
Role of the community psychiatric nurse in the management of schizophrenia

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This paper will describe the increasingly important role of the community psychiatric nurse (CPN) in the treatment and management of people with schizophrenia, and draw attention to new training programmes which have a focus on skills acquisition in evidence-based methods. However, before describing the way in which these programmes of training improve CPN skills, it is worth examining the history of community psychiatric nursing.

History of community psychiatric nursing

Community psychiatric nursing developed from humble beginnings at Warlingham Park Hospital, Croydon in 1954, when ward-based nurses were sent out into the community to follow up patients who had received treatment for schizophrenia (Greene, 1968). Their main tasks then were administering medication and monitoring patients' progress. From that time, community psychiatric nursing evolved rapidly, and specific training courses for CPNs were set up in the 1970s. Since 1980, CPNs in England and Wales have been the subject of regular surveys, and the latest (Brooker & White, 1998) showed that by 1997 there were approximately 8000 CPNs in England. In the first 25 years of their existence, CPNs worked almost exclusively with people with schizophrenia and the elderly mentally ill, and their role was very much

linked with work with consultant psychiatrists working from large Victorian mental hospitals. However, from the beginning of the 1980s, CPN roles began to change. With the setting up of district general hospitals and changes in National Health Service (NHS) management structures, CPNs began to work more independently. By 1990, they were taking as many referrals from general practice as from consultant psychiatrists (White, 1990). As a corollary of this, they were increasingly working with people with adjustment disorders and other neurotic conditions in primary care. The 1990 survey showed that they were predominantly using counselling-type approaches with this population. By 1990 the situation was such that many CPNs did not have any patients with schizophrenia on their case-load. One estimate, by the team which carried out a comprehensive review of psychiatric nursing (Department of Health, 1994), was that three-quarters of people with schizophrenia in the community had no services from a CPN. Before that time, there had been relatively little research into the efficacy of CPNs. The first major study, carried out in the late 1970s at St George's Hospital, South London, by Paykel *et al* (1982), used a randomised controlled trial (RCT) to test efficacy. This showed that CPNs who followed up patients who had suffered an acute episode that required admission, generally did as well as psychiatric registrars in the provision of after-care. In terms of outcome, patients benefited from both modes of follow-up on clinical, social and economic measures. There are only two RCTs of nurses working with primary

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care populations. In the first, Marks (1985) showed that nurses trained in behaviour therapy had excellent outcomes (over routine general practice care) with people with phobic and obsessive disorders. However, in a second study with people with general anxiety, depression and adjustment disorders, Gournay & Brooking (1994, 1995) showed that CPN interventions (which amounted to client-centred counselling) had little impact on their patients on clinical outcome measures, and the economic analysis showed that their interventions were very costly. This research, coupled with the fact that there was only a relatively small CPN workforce, demonstrated clearly that CPNs would be much better deployed working with patients with schizophrenia. The neglect of people with schizophrenia was recognised by the Review of Mental Health Nursing (Department of Health, 1994), which made a central recommendation that CPNs needed to focus their efforts on people with serious and enduring mental illness. At the beginning of the 1990s, however, a major problem for CPNs was that their training programmes lacked any emphasis on skills acquisition, and were mainly theoretical in content. One difficulty with these courses was that many had an explicit anti-psychiatry content, and often left CPNs critical of what in these courses was perceived as a malevolent medical model. Unfortunately, many of these courses persist to the present day, and psychiatrists should not underestimate the small but significant minority of CPNs who still cherish such views.

For some time now, pre-registration training for nurses has taken place in universities, rather than hospital-based training schools. This training, which is clearly at a higher academic level, has a much reduced apprenticeship component. Thus, newly qualified nurses are, in many senses, in need of more skills training than was the case with the old-style training. Unfortunately, training for CPNs is not mandatory and only about half have attended a substantial training programme to prepare them for work in the community (Brooker & White, 1998). As noted above, many CPNs attend courses which lack relevant skills training, and thus the quality of CPN input across the country is variable.

The lack of skills of CPNs in their interventions with the seriously mentally ill was recognised by a group of mental health professionals led by Dr Jim Birley, one time Dean of the Institute of Psychiatry and past President of the Royal College of Psychiatrists. Dr Birley and his colleagues (too numerous to mention, but including Professors Marks, Craig and Leff, from London, and Tarrier and Butterworth from Manchester), secured the support of the Sir Jules Thorn Charitable Trust in generously funding the eponymous programme. The Thorn Initiative was

originally based in London, at the Institute of Psychiatry, and at the University of Manchester. This training programme has the explicit aim of training nurses in evidence-based skills in schizophrenia. The early development of the programme was influenced by researchers who had shown that family interventions were an effective treatment (Leff & Vaughn, 1985; Tarrier *et al*, 1988). Dr Birley, in particular, had been greatly impressed by the work of Macmillan nurses with people with cancer and their families, and thought that Thorn nurses could be an analogous workforce in the area of serious mental illness. At the beginning of the 1990s, work in Manchester (Brooker *et al*, 1994) also showed that it was possible to train nurses in skills in family interventions, and this added impetus to the programme. At the same time, there was an overarching change in the way that mental health care was organised, and the early 1990s saw the emergence of case management as a method of service delivery, and the use of intensive methods of community treatment. The first trial of intensive community treatment in the UK was carried out at the Maudsley Hospital in the late 1980s (Muijen *et al*, 1994). This research highlighted the need for training case managers (mostly nurses) in assertive community treatment (ACT) methods. At the same time, other research (Muijen *et al*, 1992) showed that merely configuring groups of CPNs into case management teams without providing them with training had no impact on patient outcomes. Muijen *et al*'s (1994) findings have recently been confirmed by Thornicroft *et al* (1998), who showed very little difference on a range of measures between intensive case management and the more standard approach. As in the Muijen *et al* (1994) study, case managers in Thornicroft's two cohorts had not received any specific training.

The Thorn Programme ran over a three-year period between 1992 and 1995 in an experimental mode. Nurses were recruited to the course, which ran over one academic year, with students coming one day a week into the classroom. The skills taught in that classroom day were then practised during the remainder of the working week with their case-load in their work setting. A prerequisite for being accepted as trainees was that nurses had to be working with people with schizophrenia. To reinforce skills acquisition, the course also involved students making audio-tape recordings of their interactions with patients, and carrying out assessment using the methods that had been taught on the programme. Thus, students were taught the use of valid and reliable measures of symptoms and social functioning. Students were recruited in pairs from their respective areas, in order to strengthen the support provided to

students (training pairs could encourage each other while working in their home settings). This strategy has proved useful, and the need to attend to matters of continuing support outwith the training environment has been confirmed by work carried out in New South Wales by Kavannah *et al* (1993). This research showed, in a cohort of workers who had received training in family interventions, that graduates quickly stopped using the skills acquired during training, or used them in a modified fashion.

The first three years of the Thorn Programme were evaluated by research assistants who carried out independent assessments of four patients identified by each student at the beginning of the course. These patients were subject to assessments both before and after the students attended the course. Students also completed the same assessment and outcome measures on patients as the research assistants did. Data analyses showed that students were using these measures with considerable skill, and interrater reliability between students and evaluators was high. The full evaluation of the first three years of the programme is now complete and, at the time of writing, various papers are in press. However, an early report (Lancashire *et al*, 1997) that patient outcomes were positive and that trainees acquired skills, has been confirmed in the latest and more comprehensive analyses. Obviously, further evaluation of the programme is necessary, as this preliminary study did not use a control group or a randomised design.

Current picture of training

Since 1995, the Thorn Programme has undergone various modifications. These changes have come as a result of both experience of teaching the course and the emergence of new research findings. Across the UK, the programme has quickly become the 'gold standard' for the training of CPNs, and there are now at least eight programmes, with four others being developed. Wales and Scotland do not currently have programmes but, in both of these countries, there are fairly well-developed plans to begin such training soon. One major change, which stems from demand from other disciplines, is that the Thorn Programme is now no longer exclusively a nursing course. There are now trainees from clinical psychology, social work and occupational therapy, as well as workers without professional backgrounds who work in case management roles in the voluntary sector. In Manchester, the course is no longer called Thorn – it

has become assimilated into a wider training initiative called COPE (Collaboration on Psycho-social Education). There are now also masters-level programmes, which emphasise the core skills taught on Thorn but which also require students to complete a piece of empirical work for a dissertation. MSc programmes are now to be found at Manchester, Sheffield, Middlesex and Birmingham universities, with plans for similar programmes in other institutions.

Core modules

While the overall emphasis of the programme is on evidence-based skills, it has to be said that, as Lewis *et al* (1997) have pointed out, the evidence base in mental health care is poor, and there is a need for further research to identify effective interventions. Nevertheless, there is a wide range of evidence-based psychological and social interventions that can be used with people with schizophrenia and their families.

Thorn is a modular programme, and there is now general agreement that one needs to provide skills in three central areas (see Box 1).

Assertive community treatment

There are, of course, a number of terms which describe various methods of community care, and terms such as assertive community treatment (ACT), case management, home treatment and so on are often used by clinicians to describe the approach. There also remains, even among sophisticated researchers, considerable confusion regarding what these terms actually mean. For the purpose of the Thorn Programme, ACT is defined as in the Cochrane review by Marshall & Lockwood (1998). The review highlights the fact that within ACT there is team working and team responsibility. In turn, ACT teams comprise workers with a range of clinical skills, and usually there will be an emphasis on making an assessment of the patient, using valid

Box 1. Core modules in the Thorn Programme

Assertive community treatment
Psychological interventions
Family interventions

and reliable measures of symptoms, social functioning and need. Assertive community treatment teams focus on the most vulnerable patients and within model services ACT targets this population with intensive input, with keyworkers having case-load sizes of no more than 12–15 individuals.

It is worth pointing out the main differences between ACT and intensive case management. The former is carried out by autonomous groups who work entirely in the community, whereas intensive case management teams have similar case-loads, but work more closely with other parts of the psychiatric service and provide treatment in a range of settings, not just the community. This difference is important, as two studies (the UK 700 Study (Burns *et al*, 1999) and the PRiSM Study (Thorncroft *et al*, 1998)) have shown no difference between intensive and standard case management.

In this module, students acquire the principles of intensive, clinically focused treatment in the community. Emphasis is also placed on helping them acquire skills in an expanded role – in particular working with other agencies and other professions, and working within a multi-disciplinary team. Students are also trained in the use of various valid and reliable measures – for example, of symptoms (e.g. the Kavannagh–Goldberg–Vaughan (KGV) scale; Krawiecka *et al*, 1977) and need (e.g. the Camberwell Assessment of Need; Phelan *et al*, 1995). Skills training involves the use of role-play exercises, using video-tapes of patient interviews to acquire skills in identification of symptoms and signs, and practising the use of valid and reliable assessment methods with their own case-load.

Medication management

Medication management is another important topic. As noted above, nurses are often not adequately trained in these skills, often perhaps because of academically oriented pre-registration programmes which do not provide skills training. The Thorn Programme has attempted to encompass recent research (Kemp *et al*, 1996, 1998) which shows that a number of strategies based on a cognitive-behavioural model increase patient adherence to medication regimes. Thus, the medication management component of this module comprises the following central elements:

- (a) education regarding the nature and action of common drugs (it is important to provide this component, as many nurses coming to CPN roles have only rudimentary knowledge in this area);
- (b) the use of methods for educating patients and families regarding their drug treatments;

- (c) acquiring skills in the use of various measures of medication side-effects (e.g. LUNERS (Liverpool University Side Effects Rating Scale); Day *et al*, 1995); and
- (d) the use of cognitive-behavioural methods, such as motivational interviewing (Rollnick & Miller, 1995) to deal with non-adherence to medication.

In the ACT module, students are provided with skills in engagement of the most difficult-to-manage patients. They are also helped to understand the need to be assertive in their methods to maintain people in treatment, and to engage again with vulnerable people who have dropped out of treatment.

Psychological interventions

We have known for many years that there are effective psychological interventions for schizophrenia. Smith *et al* (1996) reviewed the literature on social skills training dating back to the early 1980s, and showed that this method has clear effectiveness and obvious implications for helping people with schizophrenia deal with the problems of community living. There are, of course, now a number of cognitive-behavioural approaches to dealing with psychotic symptoms, such as hallucinations and delusions, and a recent Cochrane review (Jones *et al*, 1998) testifies to the efficacy of these methods.

The Thorn Programme does not set out to train students to attain a sophisticated level of skill using psychological interventions. However, by the end of training, all students should have acquired a basic knowledge of principles (see Box 2), and be able to deliver some treatment, with the proviso that they are in receipt of supervision from a skilled practitioner.

Box 2. Elements of training in psychological interventions

Use of functional analysis in assessment
 Use of simple behavioural strategies, such as activity scheduling and reinforcement
 Use of social skills training methods
 Use of cognitive methods for dealing with hallucinations and delusions
 Principles of evaluation, using simple, reliable measures of change

Box 3. Core skills in family intervention

Family assessment methods
Providing education to the family
Working collaboratively with families and patients
Identifying strengths and deficits of families
Providing interventions to reduce family stress
Providing families with basic intervention skills

Family interventions

As noted above, the Thorn Initiative was greatly influenced by researchers who had previously carried out work on expressed emotion (Leff & Vaughn, 1985) and behavioural family work (Tarrier *et al.*, 1988). There is also systematic review evidence of the effectiveness of this approach (Mari *et al.*, 1996). Students acquire a number of core skills in family interventions (see Box 3), which provide them with basic competence.

Students are required to carry out a certain amount of work with families during the course of their training. Teaching is augmented by input from organisations such as the National Schizophrenia Fellowship, who provide the student with very valuable, first-hand knowledge of problems in caring for someone with schizophrenia. As with the psychological interventions module, the course does not set out to train students in higher-order skills, rather to provide them with a working knowledge of basic family interventions.

It has to be said that family/carer involvement in treatment is often overlooked by many services, and Thorn training sets out to ensure that family involvement becomes the norm. Students quickly realise that the negative expressed emotion often seen in families, which correlates with higher levels of relapse, may be reduced simply by helping families to reduce face-to-face contact with the affected person. In turn, students are trained to engage with families within the context of a collaborative relationship. To this end, students learn to blend educative methods with appropriate listening and interview skills.

Workforce issues

The current position regarding the skills of the professional workforce is that there are (at the time

of writing in mid-1999) approximately 750 nurses and other professionals who have received training from the Thorn and similar programmes. However, with the rapid expansion in courses, these numbers are likely to grow at a rate of several hundred per year, and the National Service Framework for Mental Health (Department of Health, 1999*a*) emphasises the need to expand training provision even further. Thus, although it will be several years before a majority of the workforce has received adequate training, psychiatrists will be increasingly working with CPNs who have learned the requisite evidence-based skills. Unfortunately, there are still some theoretical courses available to CPNs that emphasise mainly sociological and psychological theory. Hopefully, these courses will gradually be replaced by more evidence-focused programmes, but, as noted above, psychiatrists should be aware that Thorn and similar programmes are not the only educational programmes in use with CPNs.

Future developments

The growing acceptance that training in evidence-based methods should be a priority has caused a radical re-think of education for mental health nurses, and a number of new modules have been developed which complement the Thorn modules described above. For example, the Institute of Psychiatry now runs a training programme in interventions with populations who have comorbid substance misuse with their mental illness (dual diagnosis). Given that this condition is very prevalent in community services, it is likely that training programmes in this area will also develop rapidly across the country.

Another area that has been subject to further development is that of medication management. It has become clear from research (e.g. Kemp *et al.*, 1998) that providing cognitive-behavioural interventions that have a specific focus on non-compliance can yield very beneficial results for the patient, and also produce substantial economic benefits. However, it has also become clear that adequate training in medication management for nurses and other health professionals may be much more time-consuming than the original planners of programmes such as Thorn imagined. For example, a pilot programme now running at the Institute of Psychiatry requires students to attend 80 hours of instruction, apart from carrying out homework assignments and practice with patients. The importance of this topic is now being increasingly recognised, and medication management training

per se is run as a stand-alone course in both London and Manchester. Recently, the more general area of the nurse's role in treatment with medication has been highlighted, with Government initiatives aimed at giving nurses prescribing rights. Such a development would represent a truly radical change in the nurse's role. Nurse prescribing is now a reality in the USA, where 7000 nurses have prescribing authority in 38 states. It is envisaged that in the UK nurses would be given powers to prescribe under the supervision of a psychiatrist and using strict protocols. Obviously, such an initiative will require very careful piloting and, judging by the US experience, nurses will need to undergo substantial education and training in a range of areas.

Another development from Thorn is the use of this model of training applied to forensic populations. There are now developments underway to train CPNs and other mental health workers in Thorn-type skills, but modified accordingly for a forensic context.

Also, it is now recognised that nurses working in in-patient settings have been starved of skills and require new training initiatives (Department of Health, 1999b). Obviously, the core principles of skills training in evidence-based methods could be transferred to nurses working in in-patient settings, and there is evidence (Drury *et al*, 1996) that psychological interventions applied during in-patient care may provide lasting benefits. Indeed, it is arguable that family interventions are probably best provided at the beginning of a patient's illness; thus, the patient's first admission to hospital may be the optimum time to work with families.

A review by the Sainsbury Centre for Mental Health (1997), which has proved to be very influential, has emphasised the need for an identification of core competencies in working with people with serious mental health problems. In turn, the review recommended that training for mental health professionals be organised more on multi-disciplinary lines and that, regardless of professional background, those involved in working with people with

serious mental illnesses should receive their education together. The CPN clearly has a pivotal role in modern community mental health teams (CMHTs), which usually also include psychiatrists, psychologists, occupational therapists, social workers and, increasingly, generic mental health workers without any professional background. Clearly, the roles of CMHT members do overlap, but CPNs are generally responsible for medication management and for monitoring the physical well-being of patients, a task often neglected in psychiatry. In addition, as the most numerous group, CPNs need to work collaboratively with other colleagues and ensure that all patients on their individual case-loads are given access to the specific expertise possessed by the other team members. There are already several multi-disciplinary training initiatives – for example, the MSc programme at Birmingham University has people from all backgrounds, including psychiatry and general practice. At present, the benefits of such training seem clearly to outweigh any difficulties. Thus, in the future, it may be that multi-disciplinary training will become the norm rather than the exception. These initiatives may change the nature of community psychiatric nursing substantially. The future may well see other professions, such as occupational therapy and social work, undertaking many of the tasks currently carried out by the CPN. Whether this will improve matters for the patient must remain an unanswered question.

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Box 4. Future developments for CPNs

Nurse prescribing
New training programmes for use with forensic populations
More multi-disciplinary courses
Training to deal with dual diagnosis patients

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Multiple choice questions

- By 1997, community psychiatric nurses in the UK numbered approximately:
 - 30000
 - 8000
 - 15 000
 - 20 000.
- The Thorn Programme was originally inspired by research in:
 - social skills training
 - family interventions
 - medication management
 - cognitive-behavioural therapy.
- Community psychiatric nurses now receive more:
 - education on the aetiology of mental illness
 - skills in psychodynamic approaches
 - counselling skills
 - skills in evidence-based methods, such as family interventions and ACT.
- Comparisons of intensive case management *v.* standard care yield similar outcomes because:
 - there are not enough resources in the NHS
 - the effects of medication balance out results
 - case managers in both conditions have not received appropriate training
 - the numbers of patients in the studies have been too small.
- Future training initiatives for CPNs will include:
 - new methods of family intervention
 - computer-aided treatment
 - interventions in dual diagnosis
 - training in interpersonal therapy.

MCQ answers

1	2	3	4	5
a T	a F	a F	a F	a F
b F	b T	b F	b F	b F
c F	c F	c F	c T	c T
d F	d F	d T	d F	d F