

The Use of Cognitive Behaviour Therapy by Community Mental Health Nurses:

A review of the literature

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Introduction

Mental health nursing is arguably one of the most interesting and challenging areas of nursing practice. It requires an integration of professional knowledge, clinical skills, interpersonal skills and experiences (Elder, Evans & Nizette, 2005). The central activity of mental health nursing is that of forming and maintaining 'therapeutic relationships'. 'Mental health nursing is thus firstly an interpersonal process that uses self as the means of developing and sustaining nurse-client relationships' (Elder, Evans & Nizette, 2005, p.4).

Worldwide, there is a demand that only practices that have shown to be effective be sanctioned in the provision of health care. This is known as evidence-based practice (Elder, Evans & Nizette, 2005). Evidence-based practice can be identified from observable practices validated using scientific methods; evidence-based practice can be validated from the expert knowledge of professionals and, in the mental health clinical arena, evidence-based practice can be validated from the expert knowledge of people with the lived experience of mental disorder and distress (Elder, Evans & Nizette, 2005).

Research indicates that 'Cognitive Behaviour Therapy (CBT)' is the strongest non-pharmacological behavioural change intervention and is one of the most common behavioural change therapies used in the western world (McFarlane-Nathan, 2000). The therapeutic relationship in CBT is collaborative and empowering and the client is an active participant in the process (Elder, Evans & Nizette, 2005). Use of CBT by Community Mental Health Nurses (CMHN's) working in a publicly funded specialist mental health service is the clinical nursing topic chosen for this literature review.

A critical analysis of available research and scholarly literature around this topic will be presented with examination of the literature implications for New Zealand nursing education, practice and research. Initially the aims of this literature review and the search strategies sourced will be presented followed by an overview of CBT and a discussion on the role of the Clinical Training Agency (CTA) within CBT training and education here in New Zealand. The research and literature that has been sourced will then be presented under relevant topic headings. These include: Psychopathology and the role of CBT; community mental health nursing and evidence-based practice; the role of the community mental health nurse in CBT delivery; factors influencing delivery of CBT and the cultural implications of CBT delivery. The final section will discuss implications for New Zealand nursing education, practice and research followed by the conclusion where key findings of the literature search are synthesized.

The aims of the literature review and the search strategies used

The aims of this literature review are threefold:

- 1) To identify and develop an understanding of the clinical effectiveness of CBT in clients with severe and enduring mental illnesses
- 2) To identify and develop an understanding of the CMHN's role in the delivery of CBT to clients with a severe and enduring mental illness
- 3) To identify and develop an understanding of CMHN's delivery of CBT to their clients and the factors influencing this delivery

In order to achieve these aims a literature search was conducted using the databases MEDLINE and CINAHL with the key words 'CBT and nursing and research'. Out of these 'hits' literature, articles and research specifically pertaining to CMHN's use of CBT; use of CBT with clients who have a severe and enduring mental illness and literature focusing on the relationship between CMHN's and their mental health clients were accessed. Databases sourced included: PubMed; MD Consult; Cochrane and Index NZ. Using the www.rational.org website links were gained to 'Rational Emotive Behaviour Therapy (REBT) sites as well as to general CBT sites both nationally and internationally. Literature was also sourced manually by following up references in articles and through colleagues referring relevant articles of interest.

The bulk of the literature sourced was from overseas and in the form of research articles with equal amounts of qualitative and quantitative research being accessed. Three case studies detailing use of CBT with Schizophrenia were critiqued as was five articles reviewing the available research around different aspects of CBT application and delivery. Literature sourced also included two discussion papers and three action research findings involving pilot projects centered around staff training and subsequent CBT delivery. Of note in this review is the paucity of literature from New Zealand and the issues arising from this will be more fully explored in the 'Implications for New Zealand Nursing Education, Practice and Research' section of this literature review.

The research sourced for this literature review is a logical and pragmatic start to knowledge development around this highly specialized topic. Sound critical analysis of the literature accessed has been completed and has proven to be reliable and trustworthy.

An overview of Cognitive Behaviour Therapy

'People feel disturbed not by things but by the views they take of them' (Epictetus – first century philosopher, cited in Froggatt, 1993)

CBT is a proven method of psychotherapy that proposes it is not the events themselves that cause anxiety and maladaptive responses but rather people's expectations and interpretations of these events. It suggests that maladaptive behaviours can be altered by dealing directly with a person's thoughts and beliefs (Stuart & Laraia, 2001). CBT is a generic term that encompasses a number of approaches – specifically Cognitive Therapy (CT) and Rational Emotive Behaviour Therapy (REBT). CBT proposes a holistic ie. 'biopsychosocial' explanation of causation – it believes that a combination of biological, psychological and social factors are involved in the way people feel and behave (Froggatt, 2001). CBT focuses on the cognitive processes that intervene between the perception of environmental information and the consequent behavioural responses to that information (Davis & Casey, 1990).

It is imperative, in today's health environment, that nurses search for and scrutinize approaches to care that encompass alliance and partnership. Fundamental to quality mental health nursing is the establishment of a 'partnership' between the nurse and the client (Crowe, 1997). The nursing process and CBT have a lot in common. Both approaches are client centered and strongly emphasize mutuality. The client is involved in defining the problem, identifying goals, formulating treatment strategies and evaluating processes. CBT is seen as educational and skill building rather than curative, with the therapist taking a facilitative role. Genuineness, warmth, empathy and the therapeutic relationship are important, and full recognition is given to their significance in influencing the effectiveness of treatment. CBT places a strong emphasis on an objective assessment process. It uses standard measurement tools and bases treatment strategies on research evidence (Stuart & Laraia, 2001).

The Role of the Clinical Training Agency (CTA) in CBT Training and Education

In 1975 Isaac Marks, a psychiatrist and researcher in London, established the first programme to prepare nurses to be cognitive behavioural therapists. The clinical outcomes these nurses achieved were at least as good as those achieved by other professionals. Marks calculated the cost-benefit ratio of using nurses as therapists. He found that people treated by nurses used fewer health-care resources after treatment than before, resulting in a savings of resources. CBT has become an important component of the nurse's role in the United Kingdom as a result of these findings (Stuart & Laraia, 2001).

The New Zealand Mental Health Commission was initially established as a Ministerial Committee in 1993 and began operating fully in 1996 following the release of recommendations from the 1996 'Mason Inquiry' into New Zealand mental health services (Elder, Evans & Nizette, 2005). Mason Durie's 1996 investigation also included the recommendation of additional government spending and it was this allocation

of 'Mason dollars' that lead the CTA to fund delivery of CBT training programmes within New Zealand (H. Forsythe, personal communication, May 16, 2006).

The CTA is a division of the Ministry of Health, and through the Mental Health Directorate, funds a number of mental health post-entry clinical training (PECT) programmes throughout New Zealand of which CBT programmes are one (Clinical Training Agency, 2005). 'The Ministry of Health values CBT as an effective therapeutic modality for use in the mental health setting and considers it important to continue to support training in this area' (H. Forsythe, personal communication, May 2002). There are presently two CTA funded CBT training programmes offered in New Zealand. The CTA fund the 24-week postgraduate level programmes that are specifically designed for practising mental health professionals to develop skills in CBT. The programmes are clinically based and students entering the programmes must be registered health professionals employed full-time within a publicly-funded mental health service (Clinical Training Agency, 2005). The majority of the trainees are from the central region of New Zealand with both providers of the current programmes based in the North Island – potentially decreasing access for South Island mental health professionals. The majority of the trainees identify themselves as 'nurses' followed by social workers, occupational therapists and psychologists (Clinical Training Agency, 2005).

Ongoing clinical education for registered health professionals raises a number of difficulties around study leave and replacement issues. As Tarrier, Barrowclough, Haddock and McGovern (1999) report there is considerable evidence to suggest that the acquisition of clinical skills requires active and practical training in those skills rather than lecture-style didactic teaching. The CTA funded CBT programmes are significantly clinically-based programmes with the majority of the learning taking place in the employee's workplace. Another training barrier that Tarrier et al. (1999) explored is that of replacing the clinician so he/she can attend training outside of the workplace, ie. who covers for the clinician when they re-visit the classroom? The CTA's CBT programme specification incorporates a three-way contractual agreement between the CTA, the employing District Health Board (DHB) and the education provider. Included in this 'contract' is the provision that the CTA 'funds' the DHB to release the trainee and money is made available to the DHB, through the education provider, with which to fund clinical cover to replace the trainee. Another important factor for the dissemination of evidence-based practice is the necessity for management commitment for the training and practice of the new approach. Again, the three-way contractual agreement set out by the CTA stipulates the DHB's responsibility to not only release the trainee to attend the theory training blocks but also to release the trainee for regular clinical supervision and mentorship from a designated, and appropriately qualified, mentor within their immediate work environment.

The future of the CTA funding of CBT training here in New Zealand is not guaranteed and this leaves present educational providers with little clarity and certainty regarding the future delivery of this programme (R. Vernon, personal communication, May 16, 2006). While the future of government-funded CBT training is uncertain there is already one New Zealand tertiary education provider who facilitates a two-year Diploma in CBT programme through the Ministry of Education. That is, the 'student' pays the enrolment fee and other associated course costs. This programme is similar to a one-year programme in England that has been offered to mental health nurses for the past 25 years. Gournay, Denford, Parr and Newell (2000) in their 25 year follow-up study of the graduates of this programme report that recent private health insurance company directives now allow for these nurses (they are commonly known now as nurse behaviour therapists NBT's) to bill for therapeutic services in equivalent terms to chartered clinical psychologists. The study reports that the professional autonomy of the NBT's is considerable and very frequently no other professional is involved at any point in the treatment provided. Gournay et al. (2000) go on to note that these nurse behaviour therapists have an excellent level of research, educational and publishing accomplishments compared with other nurses and notes the fact that because their skills are recognized by private insurers as being equivalent to clinical psychologists, this indicates the esteem in which this qualification is held. Maybe this highlights some future possibilities for New Zealand nurses wanting to specialize as cognitive behaviour therapists or CBT nurse practitioners?

Psychopathology and the use of CBT

There is current pressure in New Zealand, and in fact worldwide, to reduce health care expenditure and to target health care spending rationally (Laube & Higson, 2000). Psychotic illnesses (for example, schizophrenia) and non-psychotic illnesses (for example, bipolar affective disorder and clinical depression) can place a substantial burden and stress on both the client and on the family as well as placing a considerable financial burden on the health care system (Laube & Higson, 2000).

'Schizophrenia is a disorder characterized by a major disturbance in thought, perception, cognition and psychosocial functioning and is one of the most severe mental disorders' (Elder, Evans & Nizette, 2005, p. 219). Even though psychopharmacological interventions are effective in minimizing many of the symptoms of schizophrenia it is recognized that approximately 30-60% of clients with a diagnosis of schizophrenia will continue to experience residual psychotic symptoms despite appropriate medication (Dickerson, 2004). CBT for psychotic illnesses has developed quickly over the past 20-30 years through cautious application and evaluation of different treatment techniques in individual cases, followed by larger systemic controlled trials (Sullivan & Rogers, 1997).

The Joanna Briggs Institute for Evidence-Based Nursing and Midwifery (1999) analysed 20 random controlled trials and found strong evidence supporting the effectiveness of CBT in improving overall mental state and global functioning of clients with schizophrenia. Conventionally, psychopharmacology is the treatment of choice for psychotic symptoms (Chan & Leung, 2002) but The Joanna Briggs Institute for Evidence-Based Nursing and Midwifery (1999) states that although pharmacological treatment does help to control psychotic symptoms it does not provide important coping skills for the illness itself. It recommends that these skills are best provided through forms of psychotherapy.

Chan & Leung (2002), in their case study on the use of CBT with a client who has a diagnosis of paranoid schizophrenia, report that CBT should be one of the treatments of choice for people with this diagnosis and they identify that CMHN's are in a key position in which to use cognitive behavioural strategies and techniques. Turkington, Kingdon & Turner (2002) report on their study which set out to test whether the benefits of CBT that accrue, in terms of improvement in symptoms of schizophrenia with highly trained and skilled CBT therapists, can be replicated in the community when the interventions are delivered by CMHN's who receive a brief 10 day intensive training in the use of CBT. The research method used was that of a pragmatic randomised trial involving 422 clients and carers and compared brief CBT intervention with treatment as usual. The study population is seen as representative of those clients with whom CMHN's deliver their services to. The authors report that overall symptomatology, insight and depression were significantly improved in the CBT group as compared to the treatment as usual group.

The improvement in insight was clinically significant in the CBT group which the researchers suggested may show that clients receiving CBT may show a potential for improved adherence, better use of coping skills and maybe, in the longer term, reduced length of time spent in hospital. It was also noted in the study findings that 'carers' were also well engaged and displayed high levels of satisfaction with the CBT. The authors report that the high levels of satisfaction expressed by the carers highlighted the importance of delivering interventions in which carers feel involved and which do not lead to feelings of alienation. The study concludes by saying that CMHN's can safely and effectively deliver a brief CBT intervention to clients with schizophrenia and their carers (Turkington et al., 2002). Many psychiatric clients remain disabled by their schizophrenia despite appropriate psychopharmacological treatment and for them CBT does represent as a promising intervention (Dickerson, 2004).

The use of antidepressant medication and CBT are effective treatment options for depression and are recommended by clinical practice guidelines (Vos, Corry, Haby, Carter & Andrews, 2005). A recent Australian research project evaluated the available evidence in costs and benefits of CBT and drug interventions in the episodic and maintenance treatment of major depression (Vos et al., 2005). The cost-effectiveness was modeled from a health-care perspective as the cost per disability-adjusted life year. The study examined CBT treatment of acute major depressive episode consisting of 12 sessions analysed separately whether provided by a psychologist or a psychiatrist in the public health service or private practice and whether provided to individuals or in a group. The other treatment modalities that were measured in this research included various groups of antidepressants for both acute episodes and maintenance treatment and the modality of bibliotherapy. The overall conclusion of the research is that CBT (especially group CBT) is more cost-effective than medication if provided by a publicly funded psychologist. Unlike antidepressant medication CBT conveyed a longer-lasting impact well beyond the time of treatment. This result led the researchers to recommend that CBT be made available to all people experiencing depression and the use of CBT bibliotherapy was also strongly advocated (Vos et al., 2005). The authors of this study identified some key policy issues regarding delivery of CBT and this mainly concerned the availability of suitably trained providers and the funding issues related to this. Vos et al. (2005) state that 'there is no explicit evidence that other providers such as nurses and social workers can deliver CBT with similar effectiveness' (p. 689). This statement is contrary to research literature cited elsewhere in this literature review (see Brooker, Falloon, Butterworth, Goldberg, Graham-Hole & Hillier, 1994; Chan & Leung, 2002; Hafner, Crago, Christensen, Lia & Scarborough, 1996). However, Vos et al. (2005) do acknowledge that because bibliotherapy had very similar effectiveness rates alongside CBT this may mean that the 'type of provider' may not be the most

critical element of CBT. The authors conclude by saying that clinical depression should be modeled as a 'chronic episodic' disorder rather than 'episode by episode' as this would further allow the evaluation of longer-term treatment strategies. They suggest that widespread implementation of CBT could lead to cost offsets. Firstly, due to a reduction in the prescribing of antidepressant medication and secondly, because of a decrease in resource usage due to a reduction in relapse and severity of depression.

Evidence is rapidly accumulating for the value and cost effectiveness of CBT in treating psychotic and non-psychotic mental illnesses. Given that clients with a diagnosis of schizophrenia comprise approximately 60-80% of a New Zealand CMHN's caseload, and another 20-40% is made up of clients with non-psychotic major mental illnesses (J. Conneely, personal communication, May 30, 2005), it is imperative that that CMHN's have access to training and clinical supervision and support in the application of CBT strategies and techniques. Cognitive behavioural interventions have substantial empirical support as a treatment modality for a wide range of psychiatric and psychological disorders (Hafner et al., 1996).

Community Mental Health Nursing and Evidence-Based Practice

The process of de-institutionalization in New Zealand over the past 20 years has shifted mental health care and treatment from hospitals to Community Mental Health (CMH) Teams. The role of the mental health nurse within this CMH team is strongly influenced by the mental health consumer movement and by the 'business' model of health care delivery (Crowe, O'Malley & Gordon, 2001). Although a number of mental health professionals are represented within a CMH team the majority of the CMH workforce is comprised of nurses (Mental Health Commission, 1999).

The Ministry of Health in 1997 published 'Moving Forward: The National Plan for More and Better Mental Health Services'. This policy document set specific targets for mental health service development. This publication estimated prevalence of mental health issues amongst adult New Zealander's with benchmarks being set for mild, moderate and severe mental disorders. Mental health service delivery was modeled on these benchmarks with 'specialist mental health services' being funded to deliver assessment, treatment, care and crisis services to three per cent of the New Zealand population who are severely affected by mental disorders. It is this client group that CMHN's are employed to work with.

Arguably the move from inpatient based mental health care to outpatient community based mental health care has not been adequately resourced or supported. Gilbert, Cicolini & Mander (2005) state that as a consequence of this '... clinical management within the public sector has experienced an ever increasing reliance on the pharmacological treatment of symptoms, often at the expense of psychological and behavioural therapies ...' (p. 72). Gilbert et al. (2005) imply that optimal mental health care and treatment includes evidence-based psychological and behavioural therapies that are being denied to clients because of an over-reliance on medication and a shortage of adequately trained therapists. Reinhard (2000), in his discussion document, postulates that the effectiveness of community based mental health treatment and care would be enhanced by incorporating evidence-based psychological therapies within a community care model. He ascertains that there is three to four decades of research which has proven the effectiveness of cognitive-based therapies to a wide spectrum of psychological and psychotic conditions. In England the 'National Service Framework for Mental Health' has prioritised the application of CBT as the primary evidence-based non pharmacological intervention for mental illnesses (Gournay et al., 2000).

Vos, Haby, Magnus, Mihalopoulos, Andres and Carter (2005a) summarized cost-effectiveness results of a range of interventions for major mental disorders. They concluded that CBT is one of the cost-effective treatment options for mental disorders that is presently under utilized. Their results suggested that ample opportunities exist to improve efficiency of mental health services if resources are shifted towards more cost-effective interventions. Their research highlighted a substantial amount of under treatment, especially related to depression and anxiety disorders, which would require considerable additional resources but which would lead to significant improvements in health outcomes. The two main issues they raised with regard to optimal utilization of CBT related to the feasibility of funding mechanisms and the required training of staff.

According to English researchers, Crawford, Brown, Anthony and Hicks (2002), there is a paucity of research addressing evidence-based practice from the viewpoint of CMHN's. In order to address this they conducted a qualitative research study using semi-structured interviews and focus groups to ascertain what evidence based practice means to CMHN's. These two methods of data collection provide a form of methodological triangulation which enhances the study's validity (Polit & Hungler, 1995). The researchers, in this study, recognize the difficulty in applying formal models of evidence based practice to psychological interventions given that delivery of these interventions will vary in clinically significant ways.

In 2000, an Australian mental health nurse researcher (O'Brien), constructed an interpretation of the experience of the nurse-client relationship in the context of community mental health nursing. She identified the 'need for community psychiatric nurses to explicate their knowledge of the purposes, development and maintenance of relationships with clients with long-term mental illness in order to develop a research-based practice that clearly articulates its value to the care of these clients' (p. 184).

O'Brien's study clearly identified the '... complexity of nursing care for clients with serious mental illness...' (p. 191) and concluded that the education of mental health nurses needs to be such so as to provide them with the required skills and knowledge. 'The role of mental health nursing involves a responsiveness to the needs of service users, which should include the active promotion of ideologies that advocate partnership and empowerment' (Crowe, 1997, p. 64).

The Role of Community Mental Health Nurses in CBT Delivery

The relationship that is established between a CMHN and a mental health client is a significant factor in that client's overall mental and physical wellbeing (Crowe, O'Malley & Gordon, 2001). In this joint New Zealand research project between mental health nurses and consumers of mental health care the issue of continuity of care was identified as being of particular importance. The consumers saw that this influenced the quality of their relationship with the CMHN and it was this relationship that was fundamental to their mental wellbeing (Crowe, O'Malley & Gordon, 2001).

English researchers (Brooker et al., 1994) designed a quantitative study that used a prospective quasi-experimental design which was used to evaluate the effectiveness of training CMHN's to undertake psychosocial interventions, of which CBT was one. They identified a number of skills that CMHN's require in order for them to work effectively with seriously mentally disordered clients and one such skill was that of CBT. The objective of the study was then to evaluate whether the use of CBT by the CMHN's improved the quality of life of clients and their carers. The CMHN's, by using cognitive behavioural strategies, were taught to help clients and their carers develop 'coping mechanisms'. The results identified that the improvements in social functioning of the clients were clearly related to the intervention provided, with no improvement noted in the control group. As well as evidence of the benefit of CBT to the mental health clients it was also noted that there was a significant reduction in the psychopathology of the carers, particularly of their depressive symptoms.

Another study, this time from Hong Kong, that offers evidence that the therapeutic skills of mental health nurses can be enhanced by the use of CBT, is that of Chan & Leung (2002). This research literature discusses the application of CBT in the treatment of clients with schizophrenia and the subsequent implications for mental health nursing practice. They claim that 'mental health nurses play a key role in the rehabilitation of clients, and an important role is to provide individual, group and family psychotherapy' (p. 218). They believe that because of their continual direct client contact mental health nurses are the ideal practitioners to deliver CBT. Chan & Leung (2002) go on to identify two challenges to mental health nurses interested in pursuing their role as cognitive behavioural therapists. Firstly, that they develop autonomy over their practice and secondly that they gain recognition, from other health care professionals, that they have the skills, knowledge and competence to practice CBT. They conclude that CBT can and should be aggressively intergrated into the role of a CMHN but full recognition is given to the required highly specialized training.

Margison et al. (2000) carried out a descriptive review of the development in measurement related to psychotherapy. Their background stance was that measurement is the foundation of evidence-based practice and that advances in measurement procedures should extend to psychotherapy practice. Their results indicated that modern methods of measurement can support 'evidence-based practice' for psychological treatment. The results also supported 'practice-based evidence' which they identified as a complementary paradigm to improve clinical effectiveness in routine practice. Their review of the literature shows that 'the therapeutic alliance' has emerged as the most consistent predictor of outcome across many studies within many different models of psychotherapy. The 'therapeutic alliance' is presented as having three components: the therapeutic bond, agreement about the task and agreement about the goals. Inherent in CBT is the nurse-client relationship/partnership and the emphasis on mutuality with regard to problem identification and formulation of treatment strategies.

Some Australian research (Hafner, Crago et al.) was published in 1996 which looked at introducing and evaluating a CBT training programme for CMHN's in their role as case managers. At the end of the six month training period the mental health nurses saw themselves as having basic skills and knowledge as cognitive behavioural therapists and arrangements were made for them to access clinical psychologists for further ongoing supervision and support. The research findings detail the initial major reservations that the

clinical psychologists had with regard to 'nurses' being trained in CBT. Their perception was that CBT required a level of skill and knowledge that could not be acquired within a six month time-frame. They also expressed that CBT was part of their 'professional turf,' for which most of them had received extensive training. The community mental health case managers in this study expressed surprise at how many of their clients, not receiving any specific psychological treatment, benefited from the CBT. The need for this psychological intervention was present in greater numbers than they had expected. This study provides evidence that mental health case managers can be trained to deliver basic but effective CBT while carrying out their usual duties. The study concludes by saying that training more CMHN's in CBT would improve the quality of community mental health treatment and would have a secondary benefit of enhancing staff morale. It was also recognized that successful treatment of a greater proportion of clients would reduce clinical case loads.

Factors Influencing Delivery of CBT

Crowe (1997) states in her 'Analysis of the Sociopolitical Context of Mental Health Nursing Practice' that it is becoming increasingly difficult for mental health nurses to care for their clients in a collaborative and empowering way within the New Zealand publicly funded mental health service. She states that 'the principle of entering into partnership and collaboration with service users is central to providing meaningful mental health nursing' (p. 630). The requirement for mental health nurses to develop and foster therapeutic relationships with their clients is near impossible, according to Crowe, if the nurses themselves are feeling unsupported and undervalued. Crowe (1997) recognizes that when a public health care system devalues partnership, co-operation and clinical expertise and when the nurse has never experienced 'being cared for' this most certainly is going to affect the quality of the nurse-client relationship.

Over the years there have been many advances in the development of psychosocial treatments for severe mental illness. Yet, as questioned by Tarrier, Barrowclough et al. (1999), why has the everyday implementation of these treatments been sporadic? They ask what is necessary in order for these research-validated treatments to become instilled within clinical practice so that clients can receive benefit from them? The Clinical Training Agency (CTA), through the New Zealand Ministry of Health, is enabling many mental health nurses to become skilled in CBT. But, there is an absence of New Zealand research around what happens when these mental health nurses complete their CBT training and return to the mental health clinical arena. What are the factors that promote and limit the use of these newly acquired skills? No New Zealand research was able to be sourced around the enablers and barriers to dissemination of cognitive behavioural strategies and techniques within our community mental health services. Although a reasonable amount of international literature was available especially around identification of barriers that hinder/impede the transfer of CBT from the classroom to the clinical area. Tarrier, Barrowclough et al. (1999) identifies reasons why dissemination of the evidence-based practice of CBT, in England, has not progressed. Reasons cited include; absence of appropriate knowledge and/or clinical skills; characteristics of the organization or workplace which constrain new developments/practices and maybe the realization that new clinical techniques are more difficult to learn and implement than initially realized.

Kavanagh et al. (1993) in their research looking at the application of cognitive behavioural strategies and techniques with family members of clients with schizophrenia found significant problems in the dissemination of the cognitive behavioural approach to the multidisciplinary setting. The most commonly reported difficulty in disseminating the CBT was the existence of time constraints due to client caseload. Other barriers included: a limited perceived demand for the intervention; resistance from administration or other staff and difficulties in engaging families.

An Australian study (Donoghue et al., 2004) involved development of a training programme in CBT for mental health case managers, of which 61% of them were nurses. Qualitative evaluation at completion of the ten module programme revealed that the participants felt more comfortable with CBT but that none of them felt fully competent to use the skills without ongoing support and supervision. Limited opportunities to practice and fine-tuning of the skills taught were highlighted as a problem in the development of confidence and competence. The participants in the study expressed difficulty in translating the skills learnt into their own clinical practice as many of their allocated clients had severe and enduring mental illnesses. It was felt that maybe the training should be presented as a 'staged process' in which initially they are taught basic CBT skills appropriate for mild-moderate uncomplicated mental illnesses and then once these 'basic/fundamental' skills are mastered adapting them to work with clients with more complex and/or co-morbid presentations (Donoghue et al., 2004).

A survey instrument tool was developed which looked specifically at 42 mental health professionals conducting individual psychotherapy with clients who have a diagnosis of schizophrenia within the American public mental health system (Zahniser, Coursey & Hershberger, 1991). The questionnaire that was developed focused on the types of interventions used and the issues and problems encountered in therapy. The study identified a number of factors that made delivery of individual psychotherapy a difficult challenge for these therapists and these included: fragmentation of the mental health service; lack of resources – both financial and other; service expectations that very specific therapeutic goals must be met; the multiple and often immediate needs of the serious mentally ill client and the inadequate funding of continuing education and professional development for the staff.

The Cultural Implications of CBT Delivery

The majority of research sourced that related to CBT had been conducted in the United Kingdom and America with Caucasian populations and there were very few studies related to the application of CBT with various different ethnic groups. Chang & Leung (2002) in their research on the use of CBT with Chinese clients, who have a diagnosis of schizophrenia, stated that ‘The Chinese experience and ways of expressing emotion in general should not be assumed to be the same as those of western populations’ (p. 221). This applies to all ethnic groups and when integrating CBT into mental health community services consideration must be taken of individual client’s cultural values and beliefs (Chan & Leung, 2002).

In Turkington, Kingdon & Turner’s (2002) pragmatic randomized trial, research participants were allocated to a ‘brief CBT intervention’ against ‘treatment as usual’. The findings highlighted very high engagement rates with the CBT group and a drop-out rate in the ‘treatment as usual’ group which was almost twice that in the CBT intervention group. The authors believed the impact of ethnicity on drop out probably related to problems in engagement and in developing explanations in clients from different cultural backgrounds. Turkington, Kingdon & Turner (2002) went on to suggest there was a need for psycho-educational materials to be available in various different languages and advocated that ethnicity awareness issues need to be made more widely available for community mental health professionals who deliver CBT.

So what are the present day cultural implications regarding the use of CBT with Maori in New Zealand? Garry McFarlane-Nathan, a Maori psychologist who works largely with the Department of Corrections in Auckland, says that CBT can be useful for Maori if the therapist can deliver the skills and strategies of the model within a context that enables the development of empowered Maori (2000). He challenges non-Maori cognitive behavioural therapists to develop a working knowledge of the life context and aspirations for New Zealand Maori and for these therapists to identify how they as cognitive behavioural practitioners can constructively apply their skills to enhance Maori development. McFarlane-Nathan (2000) asks for an increased awareness of the barriers inherent within mainstream organizational culture and recognition from managers, therapists and Maori that these can and do reduce efficacy in research, and both access by and service deliver to, Maori. There is one specific point of contention that McFarlane-Nathan (2000) identifies between CBT and the Maori client. This is that of individual focus versus whakawhangananga. That is, the Pakeha ideal of being able to stand alone and independent is actually an unhealthy position from a Maori perspective (Durie, 1994). It is paramount, because of this, that whanau are involved in the delivery of CBT to Maori clients. McFarlane-Nathan refers to this as bringing the client’s ‘sociocentric’ system on board, to clarify, to develop, to support and to be supported by the client and the therapist (2000). He concludes by saying that use of CBT can enhance Maori clients access to Tikanga Maori and Iwi support networks by assisting in the identification and reduction of the impact of dysfunctional beliefs and behaviours that have derived from the colonization process.

The Treaty of Waitangi is regarded as New Zealand’s founding constitutional document and forms the basis for development of economic, health and social policy (Durie, 1994). What gives CBT scope for cross-cultural work is its insistence on developing a collaborative relationship with the client and its practical approach to finding out ‘what went wrong’ and ‘how we can fix it up’ using client generated, rather than, therapist generated beliefs and values (McFarlane-Nathan, 2000). The primary assessment tool of CBT lends itself well to a partnership approach where the client defines the problem and then its history, frequency, intensity and development can be sought out and explained by both client and therapist. CBT is client-friendly and usually there is no difficulty in explaining its practical and common-sense theory to clients. From here the client knows ‘where the therapist is coming from’ and enters the therapy process from an informed stance (McFarlane-Nathan, 2000).

Implications for New Zealand Nursing Education, Practice and Research

Nursing Education

The New Zealand Ministry of Health continues to value CBT as an effective therapeutic modality for use in publicly funded mental health settings (H. Forsythe, personal communication, May 2002) and as a result of this continues to fund CBT training for mental health professionals through the CTA. Although the majority of the CBT research literature available has been conducted in America and in the United Kingdom there is some New Zealand research around the use of CBT with specific client groups (Secker, Kazantzis & Pachana, 2004; Johnson & Kazantzis, 2004).

We know CBT is evidenced-based and therapeutically effective. We know that as a country New Zealand funds mental health professionals to access training in CBT. But where is the research into the effectiveness or non-effectiveness of this training? Where does the standard of our training sit in comparison with training programmes overseas?

What is the experience of our CBT trainees? Does our CBT training programme equip our mental health nurses to deliver effective CBT to their clients? There is an absence of New Zealand literature around the impact of CBT training on mental health nursing practice. Questions to be asked include: What is the experience of New Zealand mental health nurses once they complete the CTA funded CBT training? Does the training they receive prepare them appropriately for the use of CBT in our public mental health service which provides care and treatment to three per cent of the population who experience serious and enduring mental illness?

Nursing Practice & Research

There is a great need for research on New Zealand nurses use of CBT in any clinical area. This research needs to occur so as to enrich the body of nursing knowledge in relation to the application of CBT within the New Zealand context. Other potential research areas include investigation and review of the use of CBT by Kaupapa Maori Mental Health Services and the use of CBT with individual clients in the context of a mental health service. Given that mental health nurses largely practice within multidisciplinary teams (MDT) research into the effective delivery of CBT by nurses and other mental health professionals within the same team need to be explored. Do different mental health disciplines experience and deliver CBT in similar ways or does the 'culture' of their discipline/professional group dictate different delivery styles? There is ample opportunity for local nursing research to be conducted so as to enrich the body of New Zealand nursing knowledge related to the implementation of CBT. The majority of research relating to CBT has been conducted overseas with Caucasian populations. There are only a few studies available that relate to the application of CBT with other ethnic groups. What is the experience of Maori mental health nurses delivery of CBT? What is the experience of Maori and Pacific Island clients receiving CBT? What are the cultural issues that need to be taken into account when delivering CBT to a multi-cultural population? Culturally sensitive research needs to be conducted to assess the use of and outcome of CBT within the New Zealand environment. As well as the cultural implications around CBT another major area requiring New Zealand research is how, in the New Zealand mental health service, do we measure the effectiveness of CBT? Overseas both quantitative and qualitative methodologies have been utilized – what are the implications for the use of either of these methods in the New Zealand context?

Given that in New Zealand, 40-50% of mental health professionals trained each year in CBT are nurses (Clinical Training Agency, 2005), there is an urgent need for New Zealand research that will provide knowledge and understanding around how CBT training actually transfers into the New Zealand mental health clinical setting. An appropriate place to start with this research would be: 'Mental Health Nurses Delivery of CBT within Community Mental Health Teams – what is the New Zealand experience?'

Conclusion

There is an increasing wealth of evidence-based interventions for clients with severe and enduring mental illnesses. The role of a cognitive behavioural approach, which emphasizes problem-orientated interventions, has a great deal to offer mental health nursing (Sullivan & Rogers, 1997). We have seen in this literature review the importance of the 'therapeutic relationship' within the clinical practice of mental health nursing. We have heard the evidence citing CBT as clinically effective and we have recognized CBT as a collaborative and empowering process in which the client is an active participant. The role of the Community

Mental Health Nurse with regard to CBT delivery has been explored and the current 'state of play' regarding CBT training and education within New Zealand has been presented.

For a treatment modality to progress from theory to practice it must be seen as clinically relevant, it must be empirically validated, it must meet prioritized needs and must be taught in a way that is accessible to staff in order for them to acquire the required knowledge and skills (Lieberman & Eckman, 1989). CBT, as a treatment modality, meets all those requirements. Research has given us evidence that CBT is efficacious. We, as a country, have a process by which CBT training and education can be and is disseminated into clinical practice. What remains are the questions around whether our mental health services, are configured or can be configured, to accommodate and facilitate Community Mental Health Nurses delivery of CBT as a treatment modality within our public mental health service.

If time and money is invested in training programmes how can we assure that a skilled workforce implements these skills to the benefit of the patient and their carer and that these skills do not fall into disuse or that organizational factors conspire against their use? (Tarrier et al, 1999, p. 576).

It is the answer to this question that currently needs to take priority within the context of New Zealand mental health nursing research and CBT training and delivery.

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