

Psychiatric Nursing – Quo Vadis?

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In the last year or so the future of mental health services in this country has been intensively discussed. COHSE, MIND, and the Richmond Fellowship have produced their 'blueprints', outlining details of the way they see services being organized. All variety of professional organizations have been busy presenting evidence to the House of Commons Social Services Committee which is specifically examining community care. The DHSS has committed more joint finance to 'care in the community' projects and Regional Health Authorities are examining the strategies to close large psychiatric hospitals. Consequently, District Health Authorities, in many cases, are planning the shape of a new mental health service which places increasingly less reliance on the large institution. The phrase 'community care' has now become so hackneyed in planning circles that for many it has lost whatever meaning it may have once had. However, despite all the rhetoric, and indeed all the planning activity, psychiatric nurses themselves have still to voice coherently their thoughts and fears about the shape of things to come.

The DHSS¹ estimates that in England there are some 34,000 trained psychiatric nurses, and further, that a mere 6 per cent of these work as community psychiatric nurses. A very simple sum therefore shows that if all hospitals in this country were to close, around 30,000 trained nurses would need to be redeployed in alternative community settings. Thus the bulk of the psychiatric nursing work-force is working in large hospitals looking after, variously, chronically institutionalized schizophrenics, elderly people with senile dementia and the new long-stay. Mann and Cree² have estimated that this latter group are composed of around half with schizophrenia, the remainder constituting those with dementia and affective disorders. However, irrespective of their diagnostic labels, these people share the problem of being likely to become more institutionalized and indeed they have been described as tomorrow's long-stay. To consider alternative roles for nurses in the community, in the light of plans to contract large hospitals, means a flexible consideration of the likely community needs of almost the entire in-patient hospital population.

As is well known, the psychiatric hospitals of today would be largely unrecognizable to our own grandparents. Treatment advances, changes in mental health law, public attitudes and government strategy have all helped to effect the alteration. Nursing itself has developed and the almost desperate pleas for professional recognition today are in marked contrast to psychiatric nurses' former image as keepers or custodians.

In our own region, plans to close two psychiatric hospitals have meant that our District Health Authority, a 'user' of the large hospital facility, has been undertaking the planning of the provision required to relocate patients

back within its catchment area boundaries. One plan envisages transferring a group of men, with long institutional histories, back to a house where the staff input would be mostly provided for by nurses. This project has required much liaison with all the professionals currently providing the service within the hospital setting. There was, and still is, much apprehension about the scheme. It has proved vital to include an input from nurses currently working on the ward to the planning discussions themselves. As an authority we hope eventually to transfer nursing staff from the ward to the house, as well as patients. Therefore, for some nursing staff we may not just be talking about a change in nursing practice and the setting in which it is carried out. The wider implications of just this one small scheme may include nurses' families, homes and maybe even income. Some nurses' mortgages rely heavily on overtime and special duty payments for antisocial hours. Already the health authority is being asked whether the same conditions of service would be maintained if these nurses were to change employer. Basic nursing pay is low and it is a totally realistic fear that added earning incentives may be lost. If psychiatric nurses move from hospitals to alternative community settings a change in role will be required, otherwise there will be a real danger of not improving services but merely relocating those that exist already. The need is obviously for some kind of in-service training or re-education prior to the redeployment of hospital-based personnel. How this should be organized or financed remains unclear. At present the Regional Health Authority has stated in our particular case that this exercise should be the individual 'user' districts responsibility. Although as a user district we would find it difficult to harness both the experience and resources required for what is a highly important task.

To conclude then, although there is agreement in principle to disperse services and move nursing staff with patients to the community, there are many issues that still need consideration. Training programmes will be required and this means resources and skilled teachers. Detailed personnel policies must be worked out in consultation with each individual nurse employed in the hospital, and this has to be seen as a priority.

Are nurses in institutions bored and apathetic, or have they over the years been seriously undermined, devalued and demoralized? The belief expressed here is that hospital nurses as a professional group have an enormous potential to offer: they have cared for the patients we are trying to resettle and relocate for many years. When the day comes for the anticipated major upheavals in patients' lives, hospital nurses who move with them to alternative provision, will represent at the very least, the reassuring presence and continuity that they will require.

For the last thirty years one small group of psychiatric nurses—community psychiatric nurses (CPNs)—have been developing a nursing role in the community. Many early CPN teams worked closely with psychiatrists, using the psychiatric hospital as a springboard. Some teams still employ this model of organization, but others have started to build up relationships with primary care teams in general practice and health clinics, whilst still maintaining their important links with psychiatrists. In Exeter, there will be forty-two CPNs working in multidisciplinary community mental health teams by 1985. In this particular health authority the increase in CPN personnel correlates strongly with decreasing reliance on Exevale Hospital, a large institution.

CPN 'care' encompasses a number of different functions including the provision of treatment, practical help, education and support. These interventions can be focused upon specific individuals or families as a whole. CPNs, like psychiatrists, have exhibited a growing tendency to specialize in the last few years, both in terms of the therapies they offer and the client groups they are referred. It is not now uncommon to find CPNs with specific therapeutic skills in areas such as behaviour therapy, psychotherapy, family therapy and counselling. There are obviously differences between working in a hospital as a trained nurse and working in the community for which the hospital nurse requires retraining.

There has been a large increase in the numbers of CPNs in this country which peaked in the late 1970s—community care strategies, as we have seen in Exeter, will undoubtedly accelerate growth again. It would be reassuring to feel that this expansion in CPN manpower was based on sound, firm, scientific research, but this is not the case, bar one recent notable exception. Paykel,³ in a comparative study, demonstrated that clients referred to CPNs working in multidisciplinary teams improved as well as those referred to out-patient care. CPNs were, in fact, rated by the clients as superior to the doctors on a number of dimensions, including client time, warmth and a global measure of satisfaction with service. The study also demonstrated how much more cost-effective CPNs were, which it must be said, came as no surprise to CPNs!

It is, of course, impossible to make wholesale inferences to the country as a whole from this one study and the CPN literature seriously lacks more evaluative studies of this kind. There are two reasons for this: on the one hand, methodological problems dog the researcher in this field,⁴ and on the other, nurses in general, but psychiatric nurses in particular, find it very difficult to obtain research funds. There are a number of fundamental questions that need answering, particularly as hospital closure policies seem to be automatically equated with huge increases in CPN personnel. What type of training for CPNs would be most effective? Based in what setting? What composition of caseload would be of most value? Finally—relating to consultant psychiatrists and GPs—in which ideal organizational framework?

If hospitals close, the nature and function of CPNs will

alter radically. CPNs will have to start taking on their caseloads, in greater quantities, ex-residents from large institutions with chronic, maybe intractable problems. Perhaps they will support hospital nurses who move with ex-residents to residential settings. Systems will be required that respond to crisis with a rapid response as the inevitable breakdowns occur without the back-up of hospital beds. Maybe British CPNs will develop in the same way as their Italian counterparts by making the nature of their work more labour-intensive, with smaller caseloads but more individual client time.

A final caveat on CPN specialization which undoubtedly should benefit client groups such as the elderly. Immense care must be taken that services do not become over-organized in terms of the specialties they offer. As specialisms develop, the referral criteria become more sophisticated and restrictive, and thus the net widens through which unattractive client groups can drop. At present, the ultimate CPN service model should be one with a strong generic base with the opportunities for skill development based very much on each individual district's needs, with some specialist appointments being seen as preferable.

As has been shown, education will play a major part in helping nurses to re-orientate themselves to a role in the community. A new syllabus for basic mental nurse training was approved in 1982 and is to be implemented nationally by 1987. In the new syllabus the accent is changed from mere knowledge acquisition to the development of nursing skills such as self-awareness, observation, goal-seeking and communication. There is also much more emphasis on gaining nursing experience in community settings. In 1980 the Royal College of Psychiatrists' working party on rehabilitation⁵ recommended that for nurses: 'there should be at least an eight week experience in a designated rehabilitation unit during training and some nurses should receive advanced training' (p 24).

In response, the new 1982 syllabus states that there should be two placements of ten or twelve weeks' duration in 'continuing care and rehabilitation services' with an emphasis on the maximization of independence for those who will require long-term care. However, the laudable aims of the syllabus do highlight problems. First, where are the nurse educationalists to be found who will actually implement the new syllabus? Secondly, there is much demand at present to provide experience in community settings. For example, many professional groups in our own Authority compete for the experience a CPN can offer, including medical students. Finally, the syllabus does not need to be implemented until 1987, which means in effect that new products of the changed education will not be necessarily in important posts until 1992. In this sense mental health nurse education and plans to close hospitals are quite out of step.

Post-basic education offered by the English National Board (ENB) that concentrates on the community rehabilitation are few and far between. There are only two courses that wear the 'hospital closures' cap at all comfortably.

ENB clinical course No 655, 'Behavioural Therapy in Residential Settings', aims to enable a nurse to develop skills in behaviour therapy in order to develop the potential of long-term patients in residential settings. This course has now run for five years and in this time has produced 17 course 'graduates'. Unfortunately little has been published to show what impact nurse training of this kind has on its target population or indeed what kind of work course 'graduates' engage in after completion.

The only other relevant course is ENB clinical course No 945, 'Short Course on the Rehabilitation of the Mentally Ill', which is offered at one centre in the country (as is ENB cc No 655). Again, little is known about course 'graduates' or indeed the impact of training. As yet it would seem that post-basic nursing education offers little in direct relevance to the broad issue of hospital closures. There does seem to be a real need here, which we in the nursing profession are reluctant to tackle, possibly due to the sheer enormity of the problem. However, is nursing standing alone in this respect?

Professor Altschul⁶ attempted to initiate a debate—should psychiatric nurses subscribe to a medical/disease model of mental health or a view that is more community/socially orientated? This discussion has prompted some nurses to examine their roles closely, not just at present, but more importantly in the future. The contraction of large psychiatric hospitals should focus these ideas sharply. Psychiatric nurses can make a major contribution to plans to disperse services from large institutions, both these groups working in the community now and those providing care in hospitals. CPNs are well placed with their experience to enable moves to the community. Nurses in hospitals, by moving and preparing their patients, should provide some continuity and security. When the new training syllabus is implemented by 1987, nurses should be more community orientated. The financial implications of retraining staff who work in large hospitals remains a large concern although it is understood that the DHSS has just provided the ENB with

£200,000 for this very task in 1985. Although this departmental initiative is welcomed, whether it will be maintained, remains to be seen.

As changes occur in psychiatric care settings in the next twenty years or so, psychiatric nurses to survive must become more flexible in the way in which they perceive and respond to patients' needs as these will undoubtedly change. We believe that nurses must embrace the concept of 'care in the least restrictive environment' and promote patient independence to its logical limit—whilst providing a range of fall-back positions (and facilities) for those who will inevitably require long-term support. Whilst community care is an ideal toward which we all strive on one level, this enthusiasm must be tempered with realism. Community care alternatives in this country are rare, especially those which are well researched and monitored. But if we as nurses merely stick our heads in the sand and wait for 'care in the community' as a concept to blow over we could be waiting a very long time and we could even become an extinct species.

REFERENCES

- ¹DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1980) *Health and Personal Social Services Statistics for England, 1980*. London: DHSS.
- ²MANN, S. A. & CREE, W. (1976) 'New' long stay psychiatric patients: a national survey of 15 mental hospitals in England and Wales 1972–3. *Psychological Medicine*, **6**, 603–16.
- ³PAYKEL, E., MANGEN, S., GRIFFITH, J. & BURNS, T. (1982) Community psychiatric nursing for neurotic patients: a controlled trial. *British Journal of Psychiatry*, **140**, 573–81.
- ⁴BROOKER, C. (1984) Some problems associated with the measurement of community psychiatric nursing intervention. *Journal of Advanced Nursing*, **9**, 165–74.
- ⁵ROYAL COLLEGE OF PSYCHIATRISTS (1980) *Psychiatric Rehabilitation in the 1980s. Report of the Working Party on Rehabilitation of the Social and Community Psychiatry Section*.
- ⁶ALTSCHUL, A. (1984) Does good practice need good principles? *Nursing Times*, **80**, 27, 36–38.

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Applications should be sent by *30 June 1985* to the Dean of the College who will be happy to answer any queries.

J. L. T. BIRLEY
Dean