A turning point for community psychiatric nurses

by Kevin Gournay (FRCN 1998)

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There have been so many who have supported, encouraged and inspired me over the past 50+ years of my career. One person stands out. Professor Isaac Marks, a psychiatrist by background, changed the course of my life when I spent 18 months training as a nurse therapist on a programme that qualified me to be an autonomous nurse practitioner.

In 1972, Isaac, in launching the first nurse therapy programme, identified mental health nurses as a much-undervalued workforce and realised that their background experience and training made them ideal candidates to deliver clinically effective interventions.

Isaac experienced great resistance to his efforts, a great deal of which came from within the nursing profession. In a sense, many believed at the time that nurses should 'know their place'. Thus, a significant contribution was made to the creation of the first generation of clinical nurse specialists in mental health; many graduates of the programme became leaders in various fields of healthcare. Most continued in clinical practice for many years. My own clinical practice has continued, alongside my other work, until the present day; now employing interventions in the COVID-19 era. For those interested in how our profession developed, Professor Peter Nolan provides what is arguably the most authoritative history of mental health nursing in his book (Nolan 1993).

Community psychiatric nurses in primary heath care

Abstract

Background Community Psychiatric Nurses (CPNs') are increasingly working in primary health care with non-psychotic patients. This study was designed to test the efficacy of this work.

Method The study was carried out in six health centres in north London with a total of 36 participating general practitioners (GPs) and 11 CPNs. Using a randomised controlled trial, 177 patients were referred by their GP and randomly allocated to continuing GP care, immediate community psychiatric nursing intervention or placed on a 12-week waiting list, after which time the patient was offered CPN intervention. A range of measures of symptoms and social function were used, and ratings were carried out at assessment and at 24 weeks.

Results Patients improved on all measures over time ($P<0.001$ for all measures). However, there was no difference between the group of patients receiving GP care and those who received immediate CPN care. Improvements seem to be independent of the amount of contact. Dropout rates from CPN intervention were high (50%). CPN dropouts had greater levels of psychiatric symptoms. Patients were more likely to drop out from the care of CPNs who had completed a one-year, post-qualifying CPN course than from the care of those without that training. Following referral, patients continued to attend the GP at the same rate

Conclusions The results add weight to the argument that CPNs should refocus their activity on people with serious mental health problems and indicate that CPN education should focus on skill acquisition and interventions of proven effectiveness.

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The author's collaborator on this research, Professor Julia Brooking, sadly died in 2014. Her contribution to nursing cannot be described with any adequacy in this footnote. See her Obituary in The Guardian (2014). The study that is the subject of this article was funded by a research grant from the UK Department of Health (1988-1991).

Notes

[1]Throughout this article, the term community psychiatric nursing (CPN) is used, rather than the term community mental health nursing. The term community psychiatric nursing has continued in common currency, used by most mental health professionals and the general public alike.

[2]The Institute of Psychiatry has been renamed as The Institute of Psychiatry, Psychology and Neuroscience (Kings College, London).

Introduction and background

In the 1960s, I began a course of integrated training that would lead me to become dually qualified, as both a mental health and learning disabilities nurse. I started my apprenticeship in two large hospitals that were typical of those dotted around the UK at that time. These hospitals contained many patients who should not have been admitted to hospital at all and who could have been safely cared for within community settings.

By the 1960s, the process of deinstitutionalisation had begun, and the number of mental health inpatient beds had fallen from 140,000 in 1960, to under 20,000 today. Over the course of the next decade, I obtained further experience in general nursing, and then as a charge nurse in a psychiatric hospital.

In 1976, I was fortunate to be selected for an innovative 18-month full time training as a nurse therapist at the Maudsley Hospital and Institute of Psychiatry[2], London. The programme, directed by a psychiatrist, Professor Isaac Marks, focused on skills acquisition in evidence-based approaches, cognitive behaviour therapy (CBT) for phobic, obsessional states and other common mental health problems. Over 25 years, this programme delivered hundreds of graduates and is regarded as one of the best examples of skills acquisition in mental health care (Gournay et al 2000). At the Maudsley/Institute of Psychiatry I was exposed to a world-leading research environment that began to form my belief that mental health care should be evidence based and that it is essential to test hypotheses using a rigorous scientific methodology.

On graduating as a nurse therapist in 1978, I began my career in a district general hospital psychiatric department. By then, I had decided to pursue my own research. With generous help from the NHS, in the form of a small research grant and study leave, I was able to undertake a randomised controlled trial (RCT) of treatments for agoraphobia. This was to become the basis of my PhD in psychology and, eventually, the basis of a textbook on outcomes and treatment process (Gournay 1989).

In the course of my clinical work, I had observed the work of CPNs in my own outpatient service. This workforce was growing rapidly, as deinstitutionalisation continued. The development of community psychiatric nursing has been well described by Brooker and White (1995) who conducted national surveys of the work of CPNs over the late 1980s and early 1990s.

A survey of CPNs in England in 1989 showed that a quarter of all CPNs did not have a single client with a severe and enduring mental illness, such as schizophrenia, on their caseload (White 1993). CPNs were increasingly based in general practice (23%) with 37% of all referrals coming from general practitioners. It had become clear that CPNs were, in the majority, working with people with non-psychotic disorders, such as general anxiety, 'stress' and relationship difficulties.

Being intrigued by these developments and finding that, at that time, there was no evidence of CPN effectiveness, I approached the UK Department of Health, arguing quite simply, that this topic should be investigated, because of the relevance to national mental health policy. As I was a full-time NHS employee, I was advised to seek a collaborator from an academic background. I then asked Julia Brooking, who was first, a senior lecturer at the Institute of Psychiatry and then, Professor of Nursing at the University of Birmingham, to join me in this research. The Department of Health grant of nearly £200,000 funded the RCT that is the subject of this paper (Gournay and Brooking 1994).

The RCT also allowed an economic analysis (Gournay and Brooking 1995); this involved a consideration of costs to patients and their families, the health care system and quality of life gains. Our analysis showed that the quality of life gain, per unit of cost for the primary care population, was considerably less than the quality of life gain in populations where CPNs were working with people with schizophrenia. In addition to the RCT and economic analysis, we also conducted a study of CPN skills in assessment methods, by collecting many hours of videotape. This process study (Devilly and Gournay 1995) demonstrated the need to develop CPN skills.

Influence and impact

The 1994 paper had both personal and more general influence and impact. With regard to general impact, at the same time as our study was being conducted (1988-1991), a classmate of mine from the Nurse Therapy Programme, Professor Charlie Brooker, reported the results of a study using a quasi-experimental design to evaluate the effect of training CPNs to undertake psychosocial interventions, with families caring for a relative with schizophrenia

(Brooker et al 1994). The study showed that CPN training led to an improvement in both positive and negative symptoms in patients, benefits to relatives and tentative evidence that their interventions reduced inpatient episodes. The results of our studies were made known, prior to publication, to the governmental review of mental health nursing led by another Fellow of the Royal College of Nursing (FRCN), Professor Tony Butterworth (Butterworth 1994). The review had come to learn that 80% of people with schizophrenia were not receiving the services of a CPN and therefore made the following recommendation: 'That the essential focus for the work of mental health nurses lies in working with people with serious or enduring mental illness in secondary and tertiary care, regardless of setting.'

This recommendation was wholeheartedly implemented across the entire UK in the years that followed. An additional measure of the influence and impact of our study and that of Brooker et al (1994) was the fact that both papers were published in the same edition of a world leading psychiatric journal, the British Journal of Psychiatry, rather than a nursing journal. For the first time, the wider mental health community was made aware of the importance of CPNs in the task of delivering appropriate care to a population in great need; that is, those with serious and enduring illnesses such as schizophrenia.

At a personal level, the study stimulated me to pursue, in addition to my clinical work, as much postdoctoral education as possible. I thus acquired knowledge and skills in epidemiology, statistics and more generally, neuroscience. As our study completed in 1991 and by a happy coincidence, Professor Dame June Clark FRCN – then President of the Royal College of Nursing (RCN), was appointed to develop a school of nursing at Middlesex University. June asked me to head the mental health division. I will be forever grateful to her for opening the door to areas of nursing and healthcare that were, at the time, foreign to me. Over a short period of time, I obtained incredibly valuable experience, serving on several governmental bodies as well as being active in the RCN Mental Health Society.

I must here acknowledge the inspiration and support I derived from society colleagues, notably Malcolm Rae, FRCN, and Tom Sandford – at that time, the RCN's mental health adviser. I was also introduced to government at the highest level by the then Chief Nursing Officer, Dame Yvonne Moores, who became yet another source of encouragement. In the mid-1990s I began visiting innovative mental health services across the world, notably in Europe, the United States, Australia and New Zealand. I developed an interest in international development; over the years and until recently, working in several countries, including the Czech Republic, Russia and Palestine. My involvement in research also continued in my clinical setting, with an epidemiological study and an RCT of treatment for body image disorders: (Boocock et al 1996, Veale et al 1996).

In 1995, I was appointed the first Professor of Psychiatric Nursing at the Institute of Psychiatry. This provided the opportunity to continue my research interests in the development and testing of training programmes for nurses and other mental health professionals. I also set up several research collaborations across Europe, Australia and the United States (US). I was honoured to be elected Psychiatric Nurse of the Year in the US in 2004. During my appointment at the Institute of Psychiatry, my psychiatrist colleagues proved to be supportive of both nurses and nursing. I served for two years as chair of the institute's academic board: an experience that taught me a great deal about higher education. Over the 11 years at the Institute of Psychiatry, I became involved with training programmes for CPNs in evidence-based approaches, notably the Thorn Nurse training programme (Gamble 1995).

Today's multidisciplinary training programmes for community mental health professionals owe much to the original Thorn Nurse concept. I also took a particular interest in nurses' skills in medication management and, with my PhD student and then postdoctoral fellow, Richard Gray, developed training programmes that were evaluated in RCTs; these studies being funded by the Medical Research Council, the European Commission and the National Government of Thailand (for example, Gray et al 2004, Gray et al 2006, Maneesakorn et al 2007). The interest in medication management led to my involvement in early work on mental health nurse prescribing and the publication of a discussion paper on the topic (Gournay and Gray 2001).

My interest in the development and evaluation of training generalised to other areas, for example, nurses working with people with multiple sclerosis (Askey-Jones et al 2012), training in the management of violence for nurses in secure units (Rogers et al 2006)

and in practice nurses in primary care settings (Plummer et al 2000). In addition to research in primary care settings, I became involved in the development of national primary care policies, starting with a discussion paper with the Professor of Psychiatry at the Institute of Psychiatry, Sir David Goldberg (Goldberg and Gournay 1997). Notably, Sir David has been a source of enormous support and encouragement to me and many other nursing colleagues, including the aforementioned Charlie Brooker and Tony Butterworth.

Thus, it might be argued that our 1994 paper had enormous personal and professional impact and influence and provided me with a springboard to pursue interests in other areas of mental health care. For example, I chaired the guideline development group for the National Institute for Health and Care Excellence (NICE) on the management of disturbed/violent behaviour in mental health care, served as a special adviser to the UK Joint Parliamentary Committee on Human Rights in their work on deaths in custody and contributed to research and practice in high secure psychiatric services at Broadmoor and Ashworth hospitals. I also secured funding for a study on nurse stress in all four UK high secure hospitals (Reininhaus et al 2007). Realising that building a research nurse infrastructure was a priority for the future, I began developing training programmes for nurse researchers. In addition to supervising PhDs, I also obtained funding for postdoctoral fellowships and took part in multidisciplinary research training initiatives. The primary lesson learned at this time was that one should regard the PhD as the starting point for training to become a competent researcher, rather than an end point.

Current and future relevance

As noted above, our study began a complex 'domino effect'. The training programmes I have mentioned had a variety of outcomes. For example, we found that specific training in medication adherence worked well in a UK community mental health team setting (Gray et al 2004) but failed to show effectiveness in a five country European study (Gray et al 2006). Similarly, the study we conducted on training professionals in the management of dual diagnosis (the combination of drug and alcohol and mental health problems) (Craig et al 2008) showed that training made little difference to mental health, social functioning and cost outcomes. The importance of evaluating training programmes has been expressed in the general psychiatric literature (Gournay and Thornicroft 2000) and in the outcome of the workforce action team that was set up to support the 1999 National Service Framework for Mental Health (Brooker et al 2002). Thus, we now face this situation. As a country, we spend many millions of pounds on the education and training of mental health professionals, in interventions from CBT for anxiety disorders to psychosocial interventions for those with serious and enduring mental illnesses.

However, there is a conundrum. Research has told us that training in evidence-based methods may, or may not, improve clinical skills and patient outcomes. Furthermore, even if training is shown to be effective in a research trial, can one then assume that the generalisation of training to the wider workforce will lead to the same results? In one sense, our 1994 paper is still relevant because of the ongoing need to ensure that the workforce has the requisite skills and knowledge. Sadly, it appears that any comprehensive evaluation of education and training for the workforce is no longer a national or global priority.

Ensuring the mental health workforce is provided with evidence-based skills should be a priority around the world. Over the past 25 years, I have been involved in research in Australia and have worked with colleagues there to develop national treatment guidelines (Gournay 2017). The challenges of workforce development are the same in that country and, as I have observed first-hand, exactly the same in the Czech Republic, the West Bank and Siberia. My experiences have led me to the view that mental health nurses, wherever they are, remain greatly undervalued and that scant attention is often given to nurturing them or providing them with high quality continuing education and training.

Finally, another lesson from 1994. The paper remains relevant insofar as it demonstrated that one can mix research methods. Under the umbrella of an RCT it is possible to undertake qualitative studies that will tell us much more than the comparison of pre and post test results on standardised measures of change.

The study also has relevance insofar as the lesson learned about the need to consider the cost and economic value of what we do. While one might argue about costing methods and whether or not one can quantify quality of life, we exist in a world reality of an expanding and infinite demand for healthcare and only a finite workforce to meet that demand.

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