

The value of mental health nurses working in primary care mental health teams

New roles have made it more difficult for nurses to validate their unique contribution, argue Carol Richards and colleagues

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Abstract

Aim To identify the benefits of inclusion of mental health nurses (MHNs) in primary care mental health teams (PCMHTs) in Greater Glasgow and Clyde.

Method Eighteen MHNs and nine team leaders from ten PCMHTs were asked by questionnaire and semi-structured interview, respectively, about the value of the work of MHNs in PCMHTs.

Results The job titles of MHNs in PCMHTs were varied, using but not recognising the broad knowledge, adaptability and specific competencies of MHNs. Team leaders described valuing all these attributes among MHNs in their teams.

Conclusions The results reinforce the view that MHNs are not able to articulate or promote their unique contribution to mental health care or to protect their professional identity, and suggest that this is an area for recognition and further work.

Keywords

Mental health nursing, mental healthcare roles, primary care mental health teams

THERE HAS been a push towards more generic ways of working and evidence-based practice in mental health services that have blurred specific mental health nursing roles (Chambers 1998) and reduced understanding of what mental health nurses can offer that is unique to their profession. The recent introduction of the Increasing Access to Psychological Therapies (IAPT) (Department of Health, IAPT 2012) programmes in England, in which delivery of interventions is not dependent on a mental health qualification, indicates that nurses may be sidelined (Caie 2011).

In Scotland, although IAPT is not being implemented, there has been an increase in the delivery of low-intensity psychological interventions by practitioners who do not have a professional mental health qualification. This has become evident in the primary care mental health teams (PCMHTs) in Greater Glasgow and Clyde, where there has been a shift to non-profession-specific roles. This means that most mental health nurses have job titles of 'primary care practitioner' or 'mental health practitioner', roles that could also be filled by other professionals including occupational therapists or social workers.

Therapeutic worth

Generally nurses appear to have difficulty expressing an explicit or defined role and traditionally are often known for doing whatever is needed to be done (Lakeman 1995). This point is further argued by Taylor (1994) who suggests that since the closure of large psychiatric institutions, mental health nurses have struggled to prove their therapeutic worth or cost effectiveness. There has been limited exploration of what they are valued for or can contribute, and of whether the loss of professional identity and expertise is important to them or to other professionals.

Study

The aim of this study was to identify what specific knowledge, skills and identity mental health nurses can bring to local PCMHTs, comparing nurses' perceptions with those of PCMHT leaders who come from a variety of professional backgrounds.

Method

An eight-item questionnaire for mental health nurses and a nine-item semi-structured interview

Box 1 Questionnaires used in the interviews

RMN questionnaire

- What is your current role in your primary care mental health trust (PCMHT)?
- When did you qualify as an RMN?
- How long have you worked in a PCMHT?
- In your opinion, what attributes or skills do you bring to the team, which are specific to your professional training?
- In your team, do you have any responsibilities or clinical skills not replicated by other professionals in the team, of an equivalent grade?
- Do you feel your nursing skills/experience are used in your team? If yes, give as many examples as you wish:
If no, please comment:
- If there were no RMNs in your team, how, in your opinion, would this affect the service provided?

Having completed this questionnaire, is there anything you wish to add/expand on, please comment:

Semi-structured interview for team leads

- What is your professional background?
- How many whole-time equivalent clinical team members do you have in your team?
- How many clinical team members have a registered mental health nurse (RMN) qualification?
- In your opinion, what are the main skills/attributes the RMN(s) bring to your team?
- In your opinion, what impact would there be on the service you provide if there were no RMNs in your team?
- When you recruited your last post (filled by an RMN), what were the specific attributes/skills you were looking for?
- In your team, does your RMN(s) have any responsibilities or clinical skills not replicated by other professionals in the team, of an equivalent grade?
- Do you consider team members' RMN qualification when delegating tasks? If yes, give examples.
- Having completed this questionnaire, is there anything you wish to add/expand on, please comment:

for team leaders were designed by the authors and piloted in a PCMHT team outside Glasgow to test for applicability and clarity. No changes were made. Participants were informed that all responses would be anonymised.

The questionnaire was circulated to all mental health nurses in all area PCMHTs to complete and return by post or email. The nurses were identified through local knowledge of the teams; this was confirmed by contacting team leaders or team administrators. Each of the team leaders was identified through the global address list of Greater Glasgow and Clyde Health Board. They were sent an email that explained the purpose of the survey and inviting them to participate. They were also asked to identify all the registered mental health nurses (RMNs) in their team who were subsequently contacted via email and with information regarding the survey and an invitation to complete a questionnaire.

The semi-structured interviews of the nine responders took place face to face in their own individual bases, with the exception of one leader, who was interviewed via the telephone, as suitable diary dates to meet were proving difficult. Interviews were recorded and notes taken.

The only additional resource that was required was the time of the authors to carry out the interviews. This was allowed by their individual line managers. Box 1 shows the questionnaires sent to the team leaders and RMNs. The questionnaire asked participants to list skills and attributes specific to their professional training. The answers excluded from the table by the authors were cognitive behaviour therapy (CBT), person-centred therapy and solution-focused therapy, undertaken as postgraduate training and are therefore not profession specific.

Results

Findings from nurses Of the 33 mental health nurses contacted, 18 (55 per cent) completed and returned the questionnaire.

Roles The nurses' answers confirmed that the MHNs' job titles were generic:

- 14 (78 per cent) were mental health practitioners.
- Two (11 per cent) were cognitive behaviour therapists.
- Two (11 per cent) were primary care liaison workers.

Experience Replies showed that the nurses were experienced across the mental healthcare system, with between six and 21 years' work since qualification. The duration of service in the PCMHT was between six months and seven years.

Skills and attributes Nurses were asked to provide examples of skills and attributes that they brought to their team that were specific to their professional training. Themes identified are listed in Box 2 in order of frequency. Some respondents found this question difficult and tended to fall back on non-nursing specific therapeutic training they had undertaken since they had graduated, for example in CBT. These responses were excluded.

Unique responsibilities One question sought to identify whether nurses thought they had any unique responsibilities or clinical skills: nine respondents said yes and nine said no. Particular competence in liaising with others was suggested, stemming from their assessment skills, clinical judgement/experience and knowledge of physical health problems, pharmacology and

Box 2 Nurses' skills and attributes

- Understanding of the spectrum of mental health problems
- Assessment skills
- Holistic approach
- Versatility/adaptability
- Multidisciplinary team working
- Value-based care
- Management skills
- Biological/medical knowledge
- Pharmacological knowledge
- Engagement
- Psychosocial interventions
- Clinical judgement
- Eclectic approach
- Clinical governance awareness
- Organisational skills
- Risk management
- Core therapeutic skills

multidisciplinary team (MDT) working. Similarly, they thought they had valuable knowledge of specific legislation, skill in allocation of certain cases when other specialist staff were unavailable, and ability to train others.

Are skills being used The nurses were asked whether they found that their nursing knowledge, skills and experience were being used; 15 (83 per cent) responded positively to this question. Consultation was most commonly mentioned, for example, on medication, referral pathways and psychiatric presentations. Other frequently used abilities were risk assessment, delivery of interventions, record keeping and intervention with particular clients. One participant added that nurses perceived that their expertise was 'used but not formally recognised'. Three respondents (17 per cent) answered negatively that 'certain mental health nursing skills are not required' and that what was needed was more 'psychological therapy training'.

Impact if there were no MHNs in the team One question focused on what the nurses thought the effect would be if there were no MHNs in their team: 17 (94 per cent) thought there would be a clear impact and one (6 per cent) was unsure. Loss of knowledge and skills across the spectrum of mental health problems was most commonly mentioned, together with increased waiting times and increased cost of practitioners, based on the assumption that more psychologists would have to be employed. One nurse predicted a less cohesive service, resulting

in a more fragmented journey for the client, while another said that 'social factors may be overlooked'.

Comments Participants were asked for further comments. These covered the following topics:

- The nurse's ability to adapt to an ever-changing environment.
- Proficiency in problem solving.
- Conflict resolution.
- Being a consistent link between the PCMHT and the community mental health team.
- The nursing model being key to the team's functioning and essential to boundaries and short-term working.
- The loss of nurses from the PCMHT would be detrimental to care and lead to a loss of advanced experience in management, clinical governance and administration.

Findings from team leaders A total of ten PCMHT leaders were contacted, reflecting the ten local PCMHTs. Eight interviews were conducted face to face, one was completed over the telephone and one leader did not respond to the invitation.

Background The first question asked for the responder's clinical background (Table 1).

Team composition Questions two and three asked about the composition of their teams. It was established that just over half of the workforce in PCMHTs is made up of mental health nurses. Three teams had a much higher proportion and one team had no MHN following a retirement.

Skills and attributes Question four asked what leaders thought were the main skills and attributes of the mental health nurses in their team (Box 3, page 22). No formal thematic analysis took place, but themes were identified by the authors by listening to the taped interviews and reading the notes. The first five entries were the most frequently mentioned by leaders. They varied slightly from those collated from the nurses who proposed that their primary attribute was their in-depth clinical skills, whereas

Table 1 Clinical background of team leaders

Clinical background	Total
Nurse	2
Occupational therapist	2
Psychologist	4
Psychiatrist	1

team leaders valued their pharmacological and biological/medical knowledge more highly.

Impact if there were no MHNs in the team Question five asked about the impact on the team if it had no mental health nurses. There was great disparity in the responses. Three participants thought there would be no impact and one suggested that nurse training was in fact a hindrance. However, five foresaw a huge impact, in particular due to the potential loss of knowledge and skills about medical conditions, assessment, diagnosis, treatment, medication and care planning, as well as a loss of experience leading to a poorer service. Two commented that nurses were a 'major asset'; one was indefinite but worried about losing a 'core set of skills' and commented that 'nurses do what others don't'.

Skills and attributes sought Question six asked what specific skills and attributes team leaders were looking for when they last recruited to a post for which a mental health nurse was selected. On the whole, participants said they were not looking for nursing skills specifically. Two wanted a core profession with additional psychological therapy skills, and in one instance competence in CBT was mentioned. Others participants highlighted the need for good assessment and communication skills,

overall knowledge of mental health and services, and ability in onward referral.

All of these skills had been identified by team leaders when replying to the previous question asking what they believed mental health nurses' main skills and attributes were. One participant was looking for someone who could contain distress, cope with a wide variety of cases and not feel overwhelmed. Two said that having recruited nurses, they would do so again in the future. One recognised that the two people selected for her team had been nurses, and reflected that perhaps mental health nurses met the criteria better than any other profession. Two participants had not been involved in recruitment since being in post.

Extra responsibilities Question seven asked about extra responsibilities or tasks that could be carried out by mental health nurses. Four of the nine team leaders stated that the nurses did not have any responsibilities or clinical competence that were not replicated in the role of someone of an equivalent band, or that the team members all worked the same way. One respondent highlighted additional skills in psychopathology and mental health assessment, and others mentioned community nursing standards, wider experience, team working, flexibility, professional commitment and supervision of medication.

Box 3 Perceived skills and attributes of nurses

- Assessment expertise
- Risk assessment
- Knowledge of psychopathology
- Pharmacological knowledge
- Biological/medical knowledge
- Care planning
- Management skills
- Goal setting
- Influence on team ways of working
- Wide range of experience
- Holistic
- Community experience
- Running groups
- Communication skills
- Complex cases
- Triage skills
- Case management experience
- Decision making and appropriate referral
- Knowledge of organisation and services
- Multidisciplinary team working
- Eclectic
- Safe pair of hands
- Commonsense approach
- Empathic and caring

Delegation of tasks Question eight asked: 'Do you consider team members' mental health nursing qualification when delegating tasks?' Five participants responded yes and four, no. Some were definite that the mental health nursing qualification was irrelevant and that the reason for their employment was more to do with the 'personality, motivation and interest of the individual'. Others said that delegation was more to do with 'experience'. Two stated that they did think about the professional background and skills of an individual in planning core interventions, including group work, referral/screening meetings, and collaboration with external organisations and services for complex cases. These duties were more likely to be delegated to the nurses in the team.

Comments The final question requested any other comments. One team leader added that having mental health nurses brought 'huge additional value' from which the 'whole team benefited' and he hoped that he would 'never work within a team that didn't have people with a mental health nursing background'. Others reiterated that nurses were a major asset and there would be a loss of psychiatric skills and medication knowledge without them. One

participant worried that nurses were perhaps losing their professional identity by working in generic posts, and that mental health nurses who were not trained in a specific psychological model were expected to deliver psychological interventions.

Conclusion

First, the authors would like to state that this was not a typical research study; using simple methods we tried to increase our understanding of what mental health nurses do that is of value in primary care mental health services.

Our findings reinforce the view that nurses working in a PCMH struggle to demonstrate that what they do that is unique to their core profession. Despite their extensive experience, the nurses in this study had difficulty in formulating what they do well in their team (Deacon *et al* 2006). From their perspective they thought that they added value, but they did not identify any specific nursing skills or attributes that could not be replicated by other professionals, such as occupational therapists and social workers.

Perhaps there is a difference in the quality of delivery. Barker (2001) appears to make this argument by suggesting that it is the way in which mental health nurses interact with their clients, not what they actually do, that is the key to helping people move towards recovery. Bucknell (2004) noted that mental health nurses can make the 'extraordinary look ordinary'. Perhaps Travelbee (1971) expressed the situation best when he suggested that to cultivate the heart of practice, mental health nurses must raise the dialogue around their interpersonal work. Mental health nurses need to increasingly articulate their learned interpersonal skills as a valued core skill of mental health nursing.

Mental health nurses' work evolved as a result of the shift away from a predominantly medical model, and the closures of psychiatric institutions, to community care. With the development of community psychiatric nurse roles in the 1980s, they began to identify with a wider range of approaches and to work with a broader group of professionals. There has been a marked move to increase nurses'

skills in evidence-based psychological therapies, such as CBT. This has meant that mental health nurses have been recruited to teams with a greater emphasis on psychological models. Perhaps these roles would be enhanced by the interpersonal skills that Travelbee (1971), Barker (2001) and Bucknell (2004) describe as being central – or even essential – to the work of mental health nurses.

Caie (2011) states: 'The survival of mental health nursing within primary mental health care depends on the ingenuity, creativity, resourcefulness and tenacity of nurses, and the unerring ability of nursing to adapt, develop and reinvent itself in the face of challenge and adversity.' Do mental health nurses need to embed all this in an evidence-based framework to support their continuing recognition and development in primary care mental health?

One team leader suggested that it was an asset for nurses 'not to be precious', meaning nurses were willing to do what had to be done for the patients regardless of traditionally whose role this would be. Another suggested that the professional qualification/background of PCMH workers was not relevant at all, and might be a hindrance in some ways. Specifically, this participant believed that nurses could be 'risk averse' because of their predominantly secondary care background and that it was more advantageous for workers to be 'psychologically minded, curious and willing to contain distress'. There was an overall reporting from the team leaders that these qualities are more likely to be manifested by the mental health nurses than any other practitioners.

Lakeman (1995) argued that it may be the diverse range of areas in which mental health nurses work that contributes to the difficulty of defining any commonalities. Whatever areas nurses work in, it would seem that their unique interpersonal skills and adaptability require testing and validation, and this should constitute an area for continuing research. Such work could provide a definitive answer as to what value mental health nurses bring to any mental health setting, and would serve to protect the future of the profession.

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Conflict of interest
None declared

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