The changing face of psychiatric nursing

Revisiting... Mental health nursing

Kevin Gournay

Abstract

Psychiatric nursing has changed significantly since I wrote a similar article almost 10 years ago. Community psychiatric nurses now focus their attentions almost entirely on people with serious and enduring mental illnesses and undertake case management roles in community teams. Many nurses have now been trained in the use of psychosocial interventions and there have been particular advances in the training of nurses in medication management. In turn, prescribing by nurses has become a reality and this role will expand rapidly over the next few years. Unfortunately, the potential for nurses to deliver cognitive–behavioural therapy to those with common mental disorders has not been realised and it is unlikely that this situation will change. Psychiatric nursing roles have increased in the forensic system and nurses are now working with people with dangerous and severe personality disorders and within prison healthcare. The education and training of nurses has undergone a fundamental shift and nurses of the future are likely to be graduates. Here I discuss the implications of these changes.

In 1996, APT published an article with much the same title and by the same author. The article, which I wrote during 1995, examined the key issues concerning psychiatric nursing (Gournay, 1996). The article began by describing the rationale for returning the focus of nursing to serious mental illness, citing the problems associated with the interventions of community psychiatric nurses (CPNs),1 during the 1980s and early 1990s, working with people with common mental disorders in primary care. I argued that, in order to be effective, nurses needed to acquire clinical skills in the management of people with schizophrenia and other serious and enduring illnesses. In particular, I argued that, unless nurses received appropriate training in these clinical skills, merely shifting the focus of their work from institutions to the community, and the patient focus from those with common mental disorders to those with schizophrenia, would prove inadequate. I also advanced the argument that the problems of people with dual diagnosis, i.e. substance misuse and serious mental illness, needed particular attention. I drew attention to the neglected nursing roles of physical healthcare and medication management, and set out a range of areas in which education and training could be improved. The training priorities included the expansion of the Thorn Programme for training nurses in psychosocial interventions, and the continuing need to train a relatively smaller number of nurses in cognitive–behavioural therapy for common mental disorders. I concluded the article by arguing for a strengthening of evidence-based approaches to nurse education and suggesting the development of research in psychiatric nursing within the context of multidisciplinary investigations using randomised controlled trials and economic analyses.

In the 9 years that have passed since that article was written we have seen major changes in the National Health Service and in mental health policy. In this revisitation article I examine what has actually happened, in this intervening period, to the topics described above, and consider other topics that have since become important.

1. Throughout this article I refer to community psychiatric nurses (CPNs) or psychiatric nurses. I acknowledge that some prefer to use the term mental health nurses.
Serious mental illness

In 1990, a quinquennial review of community psychiatric nursing (White, 1990) showed that 27% of the patients on CPN case-loads had a principal diagnosis of schizophrenia and a quarter of CPNs in the UK had no people with schizophrenia on their case-loads. Although there have been no further comprehensive surveys of community psychiatric nursing, it is clear that the vast majority of psychiatric nurses now work with people with schizophrenia within the context of the community mental health teams and the assertive outreach and crisis resolution services. Thus, the pendulum has indeed swung in the direction that was desired by so many community psychiatrists, and some nurses, in the early 1990s. However, there is now some concern that this shift has caused problems for people with common mental disorders.

As is noted below, there have been very substantial changes in the training provided to CPNs, with an emphasis on psychosocial interventions in serious mental illness (Box 1). However, there is very little training available to them in managing conditions such as obsessive–compulsive disorder, post-traumatic stress disorder, severe panic disorder and agoraphobia, and so on. It is now clear that the focus of CPNs on people with serious mental illness has consumed the CPN workforce entirely. Even so, there is a shortage of CPNs to provide skilled nursing care for people with serious and enduring mental illness. The reality is that several thousand more CPNs are needed to provide a reasonable standard of care for patients on community case-loads. Even if the money to do this were immediately available, it would not solve the problem. It takes several years to train a nurse and several years more to train them to a level where they may carry out effective community roles. Thus, it would be many years before the workforce would be sizeable enough to meet the needs of services. Furthermore, there are currently enormous difficulties in recruiting and retaining nurses in many parts of the UK and the problem is compounded by the well-acknowledged demographic time bomb, wherein disproportionate numbers of CPNs will retire over the next few years. Pay, conditions of service and the problem of house prices further exacerbate the problem. Given all of the difficulties in meeting the needs of people with serious and enduring mental illness, there seems little prospect that CPNs will have a significant role in the care of people with common mental disorders.

Contemporary nursing services and nursing roles

As noted above, the nature of community psychiatric nursing has changed considerably in the past decade or so, and the CPN may differ little in function from their case manager colleagues from other professions in the community teams. Certainly, the professional distinctions between nurses, social workers and occupational therapists have blurred somewhat, and the overlap of roles and the sharing of case management tasks seems to be to the advantage of patients.

By contrast, nurses in in-patient services continue in a custodial role. However, the nature of this role has changed. In-patient care has become one of the most difficult (and undervalued) areas of psychiatry. In my 1996 article, dual diagnosis was highlighted as an increasing problem, and there is little doubt that it still provides one of the single largest challenges in services. A number of recent studies (e.g. Wright et al, 2002) demonstrate the rising prevalence of this problem, particularly in inner cities. It is likely that, on the average acute ward, there are more people with a dual diagnosis than without. This, of course, has brought additional problems, and dual diagnosis is arguably a significant factor in the increasing levels of violence one sees in in-patient services. In turn, the in-patient population is increasingly likely to be sectioned under the Mental Health Act and to be non-compliant (non-concordant) with treatment. Thus, nurses in in-patient services have a more difficult job than in the asylum days.

The difficulties of the in-patient environment lead to problems of recruitment and retention to which no one really has a solution. The background work to the National Institute for Clinical Excellence (NICE) guidance on the short-term management of violent behaviour in psychiatric in-patient settings (National Institute for Clinical Excellence, 2005) emphasises the problem by citing the very high rates of injury to staff and patients during restraint episodes, and identifies a wide range of problems concerning the use of seclusion and training in control and restraint.

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**Box 1 Important roles of nurses in serious mental illness**

- Family interventions
- Physical healthcare
- Medication management
- Working with dual diagnosis patients
- Cognitive–behavioural therapy for delusions and hallucinations
Neglected nursing roles

My 1996 article identified two areas as being particularly important: the physical health of people with serious mental illness and the management of medication.

Physical health

The first, physical health in serious mental illness, remains a problem. However, my department at the Institute of Psychiatry has recently begun to develop modules of training for nurses working in both inpatient and community settings to deal with a very wide range of physical health issues that are of particular relevance for those with mental illness. This training includes health education and takes account of the difficulties of delivering interventions to people who may have cognitive deficits or very poor levels of motivation. The training emphasises the need to target areas such as cardiovascular and respiratory disease and sexual health and also recognises that this population may need active help to access an appropriate range of health services. There is no doubt that all those involved in nurse education must make major efforts to continue training initiatives, so that the physical health needs of those with serious and enduring mental illnesses are adequately met.

The management of medication

Medication management (Box 2) is an area in which there has been significant success. At the time of writing the 1996 article, I had begun developing educational materials for nurses on this topic. By 2004, a medication management training package for nurses had been subject to a randomised trial (Gray et al., 2004). The programme allocated 1 day a week for 10 weeks to teaching nurses to improve compliance in the manner described by Kemp et al. (1998). The training also included measures to improve nurses’ skills in using standardised instruments to assess mental state and the side-effects of medication and also to deal with patients’ beliefs and feelings about treatments. Nurses were provided with a range of other skills necessary to improve compliance. These skills centred on using a non-confrontational approach, based on the principles of motivational interviewing, and emphasised listening to the reasons why patients had difficulty complying and then negotiating compromise solutions.

The trial demonstrated not only that nurses trained in these methods improved their skills and knowledge, but, most importantly, that their intervention led to very significant changes in patient psychopathology, with a 17 point difference on the Positive and Negative Syndrome Scale (PANSS) score between the treatment and the control group.

This training package has now been disseminated to more than 1000 nurses across the UK, following another Institute of Psychiatry initiative to train trainers in all regions to deliver the training programme locally. At the time of writing, the package has also been disseminated across the states of Australia and there are similar training programmes planned for other European countries. The Gray et al. (2004) study is now being replicated with funding from the Medical Research Council.

Nurse prescribing

Although this training innovation should lead to major improvements in patients’ compliance with drug regimens, nurse prescribing is arguably a more important development. The arguments for nurse prescribing are set out in detail in Gournay & Gray (2001). Nurse prescribing is now a reality and, although psychiatric nurses are somewhat behind their general nursing counterparts in obtaining prescriptive authority, training programmes in prescribing are being set up at a number of universities across England. Within a few years it is envisaged that thousands of psychiatric nurses will be carrying out a range of prescribing tasks up to and including prescribing new psychiatric drugs independently (albeit under the overall supervision of a consultant psychiatrist). The principal advantage of nurse prescribing is that it will free up the psychiatrist to deal with the complex and difficult cases, leaving the routine to experienced nurses. To ensure that this development is both safe and effective, we need to ensure that the training and supervision of nurses are adequate and that the necessary resources are released to continue funding the initiative appropriately. Furthermore, providing nurses with prescriptive authority is clearly an important topic for evaluation and there is an obvious need to assess clinical and economic outcomes of nurse prescribing.

Box 2 Components of medication management training for nurses

- Knowledge of psychopharmacology
- Mental state assessments
- Assessment of medication side effects
- Motivational interviewing skills
- Strategies to improve adherence
The nurse cognitive–behavioural therapist

The 1996 article argued for the further development of training programmes for nurses in cognitive–behavioural therapy. Regrettably, this expansion has not come to fruition, and although there are a few hundred such qualified nurses, cognitive–behavioural therapy for people with common mental disorders is scarce, to say the least, outside of specialist centres. There has been a modest increase in the number of clinical psychology training places, but the expansion of the cognitive–behavioural therapy workforce has been completely overwhelmed by a widening of the evidence base for the efficacy of this approach. This has been emphasised even further by the NICE guidance on schizophrenia, which recommends the provision of cognitive–behavioural therapy to deal with hallucinations and delusions (National Institute for Clinical Excellence, 2002). It seems obvious that nurses are in an ideal position to become the agents for the delivery of cognitive–behavioural therapy. However, they will need a more intensive training than that currently offered on psychosocial intervention programmes (see below). Realistically, such intensive training will not be available for some time to come, as training providers are still dealing with the backlog caused by the absence of appropriate basic training for CPNs over a number of years.

Education and training

The 1996 article set out the background to the Thorn Nurse Initiative (Gournay & Birley, 1998), which at that time had delivered training to a few dozen CPNs. The Thorn Programme has now been replicated in many universities across the UK, and similar training programmes in psychosocial intervention have been developed at various educational levels, up to and including master’s degree, by other universities and the Sainsbury Centre for Mental Health. We now have thousands of mental health professionals trained in psychosocial interventions, and most community mental health teams include several workers who have received basic training in assertive community treatment methods, basic cognitive–behavioural therapy techniques for dealing with hallucinations and delusions, and family interventions.

The Thorn Programme opened its doors to other professionals several years ago and now nurses occupy about two-thirds of course places. However, while all this is very welcome, the limitations of such training need to be emphasised. What these programmes have done is to provide mental health professionals with basic skills across a number of areas. There is still a need, as with cognitive–behavioural therapy, to equip more professionals with more advanced skills in family interventions for those with schizophrenia and their carers, and also to develop specialist programmes for other groups, including those with personality disorders and the increasing community population who have fallen foul of the criminal justice system.

Undergraduate nurse education

In 1995 I highlighted some of the shortcomings of undergraduate nurse education, including the problems of teachers being located in universities rather than in clinical centres. Many departments of nursing in universities were then characterised by a preponderance of anti-psychiatric philosophy in many programmes, and lack of important information in training courses regarding the biological aspects of mental illness and pharmacology. There has been progress in some of these areas, although clinically focused training is probably an ideal rather than a reality.

The 1996 article also identified the problems of nurses who had been trained in large institutions and needed an updating in their skills. There have been several recent initiatives, including efforts by the National Institute for Mental Health (England) to improve the skills of nurses working in in-patient settings, and these are to be welcomed. However, there are now some ominous signs that, following the moves to make nursing an all-graduate profession, psychiatric and, indeed, learning disabilities nursing may disappear in their present form. For many years it has been possible to train and register as a psychiatric, rather than a general or learning disabilities nurse. However, there are moves afoot to set up generic training, so that one has to qualify as a generic registered nurse before moving on to training in psychiatric nursing as a post-qualifying specialty. In my opinion, this would compromise a number of the aforementioned initiatives. However, in the wider circles of nursing, the debate continues and it may yet be several years before any resolution, one way or the other, is achieved.

Other areas

High secure hospitals

Two areas that were not discussed in any detail in my 1996 article have now become prominent in psychiatric nursing. The first is the issue of the expansion of forensic services. Nursing in the high secure hospitals has been beset by problems over the years and these have, of course, been raised in
the two notorious reports into care and treatment at Ashworth Hospital (Department of Health, 1992, 1999). One positive effect of these scandals has been the investment in nursing in these institutions. Nevertheless, it must be said that this work is extremely demanding, with nurses (and indeed other staff) trying to balance the needs of the patient against public safety. In turn, attempting to provide therapeutic interventions within a custodial environment presents enormous challenges.

Although there are very welcome initiatives aimed at transferring many of the female patients to less intimidating environments, forensic services as a whole continue to expand. Indeed, because of the shortage of beds, forensic populations frequently overspill into local mental health services and the mixed custodial/care role of nurses is now much more mainstream than a decade ago. This is reflected in the new NICE guidelines (National Institute for Clinical Excellence, 2005) that set out guidance and methods to improve security (such as closed-circuit television) and place an understandable emphasis on searching, restraint, seclusion and the use of rapid tranquilisation. While this guidance will be very useful, it none the less emphasises the changing nature of psychiatric care.

Conclusions

In summary, the years since my original article have seen many changes in mental healthcare, which have, to a greater or lesser extent, been mirrored within psychiatric nursing. There is no doubt that the skills of psychiatric nurses have improved in many respects; in other areas, such as physical healthcare, there has been little change. Furthermore, the young (or indeed older) person entering the nursing profession will generally have a higher standard of education than in previous generations and the psychiatric nurses who qualify over the next few years will do so with an honours degree. Perhaps this fact identifies the most important shift yet to come. It seems extremely likely that the caring tasks undertaken by psychiatric nurses in years gone by, which included helping people with schizophrenia in their activities of daily living, attending to the incontinence of elderly mentally ill patients and simply looking after those who cannot care for themselves because of illness. As in the rest of psychiatry, there are uneasy questions to be asked regarding the age-old topics of mad versus bad and custodian versus carer.

References


**MCQs**

1. Psychiatric nursing is expanding into:
   a. primary care
   b. CBT for common mental disorders
   c. forensic areas
   d. general hospitals.

2. In 1990, the proportion of people with schizophrenia on CPN case-loads was:
   a. 87%
   b. 67%
   c. 47%
   d. 27%.

3. One of the most important neglected nursing roles is:
   a. public education
   b. GP liaison
   c. physical healthcare
   d. community team management.

4. Nurses working within the Dangerous and Severe Personality Disorder Initiative are now located in:
   a. one prison and one high secure hospital setting
   b. two prisons and two high secure hospital settings
   c. three prisons and three high secure hospital settings
   d. four prisons and four high secure hospital settings.

5. NICE guidance to be published early in 2005 of relevance to psychiatric nursing focuses on:
   a. schizophrenia
   b. depression
   c. disturbed/violent behaviour
   d. computer-assisted treatments.

**MCQ answers**

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Mental health nursing: issues and roles

Kevin Gournay

1994 saw the publication of the report of the Mental Health Nursing Review Team (Department of Health, 1994). This report signified the end of a three year process where mental health nursing was examined from the perspectives of practice, education, research and management. The last review of mental health nursing took place in 1968, but since that time there have been enormous changes in our thinking about mental illness, in the delivery of services and a number of very exciting developments in treatment. The review process included the widest possible consultation with other professionals, user organisations, patients, relatives and carers. It also co-opted expert advisers and took written and oral evidence, and visited clinical services across England. There were altogether 42 recommendations and during this article reference will be made to a number of the most important of these.

Before a detailed examination of the issues, it is worth commencing with the tenth recommendation of the review, i.e. that the title Mental Health Nurse (MHN) be used both for nurses who work in the community and for those who work in hospital and day services. Although there are those who would prefer to use the more descriptive term, psychiatric nurse, using one term to cover all nurses is now much more appropriate. MHNs should be using the same core skills regardless of the setting in which they practice. Current thinking about continuity of care reinforces the view that the continued separation of care and treatment between community and in-patient settings is counterproductive.

Serious mental illness

One of the most important recommendations of the Review was that nurses focus their efforts on those with serious and enduring mental illnesses. This recommendation is in accord with more general public policy and is supported by specific findings. For example, White (1990) in his quinquennial review of Community Psychiatric Nursing in the UK, highlighted the scandalous situation where 80% of people with schizophrenia in the community had no services whatsoever from a MHN. Only 27.2% of clients of CPN case loads had a principal diagnosis of schizophrenia and a quarter of CPNs in the UK had no people with schizophrenia on their case loads. At the same time, this survey showed that nurses were increasingly working with populations with depression, anxiety and non-psychotic problems in primary health care, taking their referrals directly from a GP. Recently Gournay & Brooking (1994, 1995) showed, in a large randomised controlled trial, that CPN interventions with these populations were both ineffective and very expensive.

Thus, at present the emphasis for MHNs must be with those people with the most serious illnesses, although as will be discussed below, there are limited opportunities for nursing to develop with other populations. Unfortunately, the recent National Survey of Community Mental Health Teams (Onyett et al, 1995) and the Clinical Standards Advisory Group report (DoH, 1995) showed that CPNs still have a long way to go in meeting the recommendations of the Mental Health Nursing Review and that caseloads still comprise many with less serious mental illnesses.

Contemporary services and nursing roles

Following 40 years of deinstitutionalisation we are now in an era where the unit of delivery of mental
health care is increasingly the community mental health team. In turn, the mode of delivery is of case management. This was developed from the work of Test & Stein (1980). The case manager provides a range of interventions, including the brokering of services, establishing networks with community agencies, acting as a client advocate, supervising medication, training the patient in community living skills and using various psychotherapeutic and family interventions. Case management should also include the important principle of actively seeking out people who drop out of services. The problem orientated model of case management has been gradually developed in the UK, Australia and the USA (e.g. Hoult, 1991; Marks et al, 1994) and will become much more central to the role of nurses working within community teams.

However, there are two issues which need to be considered further. First, it has become clear that nurses are not the only professionals who will adopt the role of case manager and it may be that in the future this role will also be occupied by occupational therapists, social workers or indeed non-professionals. This was confirmed by Ford et al (1993) in the study of the original case management development sites in the UK. The second issue is that there is often confusion regarding the approach described above, which is predominantly a clinical method, and care management, a term describing what is essentially an over-arching system. To complicate matters further, clinical case management has been developed in different ways with different theoretical underpinnings. For example, the ‘strengths’ model of case management (Rapp & Winterstein, 1989) concentrates on building on client strengths rather than targeting deficits. Conversely there are models of case management based on the opposite approach of targeting deficits; for example using social skills training as a central intervention. Detailed discussion of the various models of case management is out of place here but recent research has begun to identify which approaches are more effective. For a detailed discussion the reader is referred to Andrews & Teesson (1994), Muijen (1994) and Santos et al (1995).

In summary, the research findings so far indicate that clinically focused approaches are the most effective and that the brokerage models favoured by many Social Services departments may actually lead to negative outcomes (Curtis et al, 1992; Rossler et al, 1992). Although case management has become more widespread it is in itself not a panacea and certainly demands that staff are appropriately trained. For example, Muijen (1994) showed that merely reconfiguring nursing teams within case management arrangements conferred no additional benefit over nurses working in their usual generic fashion.

**Dual diagnosis populations**

Nurses in contemporary services are increasingly working with new populations which will demand changes in approach. For example, the dual diagnosis of substance misuse and serious mental illness is now a growing and substantial problem. A range of work from the US (Bartels et al, 1995; Teague et al, 1995) shows that an integrated approach to both serious mental illness and substance misuse and/or dependence is necessary for a positive outcome.

Although the majority of people with serious mental illness are no more dangerous than the general population, violence is an increasing problem in services. Work from the US (e.g. Torrey, 1994) shows that violence is particularly linked to patients who abuse substances and those who are non-compliant with medication. Although some research (Dvoskin & Steadman, 1994) has shown that intensive case management can reduce it, violence places increasing stress on mental health team workers and makes conditions of work that much harder.

**Neglected nursing roles**

**Physical health**

There are two areas traditionally associated with nursing which have been gradually neglected over the years. The physical health of people with long-term mental illnesses is, of course, an important area for attention, particularly as we know that standardised mortality rates in schizophrenia are 2.5 times those of the rest of the population and 45% of people with long-term mental illness also have substantial physical illnesses, particularly those of the cardiovascular and respiratory variety (Allbeck, 1989; DoH, 1995). Furthermore, we also know that this population is at considerable risk from infection with HIV (Sacks et al, 1990). Obviously medical care is the responsibility of both the patient’s GP and the responsible Medical Officer of the mental health team. However, as recent work (DoH, 1995) shows, patients do not always receive appropriate physical monitoring. This may be for many reasons, for example, not registering with a GP, or the GP assuming that the
Box 1. Important roles in serious mental illness

- Case management
- Psychosocial interventions
- Physical health – monitoring and education
- Medication management
- Working with dual diagnosis patients
- Behavioural therapy

Mental Health Service is attending to these needs. MHNs are ideally placed to ensure that patients are properly registered with a GP and that any clearly defined problems receive appropriate attention. Further, nurses can monitor weight, blood pressure and also provide health education and interventions in areas such as diet, smoking and sexual behaviour.

Medication management

MHNs have a natural central role in ensuring that medication is managed effectively. The importance of this cannot be overstated, particularly as there is a wide array of evidence (McCreadie et al, 1992) which shows that the majority of people with schizophrenia being treated with psychotropic medication have significant side-effects. Unfortunately medication management has not been high on the list of priorities for practice or education (White, 1990), and recent research (e.g. Bennett et al, 1995a, b) shows that nurses are often not sufficiently skilled to detect even the most serious side-effects of neuroleptic medication. There have been some commendable initiatives recently such as the guidance document issued jointly by the Department of Health and the Royal College of Nursing (1995). However, educators and managers in mental health nursing do need to place more emphasis on this important area, particularly as a new generation of drugs are gradually coming onto the market, each of these compounds having their own profile of actions and side-effects.

Nurse behaviour therapists

While there is a clear case for focusing on serious mental illness, we have known for many years that severe phobic and obsessive states can cause tremendous handicaps. However, the majority of sufferers can be helped dramatically by brief behavioural psychotherapy (Marks, 1987). The recognition that adequate numbers of sufferers could not be treated by psychiatrists or clinical psychologists alone, led to the setting up of the first Nurse Therapy Training Programme at the Maudsley Hospital in 1972 (Marks et al, 1977).

Several studies have shown that nurse therapists produce excellent results in terms of both clinical and economic outcomes (Ginsberg et al, 1984).

However, despite strong evidence, only about 200 nurse therapists have been trained since 1972 and therefore their impact on the health care system has been very limited. There is no reason why we should not develop new nurse therapy training programmes. Experienced nurse therapists could also provide support and supervision for more numerous groups, such as practice nurses and non-professionals, to deliver simple exposure-based programmes. These skills could probably be taught in a relatively short space of time to these personnel.

Education and training

Psychosocial interventions – the Thorn Programme

The UK is currently leading the world in the development of comprehensive training initiatives. The Sainsbury Centre in London has developed case management in various demonstration sites throughout the UK and their training division assists many local services. Furthermore, Masters programmes in problem orientated case management and psychosocial interventions are gradually developing in universities. For example, the author developed a multi-disciplinary programme in 1992, and Brooker commenced a similar programme in Sheffield in 1995. However, the most important development is the Thorn Nurse Initiative. This is based at the Institute of Psychiatry in London and at Manchester University, and was set up by a generous grant from the Sir Jules Thorn Trust. The first programme was developed by a team of influential psychiatrists, nurses and psychologists, including Dr Jim Birley, Professors Isaac Marks, Tom Craig, Julian Leff, Nick Tarrier, Tony Butterworth, and other colleagues. The year-long course sets out to produce a specialist nurse dedicated to work with patients with schizophrenia, analogous to the Macmillan nurse for cancer. Training is skills-based and focuses on a clinically focused and problem orientated method.
of case management. There is also training in the various contemporary psychosocial methods, including family management, cognitive-behavioural interventions with positive and negative symptoms, and prodrome and relapse strategies.

By the end of 1995 this programme had produced about 60 graduates and the plan is for satellite centres to be set up throughout the UK over the next couple of years. The programme has attempted to ensure rigorous adherence to training principles and the use of clinical supervision, as research shows that at follow-up, after training in psychosocial interventions, both of these issues seemed problematic (Kavanagh et al, 1993; McFarlane et al, 1993). Initially it was envisaged that the Thorn programme would be confined to nurses, but by late 1995 the Manchester programme had begun to admit others and the Institute of Psychiatry programme will probably also soon open its doors to psychologists, occupational therapists, and social workers.

There is a need to evaluate the work of Thorn nurses in some detail, particularly as case management outcome is still far from clear (e.g. Andrews & Teesson, 1994; Muijen, 1994; Santos et al, 1995). The Thorn programme has an integral evaluation of clinical outcomes of patients treated by students. However, full scale studies with randomised controlled trials are still some way off. On a positive note, Brooker et al (1992, 1994) have already demonstrated that CPNs can be trained, using relatively brief programmes, to become effective deliverers of family interventions.

Undergraduate nurse education

The education and training of nurses is now the responsibility of universities, the framework being Project 2000. Essentially this means that nurse training has become much more theory based, with a move away from apprenticeship. All nurses now receive a basic education within a common foundation programme for 18 months and after that they spend another 18 months studying either general nursing, mental health nursing, learning disabilities nursing or child nursing. It is likely that nursing will soon become an all graduate profession and that specialisms such as mental health will only be available at Masters level. This development is much against the recommendations of the Mental Health Nursing Review, which drew attention to the problems associated with genericism in social work and recommended unequivocally

that mental health nursing be retained in its present form (Box 2). Should nursing become an all-graduate and generic profession, it seems likely that none of the nurses of the future will want to attend to basic nursing care tasks for the mentally ill, and instead of receiving attention from a skilled registered nurse, patients will receive direct care from health care assistants, with a nurse acting as a supervisor.

There are three other major difficulties associated with nurse education. First, the Mental Health Nursing Review recognised that nurse tutors are very often removed from the realities of clinical practice and recommends that they spend at least a day a week in a clinical area. However, this recommendation does not go far enough, the optimum arrangement is that of a lecturer-practitioner with a 50-50 split. The second problem is that the current mental health nursing curriculum contains a great deal of arguably redundant theory which is often underpinned by an anti-psychiatric philosophy. On the other hand, there seems to be very little information regarding the biological aspects of mental illness or indeed little skills training in important areas such as medication management.

The final area of education which is of paramount importance concerns the large numbers of nurses who were trained in and have spent all of their working lives working in large institutions. It is completely unreasonable to expect these nurses to make the transition to community mental health teams without training. However, this is happening all over the country. Once more, we are drawn to the issue of investment in training and it is arguable

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Box 2. Recommendations of the Mental Health Nursing Review

(6) “The essential focus lies in working with people with serious or enduring mental illness”
(10) “The title Mental Health Nurse be used for nurses who work in the community and for those who work in hospital and day services”
(12) “Action is taken to improve the standards of management and leadership”
(19) “The collective and individual needs of nurses presently working in large mental hospitals should be identified and met”
(32) “Teachers of mental health nursing should spend the equivalent of at least one day per week in practice”
that this represents, alongside the provision of sufficient residential facilities, the biggest priority for future action.

Management

The Review was particularly concerned that the standards of management and leadership in mental health nursing needed strengthening and consequently the Department of Health has set up a programme to develop the leadership potential of small numbers of mental health nurses. The Review also recommended that nursing managers develop strategies with particular emphasis on use of Standards Protocols. Thus the recent Clinical Standards Project on schizophrenia provides nurses with a framework for action. Finally, the Review recognised that nurse managers need to adapt to the contemporary demands of multi-disciplinary/inter-agency working and recommended greater collaboration with other social and health care providers.

Research

The Review recognised that research in mental health nursing needs strengthening and made several recommendations to assist with the development of an appropriate infrastructure. These include the setting up of information systems and targeting central Research and Development resources on mental health nursing activity. It also seems essential that research in mental health nursing be much better integrated with the efforts of other disciplines. Furthermore, nursing interventions should be subjected to the tests of randomised controlled trials and economic analysis. Unfortunately such methods have rarely been used by nursing researchers who have generally concentrated on qualitative methods. Hopefully the establishment of mental health nursing departments within our medical schools and universities, which is now taking place, will lead to researchers being able to benefit from the collaboration and supervision of more established groups.

Conclusion

Mental health nursing, like the rest of mental health care, is in a state of rapid transition. There are clearly many opportunities for the development of mental health nursing skills and these can only be beneficial for the sufferers of mental illness. However, there are also many challenges for mental health nursing to confront in the future. Fortunately we can be guided by important work such as the Mental Health Nursing Review and the Clinical Standards Advisory Group on Schizophrenia, and these provide the basis for future action and thus improvement in what mental health nursing has to offer.

References


Multiple choice questions

1. Latest research shows that CPNs’ case loads include:
   a) 80% of people with schizophrenia in the community
   b) 50%
   c) 20%

2. The most effective form of case management is:
   a) Clinically focused model
   b) Brokerage model
   c) Strengths model

3. Standardised mortality rates in schizophrenia are:
   a) 1.5% that of the general population
   b) 2.5% that of the general population
   c) 3.5% that of the general population

4. The Thorn Nurse initiative is based on:
   a) Behaviour therapy
   b) Case management, family management and behaviour therapy
   c) Anti-psychiatric theories

MCQ answers

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1 2 3 4
a F a T a F a F
b F b F b T b T
c T c F c F c F
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Commentary on papers in *Advances in Psychiatric Treatment*

It is the intention of the Editorial Board to establish dialogue, discussion, debate and even dispute among our readership and we aim to publish correspondence, however derogatory! With this issue we are adding another contribution to the possibility of debate by having an item called 'Commentary' for some of the papers. The commentator will usually come from a different discipline or subspeciality from the original author and will therefore give the matter under discussion a different slant. We hope our commentators will be controversial or will at least produce some new ideas and perspectives. This will give another side to the arguments and discussions of treatment and will also expand particular areas. It is the nature of the article itself which will dictate the content of the commentary. We hope that this will make the journal both more lively and informative.

**Comment from Richard Lingham**

Professor Gournay's commentary on the issues and roles in mental health nursing could equally have been titled: situation and process, skills and experience, genericism and specialism, clinical and eclectic, or proactive and preventive. His research review supports a viewpoint at the structured/structured end of this continuum, where he sees ready evidence that nurses now require clinically focused training and re-training if they are to provide care and treatment for patients with the most seriously disabling mental illnesses. This reinforces the Butterworth Report's conclusions, the *Health of the Nation*'s expectations and the specifications in *Building Bridges*.

Last year, the Clinical Standards Advisory Group on Schizophrenia (DoH, 1995) found "little systematic assessment of mental health nurses' training needs in psychological/family interventions, case management approaches (including assertive outreach), and the assessment of the side-effects of medication". Also, "in some districts CPNs were unhappy about the stigmatising effects of 'labelling' and did not wish to use the term 'schizophrenia'. This led, on occasion, to a lack of co-ordination between the professions and deployment of their time away from the care of the severely mentally ill."

Professor Gournay recalls research findings from 1990 that only a small minority of patients with schizophrenia see CPNs. His own recent research concludes that their main work with primary health care patients who suffer from depression and anxiety states, is "ineffective and very expensive". He identifies the need to improve standards of management to develop focused methods of work with patients and families, and to instil basic clinical knowledge and awareness.

Much of the nursing story mirrors the path trodden by social workers. In 1970, before all social work and training became generic, six universities provided postgraduate training in psychiatric social work. None does now, but specialism has re-emerged by statutory accident since 1983, in the form of in-service training for approved social workers, which has expanded from four weeks to six months. In 1995, specialism took more substantial form in the *Statement of Competencies for Forensic Social Work* published by the Central Council for Education and Training in Social Work.

Many CPNs and social workers will need retraining and reorientation to work competently within the sort of structured programmes operating in Wisconsin, Sydney, and increasingly in this country. Successful assertive outreach work will demand that professional opinions, contributions to clinical judgement and decision making are based on secure knowledge, sound professional philosophies and shared awareness. Patients and carers must feel secure about treatment and care plans. Within their individual capacities, all members of the resultant team should know that the principal sources of understanding of mental illness stem from clinical psychiatry and psychology. The training and practice of those who earn their living in mental health care must acknowledge this reality. Apart from anything else, how can detractors of 'the medical model', when circumstances justify firm opposition to a doctor's views, hope to present a credible opinion if they do not know what they are talking about?