

TITLE OF SUBMISSION:
An Analysis of Public Expectations in Mental Health

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Because those who share very close relationship with the patient often also feel the effects of mental health problems, as information available from this category of people increases, so does the probability that what is required to support the patient would be understood. It is this understanding that is often referred to as public expectation.

This conclusion was developed from a research conducted to evaluate the impact of public view on decision making in mental health matters. The findings suggested that specific factors and sources of information are particularly relevant to the understanding of what is represented as public expectations. Thus, representative information received from these sources was compiled into portfolios containing different values of messages. Observation was then conducted to establish the extent to which varying the content of message portfolios influenced professional response to public expectations in mental health. The Representational Information Score Counting (R I S C) factors instrument developed from this was then used to predict the impact patients might have on those defined as the public before their supervisory regimes were developed.

METHOD

The programme adopted a four staged **multi-method** approach with the following objectives:-

- (a) Provide an analysis of the definitions of public and public expectations in mental health.
- (b) Compare definition of expectations to service provision in mental health.
- (c) Propose an alternative definition of public expectations
- (d) Evaluate data to explain the impact of public expectations in mental health.

The first stage of the study involved exploration to establish the descriptions of people who are often assigned to the role of the "Public" by mental health professionals. The analysis suggested that those who shared significant parts of patient's social dynamics were frequently likely to be defined as the public in mental health.

They included predictably siblings, spouses and near neighbours. What was not at first clear was the inclusion of religious Priests, local workmen and employers in the definition. It subsequently became apparent that, mental health professionals placed people in this category because they may have access to material the professional required to assess the extent to which that individual might be involved in the supervision of the patient in specific cases. The review suggested that the public variously expressed four particular categories of expectations. They are:-

- **Aesthetic Expectations:** The requirement for patients to display behaviour consistent with the social niceties of life (courtesy, appropriate clothing, absence of overt mannerisms)
- **Contingent Expectations:** Demand for the use of the most up to date scientific/technological and new social interventions in patient care (recently developed drugs, alternative medicine & psycho-dynamic approaches reported in the press)
- **Structural Expectations:** Enabling easy movement of patients between different services as their needs change (Access to Care Centres, Retraining, Housing & Financial support).
- **Traditional Expectations:** The expectation to have an unhindered access to mental health professionals and services during emergencies (Round the clock services, agreement of criteria for emergency and action & named contacts).

The **second stage** of the investigation examined relationship between what has been established as public expectations and service provision. Descriptive Survey was used. Findings at this stage suggested that existing method of establishing public expectations depended largely on the matching of patient's problem characteristics to predefined care objectives. It was clear that the approach frequently compromised the assessment of public expectations. This is because the matching process does not contain criteria for identifying the factors that the professionals have explained was particularly relevant to their understanding of public expectations. The following did emerge:-

- Explicit search to establish public expectations is not routinely pursued.
- The need to harness **therapeutic opportunity** is often the focus of professional action.
- Pursuit of **patient satisfaction** can hinder the search for public expectations.
- **Public expectation** is but one of a triad of major concerns that often required professional attention in mental health.

The **third stage**, proposed an alternative method that focused especially on defining the factors of public expectations. Descriptive Survey was used. Data analysis at this stage showed that **six** specific conditions and factors of information were often present when public expectations is acknowledged. As a result the conditions and messages exchanged observed during these periods dubbed the **Representational Information Scoring Counting (R I S C) factors** of public expectation. They are:-

- (1) Attending to the concerns of people other than the staff who regularly care for the patient.
- (2) Specification of the views expressed by those whom the professionals have defined as the “public”.
- (3) Clear definition of objectives achieved with patients prior to the prescription of their care needs.
- (4) Agreement of responsibility between those who prescribed care and those they have defined as the “public”.
- (5) Precise specification of residual problems the patient will have to overcome in either an existing or a new destination.
- (6) Prescriptions of care regimes that cover specifically the issues that formed the essence of the public’s expectations.

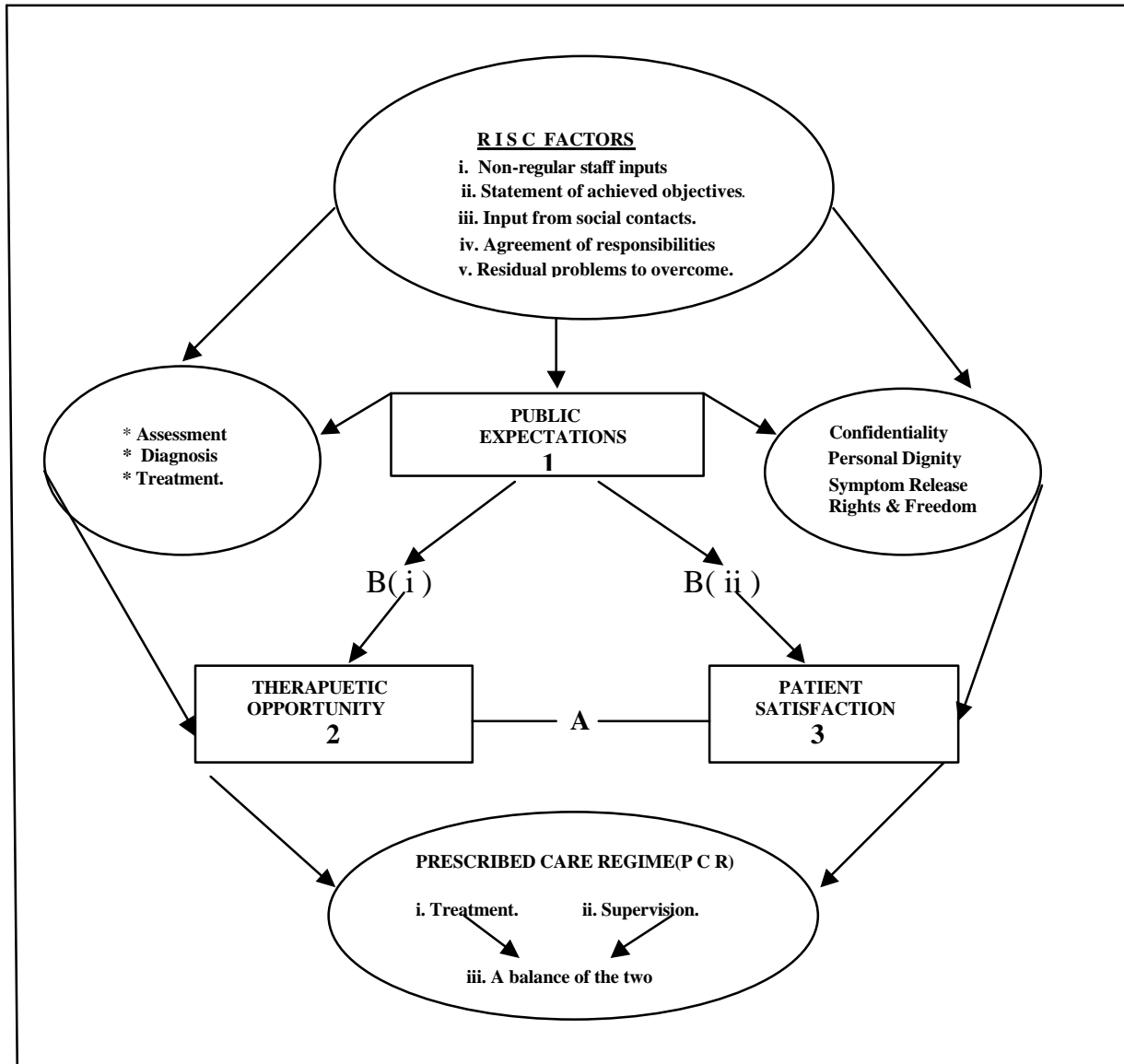
The **fourth stage** of the study used Analytical Survey. At this stage quantitative data was collected to test the extent to which attending to the six R I S C enabled public expectations to be acknowledged. First, theory was proposed from which five major hypotheses were derived and survey questionnaire developed to test the R I S C factors. The survey produced 292 responses from four separate mental health organisations.

Analysis of the responses suggested the following:-

- (i) When at least **five** of the six R I S C factors of public expectations received attention, patients were frequently assigned to care setting that met both their **treatment and supervisory** requirements.
- (ii) Where regimes only satisfied patient's **treatment or supervisory** needs, then often only **three or four** of the R I S C factors would have received attention.
- (iii) Where **two or less** of the R I S C factors were acknowledged the probability increased that neither the **treatment nor the supervision** required by the patient would be available.

The models reproduced below were summaries relationship between major elements of the study's contribution to theory, methodology and the practice in mental health supervision.

SCHEMA OF THE PUBLIC EXPECTATION PROFILING (P E P) MODEL



Public Expectation Profiling (P E P) model

P E P Model configurations of Mental Health Concerns

Profiling of care enabled by this model requires application of the formula explained below.

$$\mathbf{P C R} = (\mathbf{A}) + \mathbf{B(x)}$$

Where:-

P C R = Prescribed Care Regime and,

When:-

Intersection(A) = Care regimes prescribed with an interaction between the need to maximise **therapeutic opportunity and** requirements to realise **patient satisfaction**.

Intersection B(i) = Care regimes prescribed with an interaction between the need to meet **public expectations and** the requirement to maximise **therapeutic opportunity**.

Intersection B(ii) = Care regimes prescribed with an interaction between the requirement to realisation **patient satisfaction and** the need to satisfy **public expectations**.

Therefore, Where **P C R** is equal to **Intersection (A)**, then mental health action would be = **Treatment**. And where **P C R** is based on **Intersection B(i)**, then intervention would be = either **Treatment** or **Supervisory** but not both simultaneously. And where **P C R** is derived from **Intersection B(ii)**, then the activity would be = **Supervision**. Where **P C R** derives from **Intersection (A)+B(i) + B(ii)**, then mental health intervention would = a balance between both **Treatment and supervision**. It is at such an intersection that the impact of public expectations would be appropriately felt.

The dimensions illustrated above are the varying configurations of the competition that often exists between the three major mental health concerns. The outcomes depicted are the effects produced by regimes of care established with use of the factors of information identified by the different intersections. Factors described under the Therapeutic Opportunities dimension are the technical skills mental health staff acquired as a result of professional education. As such issues were outside the scope of the present study they were not investigated.

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