Paper

CMHNs: How do they see themselves?

This study by Steve Smith, attempts to replicate a study carried out by Barratt (1989) into the self-perceived roles of community psychiatric nurses (CPNs). Fifteen community mental health nurses (CMHNs) for the elderly were sent a questionnaire asking them to describe how they saw their role. Of the 11 (73 per cent) CMHNs who responded, nine agreed to be interviewed and, of those, seven took part in a semi-structured interview. Interviewees were asked to describe their role and responses were recorded. Transcripts of the interviews were analysed for emerging themes, which were collated and compared with the findings of Barratt's study. Findings suggest that while the CMHN role can be described in terms of medical, psychological, and social models, there is evidence of an unstated, but clearly implied body of knowledge which defines and differentiates the approach of the CMHNs studied from the models mentioned

Full title: The Self-Perceived Role of Community Mental Health Nurses for the Elderly
Author: Steve Smith BA, RMN, Dip CPN, certificate in counselling skills, community mental health nurse, Grampian Primary Care NHS Trust, Aberdeen/Lecturer-practitioner in mental health nursing
Address for correspondence: The Robert Gordon University, Aberdeen
Mental Health Nursing Vol 22 No 4 pp 13-17

Since Barratt (1989) described the self-perceived roles of 16 CPNs towards the end of the 1980s, the numbers of CPNs and the scope of their practice have increased dramatically (Brooker and White, 1997; Naji and Dow, 1996). However, there continues to be no clear consensus on what constitutes a CPN/CMHN (Ross et al, 1998), nor what the 'appropriate role' of a CMHN should be (Walker and Barker, 1998). Despite this, there appears to be a growing movement towards identifying the role of the CMHN as being exclusively involved with people with enduring mental health problems and questioning the efficacy of CMHN interventions with people presenting with other forms of mental health problems (Hannigan, 1997).

Where such uncertainty exists as to the nature and function of CMHNs (Tilley and Pollock, 2000), it would appear pre-emptive to draw conclusions as to how effective CMHNs are at fulfilling their function, and prudent to re-examine the basic questions of who CMHNs are and what their function is.

Barratt's study

Barratt (1989) reported on the self-perceived roles of 16 CPNs, who were interviewed in the course of a larger study. She utilised a semi-structured questionnaire as the focus for interviews. Interviews were tape recorded and transcribed and were then analysed for emerging themes. Additionally, Barratt described four conceptual models of psychiatry: the medical, psychological, behavioural and social models, which she attempted to link to the functions described by the CPNs. The CPNs were described as shifting from one model to another when describing their role, utilising the model they felt most appropriate to a situation.

Barratt noted that where a case was under the control of a psychiatrist the CPN's role tended towards the medical model, but where no psychiatrist was involved the CPN tended towards the behavioural or psychological models. She concluded that CPNs were 'still experimenting with their role', and suggested that they may have been in a position to provide a service to people whose mental health problems fell outside the medical model approach to care.

The study

In the absence of any meaningful consensus as to what a CPN is, what their role is, and what their role should be, this study takes a grounded theory approach to describing the role of one specific group of CMHNs. If, as Morrall (1995) suggests, CMHNs enjoy a de facto clinical autonomy covertly manufactured by themselves, then it could be argued that it is CMHNs themselves who are in the most appropriate position to describe the current role they undertake, and also the role they are likely to undertake in the future.

Therefore the aims of this study were:

- To discover how the study population of community mental health nurses for the elderly perceived their own role.
- To discover whether this suggested a predominant theoretical model which CMHNs for the elderly worked to.
- To compare the findings from this study with those of Barratt's (1989) study.

Methodology

The study population comprised 15 community mental health nurses employed within the old age psychiatry directorate of a large primary health care NHS trust in Scotland. All CMHNs were 'G' grades, registered mental nurses, 11 were

whole-time CMHNs (37.5 hours per week), four were half-time CMHNs (0.5 wte), and all held their own caseloads. A questionnaire was sent to all CMHNs in the population inviting them to provide demographic details and respond to two open questions. The questions were: 'As a community mental health nurse for the elderly, what do you see as your main role?' and 'What does this involve?'

In total, 11 CMHNs responded to the questionnaire, and nine agreed to be interviewed. Eventually, due to time constraints, seven CMHNs were interviewed. Unstructured interviews, lasting between 30 and 60 minutes, were tape-recorded and transcribed. Themes were highlighted and grouped together for self-perceived function and underlying theoretical assumptions.

Results

All 11 CMHNs had at least one further nursing related qualification. These included: two nursing degrees, six diplomas in professional studies or other CPN qualification, four registered general nurses and one enrolled nurse. All CMHNs reported being based in a hospital setting. There was an equal divide between CMHNs who accepted referrals solely from a consultant psychiatrist and those who took referrals from both consultant psychiatrists and GPs. Two CMHNs took referrals from sources other than these, both of whom identified the source as a health and social care community dementia team. No CMHNs received referrals only from GPs.

The CMHNs who completed the questionnaire identified 19 different functions. The most mentioned functions were: assessment (nine times), liaison (six times), supporting carers (five times), and supporting patients, education, monitoring mental state, and treatment (all four times each). Compared with the functions identified by the CPNs interviewed by Barratt (1989), only 'assessment' appears on Barratt's list and in the seven most frequently mentioned functions identified here.

Table 1. The self reported functions of CMHNs interviewed

Function	No of times mentioned	Rank order
Assessment	7	1
Liaison	7	1
Therapeutic Relationships	5	3
Carer support	4	4
Monitor Medication	4	4
Care Planning	3	6
Professional Accountability/Development	3	6
Teaching/Training	3	6
Anxiety Management	3	6
Referring to other skills	3	6
Counselling Skills	2	11
Health Promotion	1	12
Accepting Referrals from Consultant	1	12
Indefinable	1	12
Stop Gap for Others	1	12

Two further themes identified by Barratt were mentioned by this study group. Monitoring drug regimes was mentioned twice, as was counselling. While the questionnaire was a relatively quick and simple way to gather data, it provides little insight into what the responses meant to the CMHNs who made them. Therefore the data from the interviews was analysed to explore some of the subjective meanings communicated by the CMHNs who participated in this stage.

The CMHNs who were interviewed identified 15 different functions (table 1). Assessment remains the most frequently mentioned function, being mentioned by all participants. Liaison was also mentioned by all the CMHNs interviewed, while 'developing therapeutic relationships' (five times), 'carer support' and 'monitoring medication' (four times each) comprise the five most frequently mentioned functions. 'Health promotion', 'accepting referrals from consultant', 'being a stop gap for others' and being 'indefinable' were all mentioned only once, and, perhaps surprisingly, 'counselling skills' was mentioned by only two CMHNs.

While assessment can be seen as a key function of nursing as a whole, and has been prominent in most of the surveys of CMHNs' roles discussed above, the reason CMHNs carry out assessments and the information they assess people for will suggest an underlying philosophy of what they believe CMHN nursing to be about. For these reasons, and to facilitate a comparison with Barratt's (1989) findings, the top five ranked functions identified by the CMHNs here will be examined in more depth.

Assessment

As stated above, all participants mentioned assessment as a key function of their role. This mirrors the findings of Barratt (1989). However, it became apparent that within the study group different CMHNs meant different things by 'assessment'. Some were clearly describing a social perspective to health care where the focus was on the way in which an individual functions as part of a social system. It could be argued that these CMHNs appeared to see mental health problems as resulting from a combination of unmet needs, and saw their role as helping the individual person to balance the positive and

negative aspects of their life.

There were, however, as many responses which indicated a medical model perspective to health care as there were responses which indicated a social model perspective. The medical model described by Barratt, and for reasons of comparison used here, is one which 'views psychiatric illness as having a specific cause related to the functional anatomy of the brain' (Barratt, 1989).

Liaison

This function was placed jointly first in terms of number of times mentioned by the CMHNs interviewed. Unlike the previous function, liaison does not feature in Barratt's study at all. This may reflect a change in the way in which CMHNs see their role, moving towards greater integration in multi-disciplinary team working and multi-agency working. This could, arguably, be seen as a move away from a medically dominated perspective, towards one in which mental illness is seen in the context of social interaction, requiring input from a range of professional disciplines in the fields of health and social care. As such, this could be seen to reflect a social perspective towards mental health, a model that would appear to be reflected in many of the responses given by CMHNs at interview.

CMHN 3: 'Well, there's a lot of networking with the day hospitals, social work...just using other people for help and support and to get their opinions about things as well. To clarify roles sometimes and to let them be aware of my involvement a lot of the time. Sometimes, so that we can just sit down together and look at the whole package and everybody's involvement.'

While many responses appeared to reflect a willingness to participate in multi-disciplinary working, some of the responses appeared to reflect a more dependant role of CMHNs. Several could be seen to suggest that the CMHNs interviewed appeared to see liaison as a means of integrating themselves into the safety of a team or group responsibility. Further responses reflected a more psychological perspective, reflecting the importance these CMHNs placed on communication as a therapeutic element in its own right.

Some of the CMHNs mentioned several reasons why they considered liaison to be an important aspect of their role, some giving reasons that could not be seen to fall within any one particular conceptual framework of mental health.

CMHN 7: 'I've got very good relations with the social work department. I think their role is very different from ours...I think there's a role for both of us there, and if we can come at it from different directions and meet somewhere in the middle...I think that that's how we really do work.

Therapeutic relationships

The building of therapeutic relationships was directly mentioned by five of the CMHNs interviewed. Many of the CMHNs described the building of therapeutic relationships in terms of a psychological model. These CMHNs saw their role as being involved in an interpersonal relationship with the patient, and there is evidence to suggest that they saw the manner in which they did this as being different from the approaches utilised by other disciplines who may argue that they too utilise a psychological approach. In other words, they appear to be describing a psychological approach which they believe is particular to their role as CMHNs.

CMHN 5: 'I remember a psychologist saying that you should always be very focused going in, which you can be with some people, but (with) a lot of older people you have to be much more relaxed so that they almost don't think that you're a nurse, they see you as a person rather than a nurse.'

CMHN 1: 'A lot of people don't want to speak to a social worker, they'd rather...they feel safer with a nurse. It's quite a cultural thing; I've often heard clients say, 'I'd rather speak to the nurse'. I think as a nurse, or as a psychiatric nurse you learn to establish rapport in a relationship with somebody...I mean that's some of the skills you learn from day one...how to build relationships and establish rapport.'

CMHN 7: 'Because of our training we're supposed to understand about the things people are telling us. People are mentally ill when they come onto our caseload...We're supposed to be the group of folk who understand what that's doing to them and perhaps be able to know the remedies.'

Carer Support

Many of the CMHNs reported working with the carers of people referred to them. This may reflect both the increasing importance placed upon including relatives and families of service users in all aspects of mental health services (Brooker et al, 1994) and also the perception that many older people with mental health problems are 'cared for' by their spouses, children or siblings.

It could be argued that the views expressed by some CMHNs reflected the importance of sharing feelings and working at an interpersonal level and can be seen as representing a psychological model of working on the part of the CMHNs who expressed these views. While the emphasis of these CMHNs was on psychological support, other CMHNs reported working with carers in order to provide information on how to cope with the 'caring tasks' they were faced with. Notably, many of the CMHNs who spoke about carer support discussed it in terms of working with carers of people diagnosed as having a dementing illness.

Medication

This function, which was mentioned by

nine CPNs in Barratt's study, was mentioned by four of the CMHNs interviewed here. This might suggest that the giving and monitoring of medication has remained a key feature of the work undertaken by CMHNs over the intervening 11 years. Most of the responses given by the CMHNs reflected a medical model approach to the use of medication in the treatment of mental illness, although there was some evidence to suggest that they did not necessarily share the underpinning philosophy that informed the medical model's confidence in pharmacological intervention.

CMHN 1: 'Obviously the prescribing is the medical staff's responsibility, but we do tend to check for side-effects and the efficacy and things like that, obviously that's a big part of our role; and feeding back.'

CMHN 7: 'We are trained to recognise particular things that may be needing treatment...drugs, interactions. I mean that's very much something we ought to be able to recognise, someone's maybe unwell because they've been given piles and piles of dope that isn't agreeing with them. So we can make them better in a very practical sense by just checking the physical stuff, by making sure they're okay.'

Discussion

In common with several other studies looking at the role of CMHNs (Naji and Dow, 1996; Ross et al, 1998; Bugge et al, 1999) this study suggests that it is not possible to identify one particularly defining function that CMHNs undertake. In Barratt's study all functions reported by CPNs were of a direct patient contact nature. However, in this study, CMHNs reported defining their role by a number of functions: professional accountability and development, teaching/training, liaison, referring to other agencies, which can be described as being based on their idea of 'professionalism' or 'professional practice'.

In keeping with the findings of Barratt's earlier study, this group of CMHNs appear to take an eclectic view when it comes to adopting conceptual models to underpin their practice. They appear to be equally split between a social perspective and a medical model perspective when discussing 'assessment', but adopt a largely psychological approach when discussing 'therapeutic relationships'. The same eclecticism can be seen when the study group are discussing 'liaison', with a combination of a social perspective and a medical model perspective being evident, and in 'carer support' where the medical model and psychological models meet.

Regardless of the function being described, the CMHNs appeared at times to be attempting to express an idea of what it was to be a CMHN. The essence appeared to be that CMHNs establish relationships with people and then use these relationships to a therapeutic end. Within this, the actual physical activities which the CMHN undertakes are of relatively little importance when defining the CMHN's role.

It could be argued that it is this ability to focus on the interpersonal relationship and build on it, that the CMHNs defined as their key role, albeit in a semi-articulated manner.

CMHN 7: 'I don't have any particular perspective on it (assessment)...trying to understand them in the context that they've got an illness process going on and that aside; treating them as an individual. You look at the person behind the psychiatry, if you like.

CMHN 4: 'I think my main role is building therapeutic relationships with patients...to help them maybe not necessarily move forward, but even stay as they are.

The essential role of the CMHN does not appear to be in specific interventions with specific groups of people, so much as in the interpersonal nature of relationships which help people reconnect with the society in which they live. It is suggested here that while utilising aspects of social theory, medical theory and psychological theory, the unique concepts which define the role of the CMHN may be more likely to be found in their ability to establish and maintain a relationship which focuses on the personhood of the patient and seeks to address their goals.

Johnson et al (2001) have suggested there exists a 'dissonance' between the accepted truth of current mainstream thought regarding CMHN practice and the actual reality perceived by CMHNs in practice. This study supports that conclusion and suggests that CMHNs have a clear, if unarticulated, concept of their role and that it is likely to be this vision that informs much of the practice of CMHNs in the foreseeable future. However, further work requires to be done to describe the essential, if less visible, knowledge and skills which CMHNs possess if they are to develop openly as a professional group and make a valid specialist contribution to mental health care.

Conclusion

While this study suffers from the limitations of a small sample size, in one part of the country, and relates only to one speciality within community mental health nursing, it can be seen as a pilot for a larger study, should the opportunity be available to undertake this. While not rejecting a medical model approach to care, CMHNs clearly see their role as encompassing a number of conceptual models and move freely between them as circumstances require.

Barratt (1989) concluded that CPNs were experimenting with their role and there is evidence to suggest that, although the self-perceived role of CMHNs has developed, this experimentation continues. There is also evidence to suggest that the self-perceived role of these CMHNs differs fundamentally from the role generally held to be 'appropriate' by policy makers and pressure groups within

the wider CMHN community.

It is suggested that the CMHNs interviewed here were attempting to express a definition of their role which did not rest upon the activities they undertook but which rather was based on their ability to build relationships with people and use these relationships to enhance the mental health status of the other person. This, it is tentatively suggested, may offer an alternative approach to defining the unique contribution CMHNs bring to multi-disciplinary teamwork, and should be subject to further, broad based study. **MHN**

References

Barratt E (1989) Community Psychiatric Nurses: Their self perceived roles. *Journal of Advanced Nursing* (14) 42-48

Brooker C; Falloon I; Butterworth A; Goldberg D; Graham-Hole V and Hillier V (1994) The outcome of training community psychiatric nurses to deliver psychosocial intervention. *British Journal of Psychiatry* 165 (2) 222-230

Brooker C and White E (1997) The fourth quinquennial national community mental health nursing census of England and Wales. Manchester, Manchester and Keele Universities

Bugge C; Smith L and Shanley E (1999) A descriptive survey to identify the perceived skills and community skill requirements of mental health staff. *Journal of Advanced Nursing* 29 (1) 218-228

Hannigan B (1997) A challenge for community psychiatric nursing: Is there a future in primary health care? *Journal of Advanced Nursing*. 26 (4) 751-757

Johnson S; Coleman M and Bowler N (2001) CPNs and the severely mentally ill. *Mental Health Nursing* 21 (2) 10-15

Morrall P (1995) Clinical autonomy and the community psychiatric nurse. *Mental Health Nursing* 15 (2) 16-19

Naji A and Dow I (1996) The role of the community psychiatric nurse in community care: A national survey of present practice. Edinburgh, Scottish Office, Department of Health

Ross L; Pollock L and Tilley S (1998) Community psychiatric nurse: what does it mean? *Mental Health Nursing* 18 (1) 10-14

Tilley S and Pollock L (2000) Community psychiatric nurses' empowerment of people with enduring mental disorder in the community: Involving users to develop services. Edinburgh, Dept of Nursing Studies, The University of Edinburgh

Walker L and Barker P (1998) The required role of the CPN: Uniformity or flexibility? *Clinical effectiveness in nursing* (2) 21-29