

THE COMMUNITY PSYCHIATRIC NURSE IN SINGAPORE

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ABSTRACT

The Community Psychiatric Nursing Service in Singapore began on 1st November 1988 in recognition of the need for continuous supervision of a group of psychiatric patients following discharge from hospital. The Community Psychiatric Nurse is able to provide mental health nursing care in a community setting. Her multiple roles are described. The various problems encountered and how she tackles them are discussed. The challenges posed and the future prospects are briefly addressed.

Keywords: community psychiatric nurse, community-based treatment, care-giver, community care

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Development of the CPN in United Kingdom

The genesis of the Community Psychiatric Nurse (CPN) in the United Kingdom would not have come about without the advances made in psychiatric therapy, namely anti-psychotic and anti-depressant medication. Mental hospitals changed from being custodial to becoming therapeutic. Wards were 'unlocked', and patients were increasingly discharged home.

The first 'outpatient nurses' in Britain were appointed in 1954 at Warlingham Park Hospital, Surrey. They supervised outpatients by visiting them, attended groups and provided support.

The role of this nurse working with psychiatric patients in the community became extended with time, and evolved into a specific community psychiatric nursing service.

History of the CPN service in Singapore

The Community Psychiatric Nursing Service at Woodbridge Hospital was organised in recognition of the need for continuous supervision of a group of psychiatric patients following discharge from hospital.

Community Psychiatric Nursing in Singapore began as a six-month pilot project on 1st November 1988. It started with two full-time community psychiatric nurses. They were supported by psychiatrists, a psychologist and a medical social worker who gave valuable input at assessment meetings. Two nursing officers who had done the English National Board Course in Community Psychiatric Nursing in the United Kingdom acted as resource personnel.

At the end of the pilot study, feedback derived from a questionnaire distributed to patients and their families was favourable. They found the service useful and beneficial.

With that, the expansion of the CPN service began. Additional nurses were trained and nurses were sent on Health Manpower

Development Programme scholarships to Australia and United Kingdom. To date we have 6 full-time CPNs and 2 part-time CPNs.

The functions of the CPN service

The CPN service has its operational base at the

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Each CPN covers a defined geographical sector of Singapore under the supervision of a nursing officer:

Central sector – 1 full-time CPN and 1 part-time CPN
Northern & Southern sector – 1 full-time CPN
Eastern sector – 2 full-time CPNs
Western sector – 2 full-time CPNs and 1 part-time CPN

Referrals

The referrals are initiated by the various members of the multi-disciplinary team from the Institute of Mental Health, the psychiatric outpatient clinics and the wards of Woodbridge Hospital. Presently the CPN Service does not accept referrals directly from private psychiatrists or general practitioners.

The intake and review meetings are conducted on every Tuesday morning with the two CPN team psychiatrists. The purposes of this meeting are to

- a) discuss new referrals,
- b) discuss cases with management problems and discharges, and
- c) support each other, exchange information, ideas and experiences.

At the meeting the case can either be accepted or rejected for CPN intervention. If the referral is made and accepted at the intake meeting, the CPN concerned will visit the patient in the ward. This enables the CPN to establish rapport and the CPN can begin to formulate a pattern of care for the patient.

Urgent referrals (defined as those requiring intervention in less than 48 hours) are taken up by the CPN nursing officer and the team psychiatrist and details are discussed with the CPN concerned at the earliest opportunity.

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Roles of the community psychiatric nurse

Our CPNs are State Registered Nurses with post-basic training in psychiatric nursing and in addition each has more than fifteen years' experience in psychiatric nursing.

He/She is able to function autonomously as well as work as a member of the multi-disciplinary team to provide mental health nursing care in a community setting.

The CPN is able to carry out the 6 generally accepted roles of the CPN as first outlined by Barker (1977)⁽¹⁾ and subsequently expanded on by Carr et al (1980)⁽²⁾:

1. *Nurse Assessor* – to assess the psychiatric nursing requirements of the patient, psychological and social needs, deliver that care and assess its effectiveness.
2. *Nurse Clinician* – to be involved in clinical practice, for example administration of depot injections and monitoring its effectiveness and side-effects.
3. *Nurse Educator* – teaching patients and care-givers about the potential hazards of mental illness, preventive mental health measures and being involved in the education of other mental health professionals seeking to gain experience in working in the community.
4. *Nurse Consultant* – providing a service to the mentally ill in the community as well as acting in an advisory/liaison role to other mental health professionals within a community setting. They may use the CPN as a resource person in seeking advice on a patient.
5. *Nurse Manager* – each CPN manages her own caseload of patients.
6. *Nurse Therapist* – providing behaviour therapy and social skills training, not in isolation but in conjunction with the psychiatrist and the psychologist.

The Caseload of the CPN

A full-time CPN is able to manage an active caseload of 50 to 60 patients at any one time. The CPN makes active contact by making home visits. He/She encourages the patient to attend the psychiatric outpatient clinic, day centre or day treatment centre. The CPN also maintains phone contact in the evening with those patients or care-givers who are out working in the day.

If the CPN has reached her maximum caseload, this is brought up at the review meeting and the possibility of discharging a stabilised patient from the caseload or putting a new referral on the waiting list is discussed.

Discharge of CPN patients

The CPN provides a time-limited service whereby patients are followed up for a period of between six months to one year.

The patients and their care-givers are psychologically prepared prior to discharge by the CPN. Care-givers and patients are advised to continue follow-up at their respective psychiatric outpatient clinics. The care-giver and patient are given the CPN service telephone number and reassured that the services of the CPN is available should the need arise in the future.

We have seen a number of re-referrals of patients in an early stage of relapse requested by the care-giver. This has enabled the patients to be stabilised without the need for hospitalisation.

Patients are also discharged when they are found unsuitable for CPN intervention under the following circumstances:

- a) mental state requiring long-term institutional care,

- b) aggressive and potentially violent towards the CPN.

Problems encountered by the CPN

The CPN finds it difficult to help the following groups of patients:

- a) uncooperative patient or care-giver who refuses treatment or the services of the CPN, usually when the patient is in remission following treatment of an acute episode;
- b) patient with a wandering tendency, which makes it difficult to meet up with him.

The CPN is able to make a limited number of home visits each day because she travels on public transport and the homes may be widely separated within her geographical sector. However the CPN may take a taxi to attend to an urgent case.

The CPN faces the risk of physical assault in the patient's home. This is minimised by the following measures:

- a) being alerted by documented past history of assaultive behaviour and the present history given by the care-giver,
- b) home visit made jointly by two CPNs,
- c) avoid entering the house if the patient is alone or he remains aggressive in spite of attempts to calm him down,
- d) if the assessment is that the patient cannot be treated as an out-patient, the consent of the care-giver is sought to seek police help to get the patient admitted.

Prospects of the CPN

Community Psychiatric Nursing developed as a result of the shift from the traditional predominance of hospital-based treatment in a large mental hospital for major psychiatric disorders to a growing emphasis on community-based treatment.

Two trends can be envisaged. One is the expansion of mental healthcare to treat less severe psychiatric disorders such as anxiety disorders in the community. This may lead to greater involvement of the CPN in the role of a nurse therapist using behaviour therapy or social skills training. Such a CPN may be fully based in a psychiatric outpatient clinic or psychological medicine unit in a general hospital.

This approach was taken to an extreme in the United States where a new system of Community Mental Health Centers (CMHC), separate from the original hospital-based system, was set up in the 1960s. Its underlying philosophy was based on an enthusiasm for crisis intervention and the possibility of primary prevention of psychiatric disorders⁽³⁾.

Subsequently it was found that the chronically mentally ill who were discharged from the mental hospitals during the era of deinstitutionalisation were not given adequate care by the Community Mental Health Centers. This imbalance was addressed in the 1980s.

The second trend is the growing awareness of the unmet rehabilitation needs of the chronically mentally ill in the community after the treatment of the acute psychotic episode and the heavy burden that is being borne by the care-giver.

The emphasis of community care should be on enabling patients to live in their own homes at an optimal functioning level, providing support to care-givers, providing proper assessment of needs and good case management and linking patients to various helping agencies.

This challenge cannot be met by the Community Psychiatric Nurse alone. The need for greater involvement and input from the psychiatrist, psychiatric social worker and psychologist had been felt in a significant number of patients cared for by the CPN.

Careful planning, implementation, evaluation and research into the effectiveness of the CPN service is needed to chart the path ahead. This is especially important in view of the many

competing demands made on the limited number of trained manpower. The problems encountered in the United States, United Kingdom and Italy show that there are no ideal solutions and each country has to develop a mental health service that is suited to its own socio-cultural characteristics.

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