a consequence of the Joyce Report) and the community health council. This was considered to be a programme that had been developed in response to clients' stated needs.

Most of the Nottinghamshire projects were not aimed directly at users and have not attracted a similar constituency of support.

7 CONCLUSIONS

7.1 This study is a good illustration of both the strengths and weaknesses of qualitative evaluations. A more traditional methodology would have struggled to achieve usable data from a series of small, low-throughput service innovations, many of which did not have a clearly defined and measurable intended outcome from the start. When numbers are so small, the power of statistical analysis simply becomes irrelevant. The strategy adopted here, however, enables us to recognise that some of these innovations probably have sufficient promise to be worth commending to other FHSAs for consideration. They seem to make some difference to the quality of services offered and to be valued by both users and other providers. Perhaps more importantly, it also allows purchasers to see the implementation problems which inevitably arise from any new development and to consider the processes by which change can be successfully promoted and sources of resistance overcome. The disadvantage is that the evaluation does not end with the production of a clear set of recommendations, with the guarantee (or even the suggestion) that doing X will reduce costs by amount Y or raise quality by amount Z. But such a result is rare in human services evaluation for the reasons that have been illustrated in this report. The definitions of inputs and outputs, of what constitutes a cost and what a benefit, are located within the politics of organisational and professional life. In the real world of management decision making, the burden of choice cannot be made into a technical matter and shifted to the evaluator: the most realistic outcome to expect is better information on the options available in any particular situation, the questions that the reflective manager should ask and the factors that are likely to be relevant to their decisions.

The conclusions from this study, then, fall into two broad categories: those which are generic to the management of change and development in primary care, where, in effect, the programmes recapitulated problems which are already familiar from the published literature and those which are specific to the particular projects launched within each programme.

7.2 Generic Conclusions

The first thing to note is that programmes are not necessarily set up in ways that facilitate their evaluation. This should be of some concern to programme managers, because, under normal conditions, evaluation will be their responsibility as the final stage in any service innovation. If, from the beginning, the project is not designed in a manner that will generate the relevant data, and steps are not taken to ensure that this is being supplied, then he or she is not going to be able to determine whether it has succeeded or not. On the other hand, this takes time and resources, both of which may be in short supply, or the manager may be under pressure to deliver change regardless of whether it is beneficial or not.

7.3 In the case of this programme, both facilitators were under pressure from the limited time built into the contract. They adopted very different strategies in response to this. One thought that the important task was to make things happen quickly and to promote the particular interests of community pharmacy so that a considerable number of projects were launched, with relatively little negotiation involving other stakeholders. Many of these projects lacked clearly specified outcomes and the collection of relevant data was not consistently pursued. The other facilitator came into a situation where a group of major stakeholders had already done some work on defining projects to fit their agendas with some indication as to the outcomes they were hoping to achieve. The result, however, was a group of much smaller, more limited and, in some respects, less imaginative activities. The former approach ran into some problems from its neglect of prior consensus building, although the latter did not entirely avoid these. Although the latter group had given more thought to outcomes, these were specified in such general terms that it would be hard to know whether they had been achieved and little consideration had been given to the collection of information from which such a conclusion might be drawn. The former had even less clearly formulated outcomes, although more attention had been given to the information which might be of use to the FHSA in making its own assessment of the schemes. However, despite the facilitator's encouragement not all the participating pharmacists sought to achieve more than a limited and token compliance. (There is, of course, an interesting irony here, given the programme's concern for medication compliance!)

7.4 The conclusion from this study, as from so many others, is that the introduction of innovations needs to be preceded by an exercise to identify the major stakeholders, to involve them in the project, to seek a clear advance definition of the intended outcome and to ensure that information is collected in ways that will allow the promoters of the innovation to determine whether they have succeeded or not. This should apply regardless of whether or not there is an independent evaluation commissioned. Even with this commitment, it must be expected that new agents, beneficiaries or victims will emerge as the programme is implemented and that these parties will also need to be involved or conciliated. However, any organisational process must be sufficiently flexible to recognise unintended outcomes, whether positive or negative. In the present case, for example, it is arguable that the greatest benefits from the programme were not related to its specific objectives but to the evidence of the imaginative things that community pharmacists could do, given the opportunity and the resources.

7.5 A second general point is the importance of clarity about the status and authority of the people engaged to promote change. This is a particular issue for FHSAs who are, for the most part, dealing with independent contractors rather than with NHS employees. Although, in theory, a contractual relationship should allow the purchaser of a service to require specific performance of the activities specified in the contract from the contractor, there is clearly little support for such assertiveness in the organisational culture of FHSAs. The popularity of the word 'facilitator' for change agents in FHSAs reflects this. Facilitators are not people who tell others what to do: they merely help them to achieve what they had always wanted to. However, in this case, the facilitators were disposing of sums of money to commission work over and above that in the basic contract. They appear to have had difficulty in getting some of the contractors who had signed either service agreements or contracts to perform in the ways which they wanted and their compliance with the agreed programmes became a matter for their own choice and convenience rather than reflecting the facilitator's priorities. Something of the same problem arose from time to time in relations with other health and social care professionals, where independent contractors had failed to realise that teamwork necessarily entailed some abridgement of their autonomy and some element of responsibility or accountability to colleagues.

The evaluation of a facilitator's work must reflect the authority that he or she is given or assumes. If an FHSA is only seeking to facilitate, i.e. to employ a worker as a missionary whose main resource is persuasion, then it must be expected that success will be more limited. Participants may change their minds about some preferred course of action, but any such changes must be jointly agreed by facilitator and provider if the programme is not to be undermined. It is probably better that these issues of authority be addressed at the point of induction rather than being left to cause problems later.

7.6 Specific Conclusions

Day Centres

The participation of pharmacists in day centres for people with mental health problems was one of the unequivocally successful elements of the programme on both sites. The pharmacists' availability as a source of advice on medication regimes and their implications was universally welcomed by both staff and users. What contributed to this?

- The pharmacists' detachment from the usual tensions of relationships within and between health and social services. They stood outside the doctor - nurse - social worker triangle and were able to offer advice in ways which were neutral with respect to established sectional interests;
- The pharmacists' lack of professional pretensions and authority relative to users. This meant that they could be consulted without users feeling that the conversation might be held against them at some future date;
- The privacy and responsiveness of the advice-giving environment. Users commented on the difficulty of having comparable discussions in a shop. They also welcomed the opportunity to initiate the request for advice, which seems from other studies likely to be important in motivating them to respond positively to it.

These considerations suggest that such schemes are likely to work best where they involve community pharmacists working on a sessional basis who are seen by all parties to be independent of the existing patterns of legal, professional and organisational accountability. The physical accommodation must allow for privacy

and the users must have a free choice whether to seek out the advice or not. The outcomes are most likely to be seen in quality and user satisfaction measures. However, there were clear indications that, in individual cases, significant therapeutic improvements could be made.

7.7 Medication Supply, Review and Management in Residential Settings

This covers a more diverse range of activities where pharmacists became involved with the medication regimes in non-hospital residential facilities. These included social services or NHS sheltered or supervised accommodation, housing association group living accommodation, voluntary sector and private residential or nursing homes. The clients included both adults with long term mental health problems who had been moved out of long stay institutions and elderly people suffering from mental disorders of ageing. The results here were more equivocal, partly because of the lack of clarity about objectives and the way in which some of these could create perverse incentives. Reducing the number of prescriptions is not necessarily in the interests of a pharmacist who relies on the dispensing fee for a significant part of his or her remuneration.

- Community pharmacist intervention seemed to be more successful where it had been possible to build it in from the beginning of the programme, rather than adding it as an afterthought. It also seemed to be more welcome in those settings where it formed part of a consistent policy of transferring responsibility from hospital to primary care services. Where hospital based services continued to play a significant role in the provision of medical or nursing care, there was an evident and understandable reluctance to separate off medication supply and advice from the basic package;
- The schemes underlined the difficulty of dividing pharmacy advice from pharmacy supply. Most of the arguments in favour of this have been advanced by US writers and it may be that the separation is less relevant under UK conditions. Private and voluntary sector providers seemed to prefer a unified service;
- There seemed to be a genuine interest among home managers in receiving a service of this kind, once the liability and regulatory implications had been clarified and provided that the GPs serving the facility were also sympathetic. However, it

seemed to be most acceptable if presented as a quality enhancement rather than as a means of cost saving.

In considering such provision, then, FHSAs should look for opportunities to promote pharmacist involvements with new developments in accommodation and community based provision from the initial planning stage. The pharmaceutical input needs to be seen as part of an overall package of community based services rather than co-existing with continuing elements of hospital service. It should be expected that supply and advice will be unified unless there are pressing local reasons to the contrary, although it must be acknowledged that denying users the right to take their prescriptions where they will may lead to regulatory problems. Review services offered to the private and voluntary sectors need the active support of existing medical and other nursing care providers but are likely to be well received by the facilities' own staff and proprietors.

7.8 Domiciliary Services

In the end domiciliary visiting services only formed a small part of these initiatives. Although they seemed to have some potential value, particularly for elderly people with mental health problems and their carers, they cut across existing relationships rather than supplementing them. Where patients, carers and GPs were used to working with a particular pharmacy, they may have found it hard to see the relevance of a competing service. This suggests that an FHSA wishing to innovate in this area would probably be better advised to start by identifying existing networks and seeking to develop them, rather than trying to introduce a completely new scheme.

7.9 GP Related Services

These were, arguably, the least successful developments, although some individual pharmacists did manage to achieve some useful outcomes. However, it was clear that unless the GPs were independently motivated to become involved, there was little that either the facilitators or individual pharmacists could do to engage their interest. The programmes were being conducted in a period of considerable turmoil in general practice and dealt with a group of patients that most GPs did not see as a priority for themselves. The efforts of the programmes were outweighed by the

barrage of other changes being solicited from primary care and by the feeling of the GPs that mental health issues were better dealt with by specialists. Where GPs were interested this tended to be in the potential of the developments for cost control, either directly or as a result of improved patient compliance, which the facilitators and pharmacists saw as a low priority relative to quality improvement.

FHSAs considering this area should be wary of initiatives which are not multidisciplinary from the start. Interest needs to be stimulated among pharmacists and GPs simultaneously and the two groups encouraged to bring their own joint initiatives forward. This is particularly important if a programme is to be based on diagnostic categories or other features which imply access to GP records both to recruit a sample and to assess outcomes.

7.10 Services offered by pharmacies

No changes in customary practices and routines as a result of the programme were identified -there is a complete absence of relevant baseline data, whether local or national. However pharmacists have claimed increased confidence in the area and that they have incorporated additional knowledge into their everyday activities. It is not known how this has been received by their customers - or precisely how much additional custom has been attracted as a result. People are loyal to pharmacies for a number of reasons, many of which are unrelated to specific professional practices. Specialist community pharmacies are relatively unusual and for the client group under consideration may be of limited appeal.

7.11 Overall Conclusion

As has been noted, it is characteristic of qualitative evaluations that they promote understanding rather than neatly packaged solutions. However, perhaps the most important outcome is, in a way, also the one which is most likely to be overlooked, namely the evidence of a remarkable pool of skill, creativity and imagination among community pharmacists, which is almost certainly under-utilised at present.

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