Where does mental health nursing fit in primary care?

In this article...
- Where mental health nursing fits in the new IAPT model
- How nurses can influence health inequalities in mental health
- The key dilemmas nurses will need to consider

The Depression Report, which outlined a seven-year plan to recruit 10,000 new mental health workers, led to the introduction of the Improving Access to Psychological Therapies (IAPT) initiative (Layard, 2006). The rationale for Layard’s report was to reduce the state’s welfare bill by increasing the number of people returning to work following common mental health problems such as depression and anxiety. Funding was assured (£173m), training courses established and a host of new workers poured into primary mental health care to provide therapy (Department of Health, 2008).

These changes raise some fundamental questions for mental health nurses: with 10,000 new paraprofessionals working their way through waiting lists, is there still room for us in primary care, or have we been sidelined? Do we continue to advocate for ourselves as a separate profession, with specialist skills and knowledge, when there are few clearly defined nursing roles left?

Alternatively, do we compromise our unique professional identity and assimilate ourselves into this new model of service delivery, becoming “psychological wellbeing practitioners”, “gateway workers” or “high-intensity therapists” instead of mental health nurses?

IAPT and mental health nursing
The remit of IAPT is to provide timely and time-limited therapy to people with primary mental health needs. This is done mainly through cognitive behavioural therapy (CBT), delivered in a variety of formats, in line with National Institute for Health and Clinical Excellence (2009) guidelines. While this clearly benefits many people, there will always be those who do not fit neatly into the IAPT model, whose needs cannot be easily medicalised and pigeon-holed.

Bailey (2004) argued that “validation of nursing will come not from the approval of other professions... but from the recognition of alternative and complementary ways of achieving the empowerment and wellbeing of patients”.

This suggests there is an opportunity for mental health nursing to find some way of complementing the IAPT model, seeking gaps in its provisions to enhance and extend what IAPT can offer. However, it seems more likely that, in the current economic climate, these gaps will be filled by third sector, voluntary and community organisations.

Some nurses may be happy to accept a new role within IAPT. Indeed, high-intensity therapist posts often require a core professional qualification in nursing or psychology. New roles within the IAPT framework mean nurses can access new training and gain new skills. IAPT can provide them with a fresh approach to their practice and a different career direction.

It could be argued that, with IAPT, nursing has “to be in it to win it”, and this is one way of maintaining a nursing presence in primary mental health care.

Health inequalities
Concerns have been raised about the danger of IAPT becoming a two-tier system, with those who cannot return to work being neglected in favour of potential taxpayers (Scott, 2010).

Nursing has traditionally been a profession that is highly politically minded, and unafraid to enter into contentious debate over healthcare politics. It remains to be seen whether the new IAPT workers will embrace such an ethos. Perhaps this is
give mental health nurses the opportunity to have their skills formally recognised.

4. It is up to individual mental health nurses to decide whether they can work within an IAPT model.

5. Nursing must fight to survive and establish its place within a changing healthcare environment.

Many mental health nurses already offer high-intensity psychosocial interventions. Another area where mental health nurses can bring influence to bear within IAPT, highlighting where services fail to provide equity and accessibility.

Nursing prides itself on being a separate and unique professional group. Recent developments in primary mental health care have raised the question of whether nursing truly does have anything unique or different to bring to the table, or whether these new IAPT paraprofessionals can provide the same skills for less money. The project has already been criticised for providing care “on the cheap” – a watered-down version of previous psychological therapy services.

Is mental health nursing unique?

IAPT trainees are taught about interpersonal skills, assessment, psychological interventions and even medication management. These skills encompass what Hamblett (2000) described as nurses’ high and low-visibility skills. What expertise can mental health nursing bring to the table that is markedly different or specialised? Perhaps it is desirable to see IAPT as an opportunity to extend nurses’ traditional roles and skills. Turpin et al (2009) pointed out that “the qualified high-intensity IAPT workforce is predominantly made up of CBT therapists, counsellors, nurses and psychologists”. Mental health nurses have much to bring to an IAPT service in terms of skills, experience and competencies, over and above that which is taught as part of the IAPT training programmes.

Many would argue that mental health nurses, especially those with postregistration qualifications in areas such as psychosocial interventions and CBT, can already offer high-intensity interventions, and have been doing just that for many years before IAPT.

It could also be argued that becoming part of the IAPT structure – either as high- or low-intensity therapists – could give mental health nurses the opportunity to have these skills formally recognised as a core function of their role rather than as an adjunct to “normal” clinical practice. It could also provide them with the opportunity to work alongside other professions as equal partners, cutting through traditional professional boundaries.

It is a matter for debate as to whether this is as a positive recognition of the value of mental health nurses’ skills and a move towards a more integrated healthcare environment, or a significant step towards generic working with its associated loss of professional identity and specialist skill set.

Becoming an IAPT therapist may well mean that nurses move away from their traditional roles and functions. However, this would not necessarily be a bad thing. Nursing has always been flexible and adaptable, and has evolved to respond to patients’ and clients’ needs. There is no doubt that IAPT was established in response to a huge and previously unmet need; it is perhaps no surprise that mental health nurses are involved in this evolution and revolution in healthcare provision.

Conclusion

It is up to individual primary care mental health nurses to decide whether they can work within an IAPT model or whether they should move to another field of nursing practice.

They must decide whether, as part of IAPT, they continue to feel they are mental health nurses first and foremost and psychological therapists second, or to wholeheartedly embrace the new role and leave their identity as a nurse behind.

It is hard to see how, when working within such a tightly structured service as IAPT – with its outcome-driven approach – that mental health nursing as an art can survive.

As yet, IAPT remains in its infancy. Whether it will provide the cure for the waiting lists and welfare bills as the policymakers hope or simply open up another revolving-door healthcare culture remains to be seen. However, it is clear that, even with the best workforce providing the most up-to-date therapy, in this current political and economic climate, IAPT is unlikely to provide a cure-all for society’s ills.

Initial outcome reports from both the Doncaster and Newham IAPT pilot sites have shown some positive results (Clark et al, 2009), and the aim is to roll out this initiative out nationally. This brings obvious implications for nurses working in primary mental health services outside the IAPT model, where the question focuses on whether to adapt and assimilate or seek opportunities elsewhere.

Over the decades, many changes have occurred in mental health care and, on each occasion, the role, value and place of nurses has been debated and redefined. Whether such a debate can take place constructively in the face of IAPT – or whether nurses have already missed the boat – remains to be seen.

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.

We cannot rest on our laurels – nursing must fight to survive and establish its place as a uniquely skilled and knowledgeable professional group within an ever-evolving healthcare environment. NT

References


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