
Abstract

Internationally, the deinstitutionalization of psychiatric care has resulted in expanded roles for mental health nurses within a community interdisciplinary team setting. This presents an opportunity for mental health nurses to improve service delivery. This opportunity also results in a more empowered nursing team. This paper identifies change issues within one community psychiatric nursing team and the team’s contribution to an improved service delivery where service users can avail of same day assessment for crisis referrals, a reduction in waiting times for assessment and coordinated delivery of care with an identified key worker utilizing a recovery model philosophy.

Key words: assessment, empowerment, key worker, community mental health nursing, community mental health nursing, recovery care plans.
**Background**

Global de-institutionalism has been evident for sixty years (Hamden et al, 2011), and community mental health nurses were pivotal in the transition of services from institution to community across Australia, Europe, UK, and Ireland during the late 1950’s and 1960’s. However, the pace of deinstitutionalisation internationally is varied and dependent upon in part by funding arrangements and local traditions (Hamden et al, 2011). In the UK the move was gradual, with community mental health nurses visiting patients in their homes and organising activities with them (Hannigan, 1999). It was quickly acknowledged that when nurses spent therapeutic time with service users it was much more beneficial than their former custodial role and allowed for patients to be discharged with little input from the medical profession (Nolan, 1993).

The Irish picture is similar, with the introduction of nurses to the community to administer medication and check for side-effects (Godlin, 1996). However, nurses moved to the community with no formal preparation or post registration training for the post, which led to wide variations in practice (Barker et al, 1998).

In 1984, the report titled ‘the psychiatric services: planning for the future’ (Department of Health, 1984), laid down the structures currently in place for mental health services in Ireland. The policy outlined that psychiatric services in Ireland should be ‘community-oriented, aimed that delivering care that is continuous, co-ordinated and multi-disciplinary’ (Kelly, 2004, p.62). These developments were enhanced by a Irish nursing workforce exposed to a broader curriculum addressing for instance, current philosophies of mental health care as a result of the introduction of diploma level education in the mid 1990s, moving to degree level for all psychiatric nurse education programmes from 2002 (National Council for the Professional Development of Nursing and Midwifery (NCNM) (NCNM, 2003). In addition, nursing was emphasised as the cornerstone of a modern mental health service at this time (NCNM, 2003).

More recently, the context for mental health nurses working in interdisciplinary teams has become more complex because of directions from government legislation,
governing bodies, consumer demands and the growth of advocacy services. The strategy for delivering mental health services in Ireland (Department of Health and Children, 2006), reinforced the need to close the large institutions, and recommended the development of community mental health teams (CMHT) that are interdisciplinary. Hence the mental health nurse’s role needed to be redefined to reflect the complexity and the richness of the practice of nursing and to give it a professional status of equal standing along side other health professionals within the MDT.

Defining and harnessing mental health nurses’ roles with the CMHT is paramount in order to maximise service delivery. This paper shares the experiences of nurses in one CMHT. Developing and expanding the role of the nurse was directed by the guidelines of the nursing regulatory body (An Bord Altranais), and drew on the structured framework provided by the NCNM for developing specialist and advanced nursing roles (NCNM, 2008 a,b).

Assessments of service users
Prior to the development of the CMHT described here, mental health nurses in the team worked in a service where all initial assessments were carried out by the medical team, and the role of nursing was narrowly defined within the service and mainly around the provision of care once assessment was completed by the medical team. This resulted in underutilisation of expertise within the team and waiting times for assessment of service users of up to eight weeks for a medical assessment. Assessments focused on the medical aspects of the illness and were not recovery focused. They also lacked interdisciplinary discussion and team decision making regarding meeting the needs of the service user.

Underutilisation of expertise of team members was highlighted over two decades ago (Stevenson, 1987). When all disciplines contributions are acknowledged, meaningful involvement in decision making and responsibilities and increased job satisfaction is the outcome, which benefits both clinician and service user (Stevenson, 1987). Multiple needs of individuals with mental health problems cannot be addressed by
any one profession. A co-ordinated team-based individualised care that integrates with other health services and with generic, social and community services, is necessary to promote service users’ recovery, a good quality of life and community re-integration (Mental Health Commission, 2008).

The nursing team initially identified that their skills and experience in assessment were underutilised. With the previous system, nurses felt disempowered as their role was around service delivery once the medical assessment was completed. Nurse autonomy and decision making was limited which impacted negatively on their confidence and their role within the team. All team members are skilled to carry out assessments (Burns, 2004). A biopsychosocial assessment tool was subsequently developed by a sub group of the CMHT team, chaired by a nurse. The new assessment tool draws on international literature on assessment and the UK Care Programme Approach (CPA) (Department of Health, 1990), and assesses the biological, psychological, social and spiritual needs of the individual. A comprehensive risk assessment tool was also developed and forms part of the assessment. Team members subsequently undertook in-service training to develop competence in using the assessment tool. The assessment tool was piloted initially for a period of 6 months and following audit, the inclusion of a validated alcohol screening tool (CAGE), the most commonly used screening tool for alcohol use disorders (Culberson, 2006), was added.

The introduction of this change in practice resulted in reducing the waiting time from eight weeks to same day assessments for individuals referred to the service in crisis. Delays in waiting for a mental health assessments and accessing mental health services can increase the stress levels for both service user, family and carer thus impinging on the recovery process. In addition, non-urgent assessments were completed within a two week period thus improving response time for assessment and improving access to the service (Table 1). The amount of assessments undertaken also increased significantly (Table 2). In 2009 there was an increase in the number of referrals to the team and the number of assessments carried out by the medical team also increased when a senior registrar joining the team. Prior to this the medical team comprised of the consultant psychiatrist and two non consultant hospital doctors
(NCHD’s). This expertise was a huge advantage to the team and was utilised in a positive way.

Currently all referrals come through a central point of access to the nursing manager of the community day hospital who triages the urgency and allocation of cases. A member of the nursing team assesses crisis referrals on the day of referral and non-urgent cases are discussed and allocated at the weekly CMHT allocations meeting. All team members are skilled to carry out an initial assessment, however audits of referrals within our team from March 2005 to 2010 identified that nurses undertook the most assessments (Table 2).

**Care co-ordination/Key working**

Care coordination/key worker was another role identified by the team as essential to developing the service. The terms ‘key worker’ and ‘care coordinator’ are used interchangeably in the literature. Care coordination is described as a framework of care that “integrates the work of a range of practitioner’s and agencies while providing care that is tailored to the needs of individual users” (Onyett, 2003, p.125). An identified care co-ordinator/key worker is advocated as best practice by the Mental Health Commission (MHC) (MHC, 2006). This ensures that service users have an identified team member who coordinates their care within the wider interdisciplinary team. Moreover, the responsibility of the role ensures that the views of people involved within and beyond the team are represented, particularly those of service users and people close to them. The care coordinator is responsible for ensuring that the care plan is a collaborative live working document utilising the expertise of all interdisciplinary team members necessary to progress recovery. The role of care coordinator is not identified as a role assigned to any specific mental health professional, however, nurses make up the largest discipline on the team and are considered best placed to embrace this role (Onyett, 2003). Moreover, social workers (and community mental health nurses) are considered best placed, although not exclusively, to carry out the role (Newbigging, 2004).

Simpson (2007) argues that the effectiveness of care co-ordination is enhanced where communication among team members is respectful and team structures and policies
are in place to support the role. In view of this, it was important that policies, procedures and standards were put in place to support the changes to practice. Nurses on the CMHT are currently key working for 251 service users with 242 managed in an out patients’ department. They have developed specialist nursing practice in the area of clozaril and lithium management and manage nursing clinics alongside medical outpatient clinics.

The scope of practice expansion is supported by practice protocols/guideline and clinical supervision by the consultant psychiatrist. Furthermore specialist clozaril training education was undertaken in the United Kingdom, including phlebotomy training and education on understanding blood test results. A more structured approach was developed to managing all service users on clozaril and lithium therapy and continuous auditing was put in place to ensure the highest standard of care. Community mental health nurses on the team also undertook post graduate higher diplomas relevant to their specialist roles.

This method of case management has greatly assisted in streamlining out-patient clinics within the service and when service users that are key worked require medical review, this is jointly done in conjunction with their appointed key-worker. All team members carry a case load of service users. All service users are discussed at clinical team meetings and referred to specialist allied professionals if required. Nurses also have the highest rates of discharge within the service (Table 3). With the option of early discharge, more normalised treatment environments is promoted with supports in place from the community mental health team. Traditional services placed more emphasis on clinical recovery and treatment primarily was offered in a hospital environment. This limited the treatment option and choices for service users.

**Recovery Care Planning**

Over time, care planning in mental health nursing has become integral to working with service users. Nationally and internationally care planning has become a fundamental and essential component for all nurses within CMHTs in promoting recovery in mental health (Hall et al, 2007). The aims of developing a recovery care plan within the service were to improve the quality of care delivered, improve outcomes and offer inter-disciplinary team input for all service users. Yearly audits
and collaborative team education days which involved service providers, service users and families, in addition to practitioners’ reflections on practice, enhanced the care planning process and showed numerous benefits from all perspectives (Table 4). In addition, nurses on the team have developed working links with voluntary agencies and facilitate an Aware support group (a local organisation that supports those with depression), and a SHINE relatives’ support group (a national organisation that supports individuals and their families affected by ongoing mental health difficulties) within the service.

Discussion
Community mental health nursing is both complex and challenging in nature (Donnison et al, 2009). Additionally, changing nursing practice was not without barriers. Barriers for some nurses were driven by attitudes and beliefs about competency to carry out assessments. Other issues around role boundaries were also highlighted relating to the background of a traditional medical model and what was perceived as increased workloads for some team members. Supporting nurses through the challenges and changes was therefore essential.

These issues were overcome with continuous education, and clinical and managerial supervision. The team leadership of both the consultant psychiatrist and nursing management were pivotal in supporting the changes in practice within the team. Committed and enthusiastic mental health nurse managers can spearhead the reorganisation of nursing roles within the interprofessional team (Salhani and Coulter 2009).

One of the most effective and important ways of supporting nurses and bring about change in a positive and constructive manner is through supervision (Brunero and Stein-Parbury, 2008). Clinical supervision is considered crucial for the consolidation and bonding of teams in bringing about change and managing the emotional effects of change (Cutcliffe and McFeely, 2001). Effective mental health teams need clinical supervision to maintain the level of support they provide for their clients (Nolan et al 2004), and help minimise burnout (Edwards et al, 2006; Onyett, 2011). Supervision to support the change in role and was organised to occur at the weekly allocation meeting, where each mental health nurse completing an assessment would feedback
the information gathered during assessment to the entire team under the supervision of the consultant psychiatrist and nursing management in order to plan the delivery of a CMHT recovery package of care. In addition, clinical nursing supervision was and continues to be facilitated by an external supervisor as a means of managing the emotional impact of the changes in practice, in a safe environment. This supervision resource united, motivated, and nurtured confidence within the nursing team to feel valued as practitioners and in implementing change.

Expanding roles have enhanced the traditional role of nurses within the team from primarily one of caregiver to one of assessor and key working with the right of referral to other disciplines within the team. It also means that nurses now communicate directly with the referring General Practitioner regarding assessment, care planning and discharge, which in the past was the sole responsibility of the medical team. General Practitioners often have little training to deal with mental illness beyond their undergraduate preparation (Kerwick, 1997). Now, the role played by the community mental health nurses in providing support and expert advice to primary care teams has also developed close links. Moreover, because of the liaison role and close working relations developed with primary care, referrals have reduced because of specialist advice and gate keeping of inappropriate referrals. This illustrates the benefits of close interprofessional working, a finding reported with the introduction of the Mental Health Nurse Incentive Program in Australia (Happell et al., 2010). Furthermore, close contact and trust between professionals on the mental health team are reported as important factors in promoting interprofessional collaboration (Magnusson and Lützén, 2009). Wilson and Crowe (2009, p. 821) conclude that the role of community mental health nurses is ‘all about relationships—with service users, the organization, colleagues and their personal ones’; a view mirrored in the experiences of the team reported here.

Nurses on the team have developed and advanced their practice within the CMHT. Workplaces that have the requisite structures as in this instance, promote empowerment (Manojlovich, 2007). Nurses working in an intensive care setting report feeling empowered when working in a supportive atmosphere with good teamwork (Wåhlin et al, 2010). Moreover a study examining Irish nurses’ and midwives’ understanding and experience of empowerment, found education to
practice effectively as an antecedent condition, and beliefs about professional respect, personal power and control as central to their conceptualisation of empowerment (Corbally et al., 2007). This finding is similar to the experiences of nurses on the CMHT reported here. To feel empowered, in the context of a new employment relationship, means to understand the purpose and contribution of work, and to believe that individuals are ultimately responsible for the work they do, the service they provide, and for their own continual development and growth, personally and professionally (Cassidy and Koroll, 1994). Empowerment enables people to recognise their strengths, rights, abilities and personal power, and results in increased commitment to their work, and greater potential for working in partnership with patients and family (Rissel, 1994).

The service model described here has shown many benefits. However Service users were not included in all aspects of service development at the initial introduction of changes. Service user involvement, although as aspiration of CMHT, often does not occur (Borg et al., 2009). On reflection, service users were under utilised as a resource, however, enhanced engagement since 2008 has contributed to the ongoing development of a collaborative recovery focused mental health service.

**Conclusion**

The changes to nurses’ practice as part of the CMHT team have resulted in many benefits to the service. Nurses triage all referrals to the service, and more people are being assessed within a shorter waiting time. Furthermore, all referrals are appropriate as a result of the advisory role of the team with primary care. Service users are assessed by the person most likely to be their key worker, and the assessment is holistic in approach as well as offering a comprehensive mental state examination and risk assessment. Nurses in the role of key worker promote recovery by contributing to and coordinating inter-disciplinary care planning. They also have the highest rates of discharge to primary care and assume a consultative role with primary care personnel. Nurses now manage a weekend service incorporating home care and such a service is seen as beneficial where medication supervision is required and to prevent admission (Burns, 2004).
The close working links between nurses and voluntary agencies and support groups, illustrate service users’ involvements in service development. Moreover, nurses on the team engage in health promotion and education at local schools. Finally, team morale is very high with staff members feeling empowered. This sense of empowerment has resulted in team members getting involved in undertaking and publishing nursing research and audit (Cleary and Dowling, 2009 a,b; Cleary and Dowling, 2010; Cleary et al, in press).

**Key points**

- Mental health nurses play a central role in interprofessional working through undertaking assessments and assuming key worker roles in community mental health teams.
- Mental health nurses through care planning and care coordination of care contribute to the recovery journey of individuals and their families accessing the mental health services.
- Service users are assessed quickly, allocated a care coordinator, involved in developing care pathways and work with the team in planning and evaluation of the service.
- Mental health nurses also assume a consultative role for primary care professionals and are a resource for local organisations.
- Mental health nursing is demanding and nurses need effective support and supervision.
- Utilising nurses’ skills and expertise effectively as part of a community mental health team results in nurses feeling empowered.
References


Cleary A, Dowling M (2009a) Knowledge and Attitudes of Mental Health Professionals to the Concept of Recovery in Mental Health: a questionnaire survey. *Journal of Psychiatric and Mental Health Nursing* 16: 529-545.


Table 1 Comparison of waiting times for assessments (all referrals)

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<tbody>
<tr>
<td>Assessed within 4 weeks</td>
<td>83%</td>
<td>88.7%</td>
<td>95.2%</td>
<td>95.2%</td>
<td>96.2%</td>
<td>95.9%</td>
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<tr>
<td>Assessed within 3 weeks</td>
<td>69%</td>
<td>82.5%</td>
<td>89.7%</td>
<td>89.8%</td>
<td>84.4%</td>
<td>90.9%</td>
</tr>
<tr>
<td>Assessed within 2 weeks</td>
<td>51%</td>
<td>64.5%</td>
<td>73.12%</td>
<td>78.75%</td>
<td>72.6%</td>
<td>78.2%</td>
</tr>
<tr>
<td>Assessed with 5 days</td>
<td>22.4%</td>
<td>37%</td>
<td>47%</td>
<td>46%</td>
<td>37.1%</td>
<td>95.5%</td>
</tr>
<tr>
<td>Assessed with 2 days</td>
<td>12.2%</td>
<td>25%</td>
<td>36%</td>
<td>39%</td>
<td>27.3%</td>
<td>38.1%</td>
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Table 2- numbers of service user assessments undertaken by team members

<table>
<thead>
<tr>
<th></th>
<th>2005 (Apr-Dec)</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing</td>
<td>87</td>
<td>137</td>
<td>220</td>
<td>234</td>
<td>221</td>
<td>179</td>
</tr>
<tr>
<td>Medical</td>
<td>46</td>
<td>53</td>
<td>59</td>
<td>64</td>
<td>135</td>
<td>60</td>
</tr>
<tr>
<td>Allied Professional</td>
<td>9</td>
<td>16</td>
<td>13</td>
<td>8</td>
<td>17</td>
<td>5</td>
</tr>
<tr>
<td>Joint assessments</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>147</td>
<td>223</td>
<td>294</td>
<td>306</td>
<td>326</td>
<td>244</td>
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</table>

Table 3- rates of discharge

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
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<tbody>
<tr>
<td>Total number of referrals</td>
<td>147</td>
<td>224</td>
<td>294</td>
<td>306</td>
<td>326</td>
<td>244</td>
</tr>
<tr>
<td>Discharges</td>
<td>83 (56.4%)</td>
<td>81 (36.1%)</td>
<td>111 (37.7%)</td>
<td>148 (48.3%)</td>
<td>169 (51.8%)</td>
<td>124 (51%)</td>
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<tr>
<td>% discharges by nurses</td>
<td>42%</td>
<td>28%</td>
<td>28%</td>
<td>38%</td>
<td>39%</td>
<td>38%</td>
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Table 4. Outcomes

<table>
<thead>
<tr>
<th>To service users and family</th>
<th>For service providers</th>
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<tbody>
<tr>
<td>Service users have a plan of care with MDT input</td>
<td>Streamlined service delivery</td>
</tr>
<tr>
<td>Care plans are strengths based</td>
<td>Promotion of engagement</td>
</tr>
<tr>
<td>Care plans address family needs addressed.</td>
<td>Enhanced key working/care co-ordination</td>
</tr>
<tr>
<td>Care plans are collaborative in approach</td>
<td>Increased accountability and autonomy</td>
</tr>
<tr>
<td>Care plans are holistic</td>
<td>Empowered staff</td>
</tr>
<tr>
<td>Care plans offer treatment choice and promote personal responsibility</td>
<td>Workable case loads as recommended by the literature</td>
</tr>
<tr>
<td>Development of recovery care planning information leaflet</td>
<td>Access to both clinical and managerial supervision</td>
</tr>
<tr>
<td>Key working promotes continuity of care</td>
<td>Enhanced opportunities for clinical professional development</td>
</tr>
<tr>
<td></td>
<td>Audit and research is embedded in practice.</td>
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