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EDUCATION FOR COMMUNITY MENTAL HEALTH NURSES: A
SUMMARY OF THE KEY DEBATES

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Education for community mental health nurses: a summary of the key debates

Abstract

A wide range of post-qualifying education courses exist for community mental health nurses (CMHNs) working in the United Kingdom (UK). ‘Specialist practitioner’ courses emphasise shared learning between CMHNs and members of other community nursing branches. These programmes typically include course content drawing on the social and behavioural sciences, as well as on material more tailored to the clinical needs of practitioners. Such courses and their predecessors have been subject to criticism, however. Courses have been described as anachronistic, and failing to take account of recent advances in treatment modalities. In addition concerns about the generic focus of some programmes have also been raised. Educational alternatives, such as programmes preparing nurses and other mental health workers to provide ‘psychosocial interventions’ have, correspondingly, become increasingly popular.

In this paper we explore some of the debates surrounding the education of CMHNs, and explore the context in which CMHNs work and in which education programmes are devised. We consider: the multidisciplinary environment in which CMHNs practise; the differing client groups with which CMHNs work; the developing policy framework in which mental health care is provided; demands for more user-responsive education; and the relationship between higher education institutions and health care providers. We conclude the paper with a series of questions for CMHN educators and education commissioners.
Education for community mental health nurses

Introduction

Community mental health nursing in the UK is generally believed to have started with developments at Warlingham Park Hospital in Surrey. Here, in the mid-1950s, a small number of nurses were seconded to undertake ‘extramural’ duties. This involved following up patients discharged from hospital, and reporting back to a consultant psychiatrist (White 1999).

The growth of the community mental health nursing (CMHN) workforce in the decades which followed these earliest initiatives has been widely reported in the literature (see for example: Burke 1996; White 1993, 1999). Based on data gathered in the most recent quinquennial survey of CMHNs in England and Wales, it has been estimated that the total number of CMHNs working in these two countries of the UK in 1996 had reached some 7000 (White and Brooker 2001).

As the number of mental health nurses working in the community has grown, so too has the number and range of education courses specifically targeted at this group of practitioners. Specific post-registration courses have been available since the early 1970s (White 1990). Interestingly - and here community mental health nursing is very different from, for example, health visiting - it has never been mandatory in the UK for registered mental health nurses to complete a specific, community-oriented post-qualifying course before practising in community settings.

At the present time, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) recognises community mental health nursing as one of eight
‘specialist practice’ areas of community nursing (UKCC 2001). National Board approved courses preparing ‘specialist practitioners’ in community mental health nursing, following UKCC guidelines, are offered at at least bachelor’s degree level, and combine elements of both theory and practice. Typically, these courses are relatively broad-based and areas covered will often include material arising from the social and behavioural sciences, as well as material more precisely tailored towards clinical nursing practice. The original vision that underpinned the design of these courses was to develop a ‘unified discipline’ of community nurses, prepared to take a leadership role in the development of primary and community care (Porter 1996).

Shared learning is mandatory, so that CMHN students on these courses study next to, for example, health visitor, district nursing and community learning disability students. All nurses are required to work together on areas deemed to be equally applicable to all (e.g. health needs assessment), in addition to their own professional focus.

To what extent has the vision laid out within this framework been superseded by policy and practice development changes within the mental health field? A report on the roles and training of mental health workers (Duggan 1997) identified seven core groups who together provided mental health care: social workers, occupational therapists, doctors, psychologists, general practitioners, support workers and mental health nurses. It could be argued that the need for CMHNs to have shared practice learning with these professionals is at least as important as the need to share learning with other community nurses, who may, in fact, have little involvement (on a day-to-day basis) with the work of the CMHN. The specialist practitioner vision of a ‘unified discipline’ of community nurses may exclude other mental health workers, and create
Alternatives to ‘specialist practice’ courses and to ‘traditional’ courses for CMHNs have long existed. Reflecting the reorientation of CMHN practice towards a more exclusive focus on caring for people with severe mental illnesses, an increasing number of institutions are now offering courses in ‘psychosocial interventions’ (PSI) (Brooker and Evans, 1999). These are run at different academic levels, from undergraduate diploma through to masters’ degree. Courses of this type are often multi-disciplinary, and will include, for example, students from a diverse range of backgrounds such as nursing, occupational therapy, medicine, social work, psychology and those who are professionally non-affiliated. Although PSI courses vary in their precise form and content, all tend to offer a much more skills-oriented educational experience than do specialist practitioner programmes. Programmes are usually based on the ‘stress-vulnerability’ model of psychosis (Zubin and Spring 1977), and students are introduced to a range of evidence-based approaches that include family/carer interventions, assertive community treatment and innovative psychological and social interventions (Gournay 2000). In the light of issues surrounding the implementation of PSI (Brooker 2000), the newer PSI programmes also contain a focus on service issues that relate to the implementation of approaches in practice, and include teaching on the impact of policy and organisational directives and how to bring about sustainable change in organisations.

Many CMHNs have completed any of a wide range of other post-registration courses, either as well as or instead of the options outlined above. Many, for example, have
undertaken training in areas such as counselling and family therapy. Often, however, such courses will have been little more than brief introductions (White 1993).

In recent years, something of a debate has arisen over what the ‘appropriate’ education for CMHNs might be. Gournay (1994), for example, has characterised ‘traditional’ courses as being “anachronistic”. Elsewhere, one of the present authors has contributed to a dialogue in which the merits of the different courses available to CMHNs were discussed (Hannigan and Munton 2000). All four of us have a particular interest in this area, sharing as we do backgrounds in mental health nursing practice and education. In addition, three of us currently have specific responsibilities in our respective universities for co-ordinating and delivering post-qualifying education programmes for CMHNs. In this paper it is our intention to ‘map the territory’, rather than to generate answers or solutions to current debates. To this end, we explore a number of areas associated with CMHN practice and education, and pose a series of questions for each.

**What do community mental health nurses do?**

Arguably any “appropriate” education course for CMHNs needs to begin with an idea of what it is that CMHNs actually do. Most CMHNs in the UK work as members of multidisciplinary community mental health teams (CMHTs). Typically, CMHTs will also include representatives of a variety of other health and social care professions, including: psychiatrists, social workers, occupational therapists and psychologists. CMHTs have the task of providing locally-accessible care, to people referred from psychiatric hospitals, from primary care, and from a range of other agencies. Often, CMHTs are the main specialist mental health resources in the areas they serve. This
means that CMHT practitioners are frequently called on to carry out mental health assessments on a wide range of people, and are often required to provide specialist advice and consultation to non-mental health specialist colleagues.

The particular task of CMHTs is to provide a service for people with ‘severe mental health problems’ - though we note that, despite its common usage, the precise meaning and value of this term remains disputed (see for example: Barker et al 1998). At a strategic level this can result in a lack of shared ownership and understanding of the term with the operational consequences that CMHNs may be working within poorly defined operational criteria, with an inadequate evidence base for whichever target client group they happen to be working with.

There are implications for CMHNs of working in close proximity to multidisciplinary colleagues. Working in CMHTs, for example, raises questions over the ‘professional’ and ‘generic’ identities of practitioners (Brown et al 2000). Much of the work which goes on in CMHTs appears to be shared equally amongst the different professional groups and reflects the role of the care co-ordinator/care manager within localised arrangements for the Care Programme Approach (CPA). This work would include: assessing health and social needs; providing ongoing care and treatment; coordinating multidisciplinary and multiagency care; and so forth.

CMHNs are expected to possess particular clinical and social skills, and to be able to provide care for people experiencing a range of mental health problems. Most CMHNs are expected, in particular, to have skills to work with people with ‘severe’ mental health problems. Most of what CMHNs do clinically is, in one way or another,
about human relationships and the use of interpersonal skills (Peplau 1988). Assessing the mental health of an individual referred to a CMHT, negotiating a care plan, caring for people in distress, providing information to families, liaising with multidisciplinary colleagues - all these are activities that require a range of well-developed listening, attending, and interventions skills (Morrison and Burnard 1997).

The current emphasis on evidence-based practice, however, has meant that possessing well-developed attending and listening skills is only part of the overall menu of attributes that CMHNs are expected to possess. This is not to suggest that interpersonal skills are not evidence-based, but rather that they now form a fundamental basis from which to build more specific intervention skills. Specialist skills, such as those that are taught to nurses following psychosocial intervention-type education courses, are becoming much more sought after (Gournay and Sandford 1998). The kind of skills and knowledge taught on these programmes seem particularly appropriate to nurses who work with a particular group of service users - notably, adults with a diagnosis of schizophrenia and other ‘major’ (usually psychosis in nature) mental illnesses.

Not all CMHNs work with this particular group of service users, however. We might also note the range of other specialist areas in which CMHNs work, and the attendant specialist skills and knowledge such CMHNs might need. CMHNs are to be found working with older people with dementia, with children and adolescents, with people with substance misuse problems, with people with mental health problems who have also committed offences, and with adults of working age with all manner of problems (White and Brooker 2001). CMHNs working in all these areas need particular
constellations of skills and knowledge, which might be quite different from the constellation of skills and knowledge that practitioners working in other areas require.

We observe that, whatever the specific skills and knowledge possessed by CMHNs, and no matter what particular area they specialise in, the everyday work of this group of nurses is characterised by a high degree of unpredictability and uncertainty. There are plenty of ‘swampy lowlands’ (Schön 1991) in CMHN practice, and plenty of situations that stretch even the most ‘evidence-based’ practitioner.

What CMHNs do is affected to a considerable extent by health and social policy imperatives. Initiatives such as England’s National Service Framework for Mental Health (Department of Health 1999), and the introduction of the framework of clinical governance (Department of Health 1998), all shape (or are likely to shape) the context in which CMHNs work. Recent health policy has urged care and treatment that is ‘research’, or ‘evidence’ based, and is ‘collaborative’, ‘seamless’, ‘effective’ and ‘needs led’ (see for example: Department of Health 1997, Welsh Office 1998). Proposed changes in mental health law are also likely to have a dramatic impact on the context in which community mental health care is provided, and on the work that CMHNs are required to do. For example, the current White Paper outlining the government’s intentions to change the Mental Health Act (1983) proposes new powers which will oblige people subject to a new Act to receive compulsory care and treatment in the community, as well as in hospitals as is the case under existing legislation (Secretary of State for Health and Home Secretary 2000). Similarly, it may be that CMHNs, for the first time, actually become involved in applying powers under a new Act. For, as the White Paper states, the third professional to make decisions
regarding the use of a new Act, alongside two doctors, will be “a social worker or another approved mental health professional” (Secretary of State for Health and Home Secretary 2000, p28, emphasis added).

Finally, an abiding issue in the delivery of mental health services is the concerns expressed by service users of disempowerment. This is frequently allied to the use of power and control as exercised by the psychiatric system. Hopton (1995) argues that a neo-Fanonist approach to the practice of mental health nursing would allow some redress of these concerns and suggests amongst other strategies that service users should be involved in the education and preparation of mental health nurses. Whether or not one accepts Hopton’s argument, it remains the case that we leave ourselves open to the accusation of tokenism if we fail to design education programmes for CMHNs which do not include a measure of service user input. Rudman’s (1996) study is a rare example in the literature of service user involvement in mental health nursing education. He found among other factors that service users wanted mental health nurses to respect individual differences and the user’s experience. Service users in Rudman’s study also challenged traditional teaching in relation to “psychotic” experiences. In the light of developments with for example responses to voice hearers (Romme and Escher 1993) which are now being adopted in mainstream psychiatry it would appear that CMHNs have a lot to gain in this respect. It would seem, however, a fundamental and moral obligation that the recipients of services which emphasise a strong interpersonal element, have a say in the training of those who will be caring for them. The rhetoric of mental health services (Department of Health 1994) for a number of years now has been to promote partnerships with service users. The reality
is that much work is to be done (Campbell 1999) and there is little excuse for its absence in the education of CMHNS.

The future of community mental health nursing will also see additional developments in the form of the likely introduction of nurse prescribing (Department of Health 2001). Both this and the potential introduction for CMHNS of new formal powers in a new Mental Health Act will have implications for nursing practice in relation to the primacy of the nurse-patient relationship and also for CMHN education in relation to the preparation of these practitioners for a new practice arena.

Questions for Nurse Educators and Commissioners

What questions for educators and commissioners of education does this brief overview of the practice and context of community mental health nursing throw up? We have identified the following:

- What are the educational models available to CMHN educators, which best prepare practitioners to work with diverse partnerships in complex systems and multiprofessional settings? It may be that hybrid PSI courses offered to CMHNS in conjunction with their MDT colleagues will be one route explored. However the emphasis to date has been squarely on the seriously mentally ill, and this may ignore the breadth of CMHN practice for which educational preparation has to account e.g. care of the elderly mentally ill, care of people with mental health problems presenting in primary care settings.

- How should the best evidence for these models be generated? It is clear to date that with the exception of the equivocal efforts to generate evidence for PSI
training there remains little effort to determine the efficacy of educational preparation for CMHNs.

- Who are the most appropriate colleagues for CMHNs to engage with in shared learning? Given the everyday realities of contemporary practice, our view is that CMHNs should be provided with more opportunities to learn alongside non-nursing mental health practitioners.

- How does the concept of a ‘unified discipline of nursing’ realistically transfer to practice, and, more specifically, what service models exist that support this concept and what is the role of education in the support of these? We question whether shared learning with health visitors and district nurses is appropriate at all given that social workers, psychologists, occupational therapists and psychiatrists form the bulk of our professional relationships. We are unaware of any evidence which supports the idea that joint training with other community nurses has any beneficial impact upon the care of the mentally ill. If we were to consider general medical practice as a model for genericism in nursing then we would have to conclude that the seriously mentally ill have been ill-served by genericism. It follows then that we see the future preparation of community mental health nursing within a broader multi-disciplinary framework.

- What clinical and therapeutic skills should education courses encourage CMHNs to develop? Should education focus on the acquisition of ‘psychosocial intervention’ skills, aimed at both nurses and other mental health workers who provide services for people with severe mental health problems, or should a broader range of clinical skills be offered?

- What is driving the formation of polemic perspectives in the nurse education literature with Specialist Practitioner courses at one end, and PSI education and
training on the other? Will the formation of new partnerships (for example, the proposed Education Confederations in England) provide new opportunities for these issues to be discussed and ensure that all education supports the development of high quality and sustainable mental health services? Psychosocial intervention skills have much to offer but if they remain solely focused upon the ‘seriously mentally ill’ (SMI) group then this will not meet the needs of CMHNs who are charged with the care of other groups of patients e.g. the elderly and the less seriously mentally ill. We would advocate a broader more critical consideration of skills required to deliver services to the mentally ill so that the needs of other groups are considered as well as the obvious priority group of SMI. PSI skills alone however are not sufficient and training needs to be founded on some fundamentals, for example interpersonal, communication skills and management skills. In terms of polemic perspectives - we consider it the case that we do not serve our clients and the profession well by fashioning education for CMHNs around these polemics. A coherent image of the profession struggles to emerge because it is always unable to articulate a sense of what and for whom it exists. Our strategy should be to engage in real dialogue with service users and their families about what priorities they want from services and use this information to formulate a type of CMHN who will meet their needs and that of the community as a whole. This does not deny the need for policy direction from above but rather creates the environment in which service users and their families can influence these decisions by learning the art of articulating and asserting their needs. This will need to be balanced with a broader awareness of the needs of the often voice-less and vulnerable members of our society, that is, the homeless
mentally ill, dual diagnosis service users and the personality disordered who are even today poorly served and stigmatised within services.

- How can educators best facilitate creative, reflective and thoughtful CMHN practitioners, who are able to utilise their professional discretion in such a manner that enables those in their care to make best therapeutic choices open to them?

- How can education courses prepare practitioners for work in particular policy and legal contexts? We can facilitate the creative, reflective and thoughtful CMHN practitioners we refer to by encouraging the use of reflective practice and developing self-awareness and critical-thinking skills in our courses. So we need “education” for CMHN's not just “training” which implies that the preparation should be broader than just a focus on skills. A 3-4 year pre-registration degree in Community Mental Health Nursing that is focused exclusively on community placements and on preparing these practitioners for offering care where the majority of the mentally ill are cared for in the community, would be our preferred option. It is baffling that some HEI's are still training mental health nurses to work in hospitals.

The above questions are posed to stimulate discussion and debate. We have alluded briefly to our position in regard to these questions to illustrate the basis from which our thoughts on the future preparation of CMHNs stem. We think that the main concern at all levels within nurse education is that graduates from courses should be able to support and lead high quality service provision. In the area of one of the authors (ST), there is a drive to increase the transparency and make more overt the linkages between education and training activity with service developments that support the National Service Framework for Mental Health (Department of Health
1999). This was clearly the case when a regional tendering exercise for PSI training was integrated with a regional organisational development project (Repper 2001) coordinated by the Northern Centre for Mental Health. The historical and political nature of the competitive education tendering process serves only to create new, or sustain existing, barriers to innovative and creative partnerships. One way forward from this position could be for higher education institutions (HEIs) to enhance the permeability of their boundaries so that answers to the above questions (and more) can be generated.
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