Mental Health is in the Hands of Nurses

When Hildegard E. Peplau developed the first Master’s program in psychiatric nursing in the late 1950s, with an exclusive focus on talk therapy, this was not an idea that was received well (Callaway, 2002). Other nurse faculty saw medical–surgical areas, complete with the mechanics and technology of that day, as more important and more prominent. Other Master’s programs featured education or administration.

During summer workshops, which were carried out across the United States in state and federal psychiatric hospitals, Peplau’s efforts were to persuade nurses to leave their offices, which were often behind glass barriers, and come into the wards. She demonstrated how to talk with patients, both individually and in groups. Medications were never part of her agenda. The fact was that at that time, other than haloperidol, the only antipsychotic drug was chlorpromazine (Thorazine®), which was being adopted only in hospitals that could afford to add it to their treatment regime.

Past decades, unfortunately, have seen the domination of psychiatrists, whose main treatment strategy is prescribing medications. Advanced practice nurses (APNs), who have prescriptive authority, fall into the same patterns. This prescribing habit happens because they often work in clinical settings requiring cost-accounting for the hours spent working. Talk therapy is not part of their reimbursable package.

TIMES ARE CHANGING

Talk therapy, as a treatment strategy, is found in new community approaches to how health care is delivered today. The community approaches have names such as One Home for All Care, Community Support Models, Basic Needs Models, Integrated Care Clinic, and so on. As medical (physical) and mental (interpersonal or psychosocial) domains come together, a substrate is a focus on talk.

The Charities Aid Foundation, supported by the Robert Wood Johnson Foundation, funds a study to assess the feasibility of implementing the BasicNeeds Model for Mental Health and Development in the United States (BasicNeeds, 2015). Within this vast cultural change undertaking is the bedrock of communication and dialogue (talking) that departs from seeing only physical illnesses, symptoms, and medications as chief concerns. The U.S. mental health system is going through “extraordinary changes as more and
more services are covered as essential health benefits under health care reform, and as the high cost of untreated mental illness to society and to health plans become widely recognized” (BasicNeeds, 2015, para. 2). Talk therapy exists within the descriptions and discussions regarding continuation of coordinated and evidence-based services.

Opportunities for nurses to use talk therapy arise in settings where psychiatrists are absent and where the need for psychiatric care is not met. Carey (2015a) recently reported on communities in West Africa where mental health is in the hands of nurses, associated with non-profit and community organizations. One of the stories in his feature article described a nurse who traveled on a motorbike to reach a young woman experiencing severe hallucinations and delusions during a first episode of schizophrenia. It took persuasion (i.e., talk) to convince her parents that help beyond herbs and exorcism might be beneficial. The nurse’s intervention resulted in the wooden shackles being removed, and the woman enrolling to take sewing lessons. Quoting from the head of a Presbyterian Community–based center, Carey states: “The trained nurses we use can do everything: diagnose, prescribe, even provide some talk therapies” (Carey, 2015a, para. 6).

AROUND THE WORLD
Global health officials have long concentrated on communicable diseases, such as malaria, tuberculosis, or HIV. However, last month, the United Nations (2015) made its first change of commitment to promote mental health and well-being. Seventeen Sustainable Development Goals are presented in the document, “Transforming our World: The 2030 Agenda for Sustainable Development” (United Nations, 2015). Many of the goals have persuasion and talk therapy embedded within them. For instance, point 26 states: “We are committed to the prevention and treatment of non-communicable diseases, including behavioural, developmental and neurological disorders, which constitute a major challenge for sustainable development” (United Nations, 2015, p. 7). Depending on how the statistics are computed, the years of life lost by individuals with mental illness due to associated comorbidities of diabetes, heart disease, and obesity ranges from 20 to approximately 40 years. One of the goals (3.4) of the United Nations (2015) is to reduce such premature mortality. Behavioral change and talk are intertwined. Of course, listening precedes (or should) talking. Nurses first need to learn how patients perceive the causes of their comorbidities.

NEW STUDY FUNDED BY THE NATIONAL INSTITUTE OF MENTAL HEALTH (NIMH)
Carey (2015b) reported a landmark government-funded study that questioned the “drugs primarily” approach to care for individuals with schizophrenia. According to Carey (2015b):

The findings, from by far the most rigorous trial to date conducted in the United States, concluded that schizophrenia patients who received smaller doses of antipsychotic medication and a bigger emphasis on one-on-one talk therapy and family support made greater strides in recovery over the first two years of treatment than patients who got the usual drug-focused care. (para. 2)

The Early Treatment Program (ETP) is part of the work that the NIMH continues to implement across the United States. The ETP is included in NIMH’s RAISE (Recovery After an Initial Schizophrenia Episode) initiative, and is part of the design of the new study, “Comprehensive versus Usual Community Care for First-Episode Psychosis: 2-year Outcomes from the NIMH RAISE Early Treatment Program” (Kane, 2015). The aims of RAISE are to develop, test, and implement new community-based programs.

Study participants comprised 404 individuals, ages 15 to 40 years, with various schizophrenia diagnoses. These individuals were located within 34 community mental health treatment centers in 21 states, meeting eligibility criteria. Enrollment occurred between July 2010 and July 2012, with each participant being treated for 2 years. The experimental treatment included personalized medication management, web-based decision support, family psychoeducation, resilience-focused individual therapy, and supported employment and education. Significant results included effects seen in length of
treatment time, quality of life, increased participation in work and school, and decreases in symptoms.

The study, which began in 2009, had an initial design that called for two parallel trials, each with hundreds of first-episode patients. It was later modified, because recruitment of patient-subjects was difficult. Five years later, Congress awarded $25 million in block grants to states to be used for early intervention programs. However, the 32 states with funding have not systematically reported how these resources have been used.

Nurses are often the first clinicians to see patients who are having their first psychotic episode. These patients are afraid of what is happening to them, do not know how to deal with their symptoms, and are mistrustful of authority figures. Nurses and talk therapy are what patients need to sort out all these experiences. Nurses can skillfully explain why medications may be beneficial.

TAKE HOME

When psychiatric nurses are asked what they do and explain that “talk” is a large part of their work, they now have significant national and international studies and implementations on which to rely. However, talk is not cheap, as an old saying claims. Nurses need to work on how to present their talk work and evidence about outcomes to assure that their billing is fair and reimbursed as intended.

REFERENCES


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