AMERICAN NURSES ASSOCIATION

American Psychiatric Nurses Association

ISPN

Scope AND Standards OF PRACTICE

Psychiatric-Mental Health Nursing

2ND EDITION

NURSING STANDARDS

NURSING STANDARDS

ANA Standards of Psychiatric–Mental Health Nursing Practice

The Standards of Practice for Psychiatric–Mental Health Nursing describe a competent level of nursing care as demonstrated by the critical thinking model known as the nursing process. The nursing process includes the components of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. Accordingly, the nursing process encompasses significant actions taken by psychiatric–mental health (PMH) registered nurses and forms the foundation of the nurse's decision-making.

American Psychiatric Nurses Association

http://www.apna.org/

Visionary Leadership for Psychiatric-Mental Health Nurses Around the World

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ANA

AMERICAN NURSES ASSOCIATION

http://www.Nursingworld.org

Standards of Practice for Psychiatric–Mental Health Nursing

Standard 1. Assessment
The PMH registered nurse collects and synthesizes comprehensive health data that are pertinent to the healthcare consumer's health and/or situation.

Standard 2. Diagnosis
The PMH registered nurse analyzes the assessment data to determine diagnoses, problems, and areas of focus for care and treatment, including level of risk.

Standard 3. Outcomes Identification
The PMH registered nurse identifies expected outcomes and the healthcare consumer's goals for a plan individualized to the healthcare consumer or to the situation.

Standard 4. Planning
The PMH registered nurse develops a plan that prescribes strategies and alternatives to assist the healthcare consumer in attainment of expected outcomes.

Standard 5. Implementation
The PMH registered nurse implements the specified plan.

Standard 5A. Coordination of Care
The PMH registered nurse coordinates care delivery.

Standard 5B. Health Teaching and Health Promotion
The PMH registered nurse employs strategies to promote health and a safe environment.

Standard 5C. Consultation
The PMH advanced practice registered nurse provides consultation to influence the identified plan, enhance the abilities of other clinicians to provide services for healthcare consumers, and effect change.

Standard 5D. Prescriptive Authority and Treatment
The PMH advanced practice registered nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

Standard 5E. Pharmacological, Biological, and Integrative Therapies
The PMH advanced practice registered nurse incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore the healthcare consumer's health and prevent further disability.

Standard 5F. Milieu Therapy
The PMH advanced practice registered nurse provides, structures, and maintains a safe, therapeutic, recovery-oriented environment in collaboration with healthcare consumers, families, and other healthcare clinicians.

Standard 5G. Therapeutic Relationship and Counseling
The PMH registered nurse uses the therapeutic relationship and counseling interventions to assist healthcare consumers in their individual recovery journeys by improving and regaining their previous coping abilities, fostering mental health, and preventing mental disorder and disability.

Standard 5H. Psychotherapy
The PMH advanced practice registered nurse conducts individual, couples, group, and family psychotherapy using evidence-based psychotherapeutic frameworks and the nurse–client therapeutic relationship.

Standard 6. Evaluation
The PMH registered nurse evaluates progress toward attainment of expected outcomes.

SOURCE: American Nurses Association, American Psychiatric Nurses Association & International Society of Psychiatric–Mental Health Nurses (2013). *Psychiatric–Mental Health Nursing: Scope and Standards of Practice, 2nd Edition*. Silver Spring, MD: Nursesbooks.org.

AMERICAN NURSES ASSOCIATION

American Psychiatric Nurses Association

Scope AND Standards OF PRACTICE

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The American Psychiatric Nurses Association (APNA), the International Society of Psychiatric-Mental Health Nurses (ISPN), and the American Nurses Association (ANA) are national professional associations. This joint publication, *Psychiatric Mental Health Nursing: Scope and Standards of Practice, 2nd Edition*, reflects the thinking of the practice specialty of psychiatric-mental health nursing on various issues and should be reviewed in conjunction with state board of nursing policies and practices. State law, rules, and regulations govern the practice of nursing, while *Psychiatric Mental Health Nursing: Scope and Standards of Practice, 2nd Edition* guides psychiatric-mental health nurses in the application of their professional skills and responsibilities.

The American Psychiatric Nurses Association (APNA) is your resource for psychiatric-mental health nursing. A professional organization with more than 9,000 members, we are committed to the practice of psychiatric mental health (PMH) nursing, health and wellness promotion through identification of mental health issues, prevention of mental health problems and the care and treatment of persons with psychiatric disorders. To facilitate professional advancement, APNA provides quality psychiatric-mental health nursing continuing education; a wealth of resources for established, emerging, and prospective PMH nurses; and a community of dynamic collaboration. APNA champions psychiatric-mental health nursing and advocates for mental health care through the development of positions on key issues, the widespread dissemination of current knowledge and developments in PMH nursing, and collaboration with consumer groups, to promote evidence-based advances in recovery-focused assessment, diagnosis, treatment, and evaluation of persons with mental illness and substance use disorders. For more information: www.apna.org.

The International Society of Psychiatric-Mental Health Nurses exists to unite and strengthen the presence and the voice of specialty psychiatric-mental health nursing while influencing healthcare policy to promote equitable, evidence-based and effective treatment and care for individuals, families, and communities. http://www.ispn-psych.org

The American Nurses Association is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent/state nurses associations and its organizational affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on healthcare issues affecting nurses and the public.

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About the American Psychiatric Nurses Association

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About Nursesbooks.org, The Publishing Program of ANA

Nursesbooks.org publishes books on ANA core issues and programs, including ethics, leadership, quality, specialty practice, advanced practice, and the profession's enduring legacy. Best known for the foundational documents of the profession on nursing ethics, scope and standards of practice, and social policy, Nursesbooks.org is the publisher for the professional, career-oriented nurse, reaching and serving nurse educators, administrators, managers, and researchers as well as staff nurses in the course of their professional development.

Preface

In 2011, the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric-Mental Health Nurses (ISPN) appointed a joint task force to begin the review and revision of *Psychiatric-Mental Health Nursing: Scope and Standards of Practice*, published in 2007 by the American Nurses Association (ANA, 2007). The taskforce members were comprised of psychiatric-mental health nursing clinical administrators, staff nurses, nursing faculty, and psychiatric advanced practice registered nurses working in psychiatric facilities and the community. This taskforce convened in July 2011 to conduct an analysis of the existing document and begin crafting sections incorporating the results of the analysis.

In accordance with ANA recommendations, this document reflects the template language of the most recent publication of ANA nursing standards, *Nursing: Scope and Standards of Practice*, *Second Edition* (ANA, 2010). In addition, the introduction has been revised to highlight the leadership role of psychiatric-mental health nurses in the transformation of the mental health system as outlined in *Achieving the Promise*, the President's New Freedom Commission Report on Mental Health (United States Department of Health and Human Services, 2003) and the Institute of Medicine's Report (IOM) *The Future of Nursing* (2010). The prevalence of mental health issues and psychiatric disorders across the age span, and the disparities in access to care and treatment among diverse groups attest to the critical role that psychiatric-mental health (PMH) nursing must continue to play in meeting the goals for a healthy society. Safety issues for persons with psychiatric disorders and the nurses involved in the recovery processes of persons with mental disorders are major priorities for PMH nursing in an environment of fiscal constraints and disparities in reimbursement for mental health services.

Development of this edition of *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* included a two-stage field review process: 1) review and feedback from the boards of the American Psychiatric Nurses Association and the International Society of Psychiatric-Mental Health Nursing and 2) posting of the draft for public comment at www.ISPN-psych.org with links from the ANA website, www.nursingworld.org, and the APNA website, www.apna.org. Notice of the public comment period was distributed to nursing specialty organizations, state boards of nursing, nursing schools, faculty groups,

and state nurses associations. All groups were encouraged to disseminate notice of the postings to all of their members and other stakeholders. The feedback was carefully reviewed and integrated when appropriate.

Scope of Practice of Psychiatric-Mental Health Nursing

Psychiatric-mental health nursing is the nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the lifespan. Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes.

Introduction

By developing and articulating the scope and standards of professional nursing practice, the nursing profession both defines its boundaries and informs society about the parameters of nursing practice. The scope and standards also guide the development of state level nurse practice acts and the rules and regulations governing nursing practice.

Because each state develops its own regulatory language about nursing, the designated limits, functions, and titles for nurses, particularly at the advanced practice level, may differ significantly from state to state. Nurses must ensure that their practice remains within the boundaries defined by their state practice acts. Individual nurses are accountable for ensuring that they practice within the limits of their own competence, professional code of ethics, and professional practice standards.

Levels of nursing practice are differentiated according to the nurse's educational preparation. The nurse's role, position, job description, and work setting further define practice. The nurse's role may be focused on clinical practice, administration, education, or research.

This document addresses the role, scope of practice, and standards of practice specific to psychiatric-mental health nursing. The scope statement defines psychiatric-mental health nursing and describes its evolution in nursing, the

levels of practice based on educational preparation, current clinical practice activities and sites, and current trends and issues relevant to the practice of psychiatric-mental health nursing. The standards of psychiatric-mental health nursing practice are authoritative statements that describe the responsibilities for which its practitioners are accountable.

History and Evolution of Psychiatric-Mental Health Nursing

Psychiatric-mental health nursing began with late 19th century reform movements to change the focus of mental asylums from restrictive and custodial care to medical and social treatment for the mentally ill. The "first formally organized training school within a hospital for insane in the world" was established by Dr. Edward Cowles at McLean Asylum in Massachusetts in 1882 (Church, 1985). The use of trained nurses, rather than "keepers," was central to Cowles' effort to replace the public perception of "insanity" as deviance or infirmity with a belief that mental disorders could be ameliorated or cured with proper treatment. The McLean nurse training school was the first in the United States to allow men the opportunity to become trained nurses (Boyd, 1998). Eventually, asylum nursing programs established affiliations with general hospitals so that general nursing training could be provided to their students.

Early on, training for psychiatric nurses was provided by physicians. The first nurse-organized training course for psychiatric nursing within a general nursing education program was established by Effie Jane Taylor at Johns Hopkins Hospital in 1913 (Boyd, 1998). This course served as a prototype for other nursing education programs. Taylor's colleague Harriet Bailey published the first psychiatric nursing textbook, *Nursing Mental Disease*, in 1920 (Boling, 2003). Under nursing leadership, psychiatric-mental health nursing developed a biopsychosocial approach with specific nursing methods for individuals with mental disorders. The PMH nurse also began to identify the didactic and clinical components of training needed to care for persons with mental disorders. In the post-WWI era, "nursing in nervous and mental diseases" was added to curriculum guides developed by the National League for Nursing Education and was eventually required in all educational programs for registered nurses (Church, 1985).

The next wave of mental health reform and expansion in psychiatric nursing began during World War II. The public health significance of mental disorders became widely apparent when a significant proportion of potential military

recruits were deemed unfit for service as a result of psychiatric disability. In addition, public attention and sympathy for the large number of veterans with combat-related neuropsychiatric casualties led to increased support for improving mental health services. As a psychiatric nurse consultant to the American Psychiatric Association, Laura Fitzsimmons evaluated educational programs for psychiatric nurses and recommended standards of training. These recommendations were supported by professional organizations and backed with federal funding to strengthen educational preparation and standards of care for psychiatric nursing (Silverstein, 2008).

The national focus on mental health, combined with admiration for the heroism shown by nurses during the war, led to the inclusion of psychiatric nursing as one of the core mental health disciplines named in the National Mental Health Act (NMHA) of 1946. This act greatly increased funding for psychiatric nursing education and training (Silverstein, 2008) and led to a growth in university-level nursing education. In 1954, Hildegard Peplau established the first graduate psychiatric nursing program at Rutgers University.

The post-war era was marked by growing professionalization in psychiatric-mental health nursing (PMH). Funding provided by the NMHA led to a rapid expansion of graduate programs and the start of psychiatric-mental health nursing research. In 1963, the first journals focused on psychiatric-mental health nursing were published. In 1973, the ANA first published the *Standards of Psychiatric-Mental Health Nursing Practice* and began certifying generalists in psychiatric-mental health nursing (Boling, 2003). Peplau's *Interpersonal Relations in Nursing* (1992), which emphasized the importance of the therapeutic relationship in helping individuals to make positive behavior changes, articulated the predominant psychiatric-mental health nursing approach of the period.

The process of deinstitutionalization began in the late 1950s when the majority of care for persons with psychiatric illness began to shift away from hospitals and toward community settings. Contributing factors included the establishment of Medicare and Medicaid, changing rules governing involuntary confinement, and the passage of legislation supporting construction of community mental health centers (Boling, 2003). Although psychiatric-mental health nurses prepared at the undergraduate level continued to work primarily in hospital-based and psychiatric acute care settings, many also began to practice in community-based programs such as day treatment and assertive community treatment.

Mental health care in the United States began another transformation in the 1990s, the "Decade of the Brain." The dramatic increase in the number of psychiatric medications on the market, combined with economic pressures to reduce hospital stays, resulted in briefer psychiatric hospitalizations characterized by use of medication to stabilize acute symptoms. Shorter hospital stays and higher patient acuity began to shift psychiatric nursing practice away from the emphasis on relationship-based care advocated by Peplau and toward interventions focused on stabilization and immediate safety. Psychiatric-mental health nursing education began to include more content on psychopharmacology and the pathophysiology of psychiatric disorders.

More recent trends in psychiatric-mental health nursing include an emphasis on integrated care and treatment of those persons with co-occurring psychiatric and substance use disorders, as well as integrated care and treatment of those with co-occurring medical and psychiatric disorders. Integrated care emphasizes that both types of disorders are primary and must be treated as such.

Since the Substance Abuse and Mental Health Services Administration (SAMHSA) has declared that recovery is the single most important goal in the transformation of mental health care in America (SAMHSA, 2006), psychiatric-mental health nursing is moving to integrate person-centered, recovery-oriented practice across the continuum of care. This continuum includes settings where psychiatric-mental health nurses have historically worked, such as hospitals, as well as emergency rooms, jails and prisons, and homeless outreach services. Psychiatric-mental health nursing is also tasked with developing and applying innovative approaches in caring for the large population of military personnel, veterans, and their families experiencing war-related mental health conditions as a result of military conflicts.

Major developments in the nursing profession have a corresponding effect within psychiatric-mental health nursing. The Institute of Medicine's (2010) report, *The Future of Nursing: Leading Change to Advance Health* has strengthened the role of psychiatric-mental health nurses as mental health policy and program development leaders in both national and international arenas. Nursing's emphasis on the use of research findings to develop and implement evidence-based practice is driving improvements in psychiatric-mental health nursing practice.

Origins of the Psychiatric-Mental Health Advanced Practice Nursing Role

Specialty nursing at the graduate level began to evolve in the late 1950s in response to the passage of the National Mental Health Act of 1946 and the creation of the National Institute of Mental Health in 1949. The National Mental Health Act of 1946 identified psychiatric nursing as one of four core disciplines for the provision of psychiatric care and treatment, along with psychiatry, psychology, and social work. Nurses played an active role in meeting the growing demand for psychiatric services that resulted from increasing awareness of post-war mental health issues (Bigbee & Amidi-Nouri, 2000). The prevalence of "battle fatigue" led to recognizing the need for more mental health professionals.

The first degree in psychiatric-mental health nursing, a master's degree, was conferred at Rutgers University in 1954 under the leadership of Hildegard Peplau. In contrast to existing graduate nursing programs that focused on developing educators and consultants, graduate education in psychiatric-mental health nursing was designed to prepare nurse therapists to assess and diagnose mental health problems and psychiatric disorders and provide individual, group, and family therapy. Psychiatric nurses pioneered the development of the advanced practice nursing role and led efforts to establish national certification through the American Nurses Association.

The Community Mental Health Centers Act of 1963 facilitated the expansion of psychiatric-mental health clinical nurse specialist (PMHCNS) practice into community and ambulatory care sites. PMHCNSs with master's and doctoral degrees fulfilled a crucial role in helping deinstitutionalized mentally ill persons adapt to community life. Traineeships to fund graduate education provided through the National Institute of Mental Health played a significant role in expanding the PMHCNS workforce. By the late 1960s, PMHCNSs provided individual, group, and family psychotherapy in a broad range of settings and obtained third-party reimbursement. PMHCNSs also functioned as educators, researchers, and managers, and worked in consultation-liaison positions or in the area of addictions. These roles continue today.

Another significant shift occurred as research renewed the emphasis on the neurobiologic basis of mental disorders, including substance use disorders. As more efficacious psychotropic medications with fewer side effects were developed, psychopharmacology assumed a more central role in psychiatric treatment. The role of the PMHCNS evolved to encompass the expanding biopsychosocial perspective, and the competencies required for practice

were kept congruent with emerging science. Many psychiatric-mental health graduate nursing programs added neurobiology, advanced health assessment, pharmacology, pathophysiology, and the diagnosis and medical management of psychiatric illness to their curricula. Similarly, preparation for prescriptive privileges became an integral part of advanced practice psychiatric-mental health nursing graduate programs (Kaas & Markley, 1998).

Other trends in mental health and the larger healthcare system also sparked significant changes in advanced practice psychiatric nursing. These trends included:

- A shift in National Institute of Mental Health (NIMH) funds from education to research, leading to a dramatic decline in enrollment in psychiatric nursing graduate programs (Taylor, 1999);
- An increased awareness of physical health problems in mentally ill persons living in community settings (Chafetz et al., 2005);
- A shift to primary care as a key point of entry for comprehensive health care, including psychiatric care; and
- The growth and public recognition of the nurse practitioner role in primary care settings.

In response to these challenges, psychiatric nursing graduate programs modified their curricula to include greater emphasis on comprehensive health assessment, referral, and management of common physical health problems, and a continued focus on educational preparation to meet the state criteria and professional competencies for prescriptive authority. The tremendous expansion in the use of "nurse practitioners" in primary care settings had made nurse practitioner (NP) synonymous with "advanced practice registered nurse" in some state nurse practice acts and for many in the general public. In response to conditions including public recognition of the role, market forces, and state regulations, psychiatric-mental health nursing began utilizing the Nurse Practitioner title and modifying graduate psychiatric nursing programs to conform to requirements for NP credentialing (Wheeler & Haber, 2004; Delaney et al., 1999). The Psychiatric-Mental Health Nurse Practitioner role was clearly delineated by the publication of the *Psychiatric-Mental Health Nurse Practitioner Competencies* (National Panel, 2003), the product of a panel with representation from a broad base of nursing organizations sponsored by the National Organization of Nurse Practitioner Faculty (NONPF).

Whether practicing under the title of clinical nurse specialist (CNS) or NP, Psychiatric-Mental Health Advanced Practice Registered Nurses share the same core competencies of clinical and professional practice. Although psychiatric-mental health nursing is moving toward a single national certification for new graduates of advanced practice programs, titled *Psychiatric-Mental Health Nurse Practitioner*, persons already credentialed as Psychiatric-Mental Health Clinical Nurse Specialists will continue to practice under this title (NCSBN Joint Dialogue Group Report, 2008).

Current Issues and Trends

Since the publication of the landmark report *Achieving the Promise: Transforming Mental Health Care in America* (DHHS, 2003), mental health professionals have been sensitized to the need for a recovery-oriented mental health system. Further, in 2010, SAMHSA approved awards to five national behavioral healthcare provider associations, including the American Psychiatric Nurses Association, to promote awareness, acceptance, and adoption of recovery-based practices in the delivery of mental health services. This theme of integrating recovery in practice has been echoed in *Leading Change*, SAMHSA's (2011) most recent statement on federal priorities in mental health. Here recovery is endorsed as the essential platform for treatment, along with seven other foci: prevention, health reform, health information technology (IT), data/quality and outcomes, trauma and justice, military families, and public awareness and support. These themes are echoed in important reports from the Centers for Disease Control and Prevention (CDC) and the Institute of Medicine, and have been endorsed by consumer groups.

The current mental health treatment landscape has also been shaped by multiple legislative and economic developments. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that has and is expected to continue to favorably affect the quality of care for individuals with mental and substance use disorders. The MHPAEA prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations for MH/SUD benefits than on medical/surgical coverage. Thus, this vulnerable and highly stigmatized population will have equivalent MH/SUD benefits to those that are provided for general medical treatment.

Another important development is the Patient Protection and Affordable Care Act (PPACA) that brought, among other transformational changes, the promise of expanded healthcare coverage and an assessment of the current system's capacity to address anticipated demand. In the midst of launching this landmark policy, the economic downturn reverberated through federal and state budgets, which created immediate impacts on mental health services and became a harbinger of a decade of fiscally conservative policies (National Alliance on Mental Illness, 2011). Another major focusing event was the publication of data on the medical comorbidities and decreased life expectancy of individuals with serious mental illness (McGuire et al., 2002). These data hastened the movement toward integrated behavioral/primary care with the Centers for Medicare and Medicaid Services (CMS) monies rapidly shifting to fund innovations in integrated care delivery.

The mental health initiatives of the PPACA and SAMHSA are also affected by the triple aim of the broader federal policy agenda: improving the experience of care, improving the health of populations, and reducing per capita costs of health care (Berwick, Nolan, & Whittington, 2008). This shift is accompanied by significant payment reform (most prominently the return of case based and capitation models) and a call for partnership with healthcare consumers (Onie, Farmer, & Behforouz, 2012). This federal focus is finding its way into mental health care, particularly via initiatives to move Medicare and Medicaid into a capitated system (Manderscheid, 2012). This shifting reimbursement structure reflects the realization that engineering a significant impact on the mental health of individuals demands building healthy communities that increase support, reduce disparities, and promote the resiliency of members. This 21st century mental healthcare system must be equally focused on prevention, quality, an integrated approach to health, and a paradigm shift that puts mental health care into the hands of the consumer.

PREVALENCE OF MENTAL DISORDERS ACROSS THE LIFESPAN: CRITICAL FACTS

Despite the promise of recovery, the prevalence of mental disorders continues to impose a significant burden on individuals, families, and society. According to 2008 SAMHSA data, during the preceding year, an estimated 9.8 million adults aged 18 and older in the United States had a serious mental disorder and 2 million youth aged 12 to 17 had a major depressive episode. More recent incidence data (CDC, 2011) indicate that 6.8% of U.S. adults had a diagnosable episode of depression during the 2 weeks before the survey was administered. In a multi-state survey spanning 2-year collection points, the reported rates of

lifetime depression were similar in 2006 (15.7%) and 2008 (16.1%). The prevalence of lifetime diagnosis of anxiety disorders was 11.3% in 2006 and 12.3% in 2008. Finally in 2007, the National Health Interview Survey data on lifetime diagnosis of bipolar disorder and schizophrenia indicated that 1.7% of participants had received a diagnosis of bipolar disorder, and 0.6% had received a diagnosis of schizophrenia (CDC, 2011).

Although the prevalence of mental disorders remains high, treatment rates are distressingly low. In 2010, fewer than 40% of the 45.9 million adults with mental disorders had received any mental health services. The figure only improved slightly for those individuals with serious mental illness (SMI). Approximately 60% of the 11.4 million adults with SMI in the prior year had received treatment (SAMHSA, 2012).

In 2006, increased mortality was found to be coupled with high prevalence of chronic medical conditions in individuals with mental health issues (Parks, Svendsen, Singer, & Forti, 2006). Further study indicated that, on average, people with SMI die 25 years earlier than those without these illnesses, and little of that increased mortality is attributable to direct effects of the SMI (Prince et al., 2007). These findings lent increased urgency to the call for integration of medical and mental health services (Manderscheid, 2010). In addition to premature mortality, Scott et al. (2009) found that comorbidity of chronic physical and mental disorders creates a synergistic impact on disability, thus supporting the need to give both mental and physical conditions equal priority in order to adequately manage comorbidity and reduce disability. These comorbidities significantly increase healthcare costs (Melek & Norris, 2008), with only a small fraction of those costs (16%) attributable to mental health services. Estimates show that 2.8 million citizens in the United States are dealing with problems related to substance use. This figure is expected to double in 2020, particularly in adults over 50, casting specific concerns for the older adult population (Han, Gfroerer, Colliver, & Penne, 2009).

SUBSTANCE ABUSE DISORDERS: PREVALENCE AND COMORBIDITIES

High rates of substance use disorders (SUD) and co-occurring serious mental disorders are also of great concern. The National Drug Use and Health survey estimates that 25.7% of adults with SMI had co-occurring dependence or abuse of either illicit drugs or alcohol (SAMHSH, 2009). This figure puts co-occurring substance use disorders among individuals with SMI at a rate nearly four times higher than SUD in the general population (SAMHSH, 2012). These individuals, particularly persons dealing with co-occurring SUD

and major depression or post-traumatic stress disorder (PTSD), demonstrate poorer life outcomes (Najt, Fusar-Poli, & Brambilla, 2011) such as increased disability and higher suicide rates.

CHILDREN AND OLDER ADULTS

Prevalence of psychiatric disorders in children is not as well documented as it is in the adult population. It is estimated that approximately 13% of children ages 8 to 15 had a diagnosable mental disorder within the previous year (Merikangas et al., 2010). The 12-month prevalence estimates for specific disorders of children range from a high of 8.6% for attention deficit/hyperactivity disorder to a low of 0.1% for eating disorders (Merikangas et al., 2010). Similarly, the prevalence estimate of any *Diagnostic and Statistical Manual, 4th Edition* (DSM-IV) disorder among adolescents is 40.3% at 12 months (79.5% of lifetime cases); the most common disorder among adolescents is anxiety, followed by behavior, mood, and substance use disorders (Kessler et al., 2012).

Approximately 10.8% of the older adult population had some form of mental distress in 2009, and half of nursing home residents carried a psychiatric diagnosis (SAMHSA, 2009). This prevalence does not include cognitive impairments and dementias like Alzheimer's disease, the most common of these impairments (New Freedom Commission on Mental Health, 2003). Considering that in 2030, 20% of United States residents will be 65 years or older (Vincent & Velkoff, 2010), the need for mental health services for this population will continue to increase (SAMHSA 2009, 2012).

DISPARITIES IN MENTAL HEALTH TREATMENT

Data from the U.S. Census Bureau (2004) demonstrate significant changes in the racial and ethnic composition of the U.S. population. Most significant is the steady increase in the Hispanic or Latino population, which rose to 12.6% in 2000 and will likely rise to 30.2% in 2050 (Shrestha & Heisler, 2011). Although rates of mental disorders in minority populations are estimated to be similar to those in the white population, minorities are less likely to receive mental health services for many reasons, including financial, affective, cognitive, and access barriers (Leong & Kalibatseva, 2012). Efforts to improve quality and access to mental health services for minority populations will need to include greater emphasis on expanding outreach to ethnic communities, developing cultural awareness and sensitivity among individual mental healthcare providers, and increasing cultural sensitivity in healthcare organizations.

Barriers to social inclusion, as well as barriers to accessible, effective, and coordinated treatment, contribute to health disparities within the entire

population (Institute of Medicine, 2005). Financial barriers include lack of parity in insurance coverage for psychiatric-mental health care and treatment, resulting in restrictions on the number and type of outpatient visits, limits on the number of covered inpatient days, and high co-pays for services. The payment changes anticipated by the PPACA, particularly the expansion of Medicaid to 133% of persons above the poverty level, are likely to bring more individuals into the mental health system. However, the probability of receiving actual treatment may be affected by barriers such as scarcity and maldistribution of mental health providers. Geographical barriers include lack of affordable, accessible public transportation in urban areas and lack of accessible clinical services in rural areas. Cultural issues, including lack of knowledge, fear of treatment, and stigma associated with mental disorder, also constitute barriers to seeking help for mental health problems. Though growing evidence shows the effectiveness of treatment for behavioral problems and psychiatric disorders, these disparities necessitate further efforts to improve access to mental health services.

OPPORTUNITIES TO PARTNER WITH CONSUMERS FOR RECOVERY AND WELLNESS

The growing demand for coordinated, cost-effective psychiatric-mental health nursing presents the opportunity to be creative in developing psychiatric-mental health registered nurse (PMH-RN) roles in care coordination, enhancing psychiatric-mental health advanced practice registered nurse (PMH-APRN) roles in integrated care, and developing service delivery models that align with what consumers want. The reimbursement shift away from fee for service and toward caring for populations creates incentives to develop non-traditional services that may have greater effectiveness in supporting the mental health of individuals and families and the construction of healthy communities.

The focus on recovery supports PMH traditions of relationship-based care where the focus is on the care and treatment of the person with the disorder, not the disorder itself. By using therapeutic interpersonal skills, PMH-RNs are able to assist persons with mental disorders in achieving their own individual recovery and wellness goals. Research specific to recovery-oriented PMH nursing practices is beginning to emerge. However, more of this research needs to be conducted in varied care and treatment settings and specific outcomes must be connected to recovery-oriented nursing interventions (McLoughlin & Fitzpatrick, 2008).

At the systems level, current developments offer opportunities for psychiatric-mental health nurses to connect to the broader nursing and

healthcare community to achieve a public health model of mental health care. In such a model, individuals would receive mental health and substance use interventions at multiple points of connection with the healthcare delivery system and the system would aim to match the intensity of service with the intensity of need. The vision must aspire to create a person-centered mental health system where prevention efforts are balanced with attention to individuals with serious mental disorders. Such a vision will require unifying nurses from a wide range of specialties to create the structure for integrated care; it will also involve constructing consumer-centered outcome evaluation strategies so that all efforts are aligned with the individual goals of the person seeking care or treatment.

STRUCTURE OF A PERSON-CENTERED, RECOVERY-ORIENTED PUBLIC HEALTH CARE MODEL: UNIFYING EFFORTS

Prevention: The Promise of Building Resiliency

In 2009, the Institute of Medicine released its report *Preventing Mental, Emotional and Behavioral Disorders among Young People: Progress and Possibilities* (O'Connell, Boat, & Warner, 2009). The report contained a landmark synthesis of what was known about the onset of mental disorder, risk factors, environmental influences, and how prevention was possible through strengthening protective factors and reducing risk factors. The report also provided a systematic review of the science of the prevention of mental disorders, articulating the promise of developmental neuroscience not only to map the possible origins and courses of disorders, but also to demonstrate how prevention and early intervention might build resiliency. Clearly, the future of mental health must be grounded in prevention, on platforms of effective programs such as newborn home visiting for at-risk mothers, early childhood interventions, increasing children's social and emotional skills, and creating social supports within communities (Beardslee, Chien, & Bell, 2011).

This paradigm shift has profound implications for PMH nurses, particularly in regard to their work with children and adolescents and their families. Creating a prevention-oriented mental health system will demand that PMH nurses, pediatric nurses, and family nurses understand the science base that supports prevention and the scientific principles aimed at helping children achieve regulation and build resiliency (Greenberg, 2006). Further, it is essential that nurses communicate how a shared science base will help nurses refine interventions that are applicable in both primary care and mental health care (Yearwood, Pearson, & Newland, 2012).

Understanding the interplay of environment and risk has implications for SMI prevention throughout the lifespan. Such an approach recognizes the multiple determinants of mental health, risk, and protective factors (WHO, 2004). In a report about global initiatives on prevention, the World Health Organization (WHO) carefully traced the relationship of SMI to social problems, particularly poverty, as well as the relationship of SMI to nutritional, housing, and occupational issues. Prevention, therefore, relies on impacting social determinants of health and reducing the impact of factors that increase risk, such as poverty and abuse/trauma (Onie, Farmer, & Behforouz, 2012). An increasingly important emphasis is placed on strengthening the health of communities, which empowers and supports individuals, as well as builds protective connectivity.

Screening and Early Intervention

Evidence that roughly half of all lifetime mental health disorders start in the mid-teens (Kessler et al., 2007) increases the need for screening and early intervention in children and adolescents. The synergy of prevention and developmental neuroscience is progressing, particularly at the juncture where early intervention targets psychological processes relevant to the origins of particular mental disorders (March, 2009). Evidence-based programs are increasingly emerging to address early signs of anxiety, depression, and conduct issues in children and teens (Delaney & Staten, 2010). The profound impact of early adverse childhood events (ACE) such as family dysfunction and abuse on an individual's mental and physical health throughout the lifespan is well documented (Felitti et al., 1998) and informs innovative programs for addressing early trauma and its impact (Brown & Barila, 2012).

Screening and early intervention is critical throughout the lifespan, requiring shifting attention away from pathology and dysfunction and toward optimal functioning. Recent recommendations include depression screening in primary care when practices have the capacity for depression care support (USPSTF, 2012). There is increasing interest in prevention of depression relapse and the possible mechanisms that may limit its all too frequent occurrence (Farb, Anderson, Block, & Siegel, 2012). Embedding screening and early intervention into practice will require shifting attention away from pathology and dysfunction and toward optimal functioning. Psychiatric nursing will be pivotal in weaving together the emerging neuroscience that supports building resiliency and the evidence-based practices that support early intervention. Their efforts

must extend to building communication networks with nurses in primary care specialties to create prevention efforts that span disciplinary silos.

Integrated Care

Several promising initiatives, such as the Penn Resiliency program for teenage depression, demonstrate how to structure early intervention as signs of mental distress are emerging. In this program, using a cognitive behavioral therapy (CBT) approach, preadolescents are taught how to challenge negative thinking; i.e., by evaluating the accuracy of the thought, assessing the evidence to support it, and then devising an alternate response. This program has been implemented in a variety of settings, including schools. In program outcomes across 13 studies, data demonstrate that intervention prevents symptoms of anxiety and depression (Gillham & Reivich, n.d.). Healthcare systems, such as Intermountain Healthcare, have developed scales for systematically screening healthcare consumers; after the assessment, professionals complete a Mental Health Integration form based on the scale scores. The healthcare consumer is then assigned a level of treatment that matches her or his level of service need (Intermountain Healthcare, 2009). Such secondary prevention efforts of school-based health centers and large primary care organizations such as Intermountain must become the norm if APRNs are to engineer systems where persons are treated holistically, and mental health and medical needs are systematically acknowledged with equal vigor. This effort will demand that nurses see themselves as one workforce while recognizing the unique skills that each specialty contributes to the team.

Problems such as high costs, fragmentation, gaps in coverage and care, and tendency to deliver care in highly specialized subsystems in the United States healthcare system have provided momentum to the movement toward an integrated care system. Integrated care involves caring for the whole person in a single place, an organization of services that is both more effective and less costly (Manderscheid, 2012). Manderscheid (2012) believes the pace of organizational change to accommodate integrated care is accelerating "like snow in an avalanche." Initially, models of integrated care called for variations in colocation of services where the emphasis of treatments depended on the needs of the population (National Council for Community Behavioral Healthcare, 2009; Parks et al., 2005). These diverse and evolving models rely on technology and innovations such as integrated services in healthcare homes (Collins, Hewson, Munger, & Wade, 2010). Psychiatric nurses, who always remain close to the needs of the consumer, must ensure that as systems of integrated care

are constructed, there is a parallel effort to ensure that individuals can access them, are not intimidated by them, and know how to make the most of the services offered (Geis & Delaney, 2011). Integration should also be guided by the voice of consumers who outline how to build systems on collaboration, effective communication, use of peer navigators, and the critical support of family and community members (CalMed, 2011).

Technology of a Public Health Model of Mental Health Care

Healthcare technology will be expanded in the coming decade via the increasing use of telehealth and Internet-delivered services, the rising prevalence of Health Information Technology (HIT) to connect service sectors and build care coordination, and the integration of data systems to track outcomes and engineer rapid quality improvement. In their vision for the use of health information technology, SAMHSA (2011) plans innovation support of HIT and the electronic health record (EHR) to reach a 2014 goal of behavioral health care interoperating with primary care. Within this initiative are plans for developing the infrastructure for an interoperable EHR and addressing the accompanying privacy, confidentiality, and data standards. Such information exchange is anticipated to integrate care, contain costs, and increase consumers' control of their personal health care and health information.

Internet-delivered behavioral health interventions, such as online cognitive-behavioral treatments for depression and anxiety, are rapidly being developed, which continues to clarify their key elements and outcomes (Bastelaar et al., 2011; Bennett & Glasgow, 2009). Rapid growth in Internet behavioral health treatment is likely to continue, and must address the challenge of creating interventions with fidelity to the framework of the original intervention and the careful measurement of outcomes.

Emerging Models of Acute Care

While there is widespread agreement among mental health providers and consumers that treatment should be provided in the least restrictive environment, there is also recognition that, when needed, inpatient services must be available for those in crisis (NAMI, 2011). The continual shrinkage of inpatient psychiatric beds in the United States, which some estimates put at a deficit of nearly 100,000, has caused increases in homelessness and the use of emergency rooms, jails, and prisons as de-facto psychiatric inpatient treatment centers (Bloom, Krishnan, & Lockey, 2008; Treatment Advocacy Center, n.d.). In tandem with efforts to preserve needed inpatient beds are evolving models to provide acute care services to individuals in crisis both within emergency

departments and on small specialty units (Knox, Stanley, Currier, Brenner, Ghahramanlou-Holloway, & Brown, 2012; Kowal, Swenson, Aubry, Marchand, & MacPhee, 2011).

The integration of Mental Health Recovery components into all service systems, including into all forms of acute treatment, is now considered vital. Persons in crisis need a safe environment and, as their illness stabilizes, a culture that empowers them to re-engage with life in the community (Tierney & Kane, 2011; Barker & Buchanan-Barker, 2010; Sharfstein, 2009). Consumers, the federal government, and regulators believe that to reach these goals psychiatric services must be recovery-oriented and delivered using a person-centered approach.

Since the elements of the recovery framework mirror the Institute of Medicine's indicators for quality in health services (IOM, 2001), PMH nurses now have a platform for assessing quality in inpatient psychiatric care. This is a welcome expansion of inpatient quality indicators that have centered on limiting restraint and seclusion use in the last decade (Joint Commission, 2010; Stefan, 2006). While restraint reduction is critical, this narrow focus on quality fails to recognize that in addition to a safe environment, individuals with SMI need services that are person-centered and recovery-oriented. As the single largest professional group practicing in inpatient arenas, PMH nurses must provide leadership in constructing recovery-oriented environments and measuring these efforts with tools that capture the social validity of the services provided; e.g., the extent to which the type of help provided in inpatient care is seen as acceptable and having a positive impact in ways that are important to consumers (Ryan et al., 2008).

Workforce Requirements for a Public Health Model of Mental Health Care

Availability of a mental health workforce with the appropriate skills to implement necessary changes in the healthcare system, as well as appropriate geographic distribution of this workforce, is crucial to improving access and quality. While the overall number of mental health professionals appears adequate, rural areas face shortages of clinicians (SAMHSA, 2012). Independent of healthcare reform and its potential to increase access through expansion of health insurance, an estimated 56 million individuals nationally will face difficulties accessing needed health care because of shortages of providers in their communities (National Association of Community Health Centers [NACHC], 2012).

Nursing models for rural mental health care specifically address the interplay of poverty, mental disorders, and social issues (Hauenstein, 1997). Such nursing models recognize that resource-poor environments require service models that move clients into self-management and bridge systems so that medical issues are addressed. The need for PMH nurses is great because their command of multiple bodies of knowledge (medical science, neurobiology of psychiatric disorders, treatment methods, and relationship science) positions them as the healthcare professionals best suited to facilitate connections between mental health, primary care, acute care, and case management systems (Hanrahan & Sullivan-Marx, 2005).

Given that the supply of psychiatrists is showing only modest increases (Vernon, Salsberg, Erikson, & Kirch, 2009), there is a great need, especially in rural areas, for additional clinicians who can provide psychotherapy, case management, medication management, and a range of other services. PMH-APRNs are prepared to provide a full scope of behavioral health services, including both substance use and mental health services (Funk et al, 2005). However, restrictive reimbursement policies and regulatory barriers associated with scope of practice that limit healthcare consumer access to APRNs must be addressed to achieve access and quality goals. PMH-APRNs need to continue systematic and enhanced data collection on practice and outcomes to document their contribution to quality health care.

Several curriculum frameworks have been developed to prepare nurses with the appropriate knowledge and skills to meet future healthcare challenges. Essential PMH competencies have been presented for all practicing RNs (Psychiatric-Mental Health Substance Abuse Essential Competencies Taskforce of the American Academy of Nursing Psychiatric-Mental Health Substance Abuse Expert Panel, 2012). The APNA Recovery to Practice (RTP) curriculum committee is producing a curriculum to integrate recovery into PMH nursing practice, which will be disseminated by SAMHSA as part of the Recovery to Practice initiative. A key aspect of this curriculum development, and of program development in general, is having consumers of these mental health services at the table and contributing to the development of these systems of care (SAMHSA, 2010). Curriculum models should also include the competencies promoted by the Quality and Safety Education for Nurses (QSEN) Institute, which provides "the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the healthcare systems in which they work" (QSEN, n.d.).

A comprehensive blueprint for building the PMH-APRN workforce has been suggested that includes recommendations for how the PMH nursing will increase its numbers and prepare practitioners with the specific competencies needed to build a transformed mental health system (Hanrahan, Delaney, & Stuart, 2012). This workforce plan calls on PMH-APRNs to include the role of individuals in recovery into every aspect of planning and delivery of mental health care. An additional emphasis focuses on expanding the capacity of communities to effectively identify their needs and promote behavioral health and wellness. Indeed, the coming era will demand strong alliances with individuals, families, and communities to build health, recovery, and resilience.

PSYCHIATRIC-MENTAL HEALTH NURSING LEADERSHIP IN TRANSFORMING THE MENTAL HEALTH SYSTEM

In the course of their practice, it is critical that PMH nurses consider the particular vision of mental health care that informs their practice. Federal agencies, commissions, and advocacy groups have identified a future vision of a mental healthcare system as person-centered, recovery-oriented, and organized to respond to all consumers in need of services. These reports converge on several points, but most crucial is that a transformed mental health system is centered on the person. Integral in this vision are strategies for remedying the inadequacy and fragmentation of services, and for creating a workforce to carry out the transformation. There is particular emphasis on providing services to children, adolescents, older adults, and other underserved populations. In leading the transformation of the mental healthcare delivery system, PMH nurses must understand the key threads in the government/agency/consumer group plan and the factors that can affect enactment.

The transformed mental health system will require nurses who can work between and within systems, connecting services and acting as an important safety net in the event of service gaps. PMH nurses are perfectly positioned to fill this role and make significant contributions to positive clinical recovery outcomes for this vulnerable and often underserved population.

Definition of Psychiatric-Mental Health Nursing

Nursing's Social Policy Statement (ANA, 2010) defines nursing as "the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations."

Psychiatric-mental health nursing is the nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the lifespan. Psychiatric-mental health nursing intervention is an art and a science, employing a purposeful use of self and a wide range of nursing, psychosocial, and neurobiological evidence to produce effective outcomes.

PMH nurses work with people who are experiencing physical, psychological, mental, and spiritual distress. They provide comprehensive, person-centered behavioral and psychiatric care in a variety of settings across the continuum of care. Essential components of PMH nursing practice include health and wellness promotion through identification of mental health issues, prevention of mental health problems, care of mental health problems, and treatment of persons with psychiatric disorders, including substance use disorders. Due to the complexity of care in this population, the preferred educational preparation is at the baccalaureate level with credentialing by the American Nurses Credentialing Center (ANCC) or a recognized certification organization.

The role of the PMH nurse is to not only provide care and treatment for the healthcare consumer, but also to develop partnerships with healthcare consumers to assist them with their individual recovery goals. These goals may include: renewing hope, redefining self beyond illness, incorporating illness, becoming involved with meaningful activities, overcoming barriers to social inclusion, assuming control, becoming empowered, exercising citizenship, managing symptoms, and being supported by others (Davidson, O'Connell, Sells, & Stacheli, 2003). The PMH nurse has the responsibility to do more for the person when the person can do less, and to do less for the person when he or she is able to do more for him or herself. In this way PMH nurses develop and implement nursing interventions to assist the person in achieving recovery-oriented outcomes (McLoughlin, 2011). This philosophy of directing and providing care when the person is in acute distress and eventually transferring the decision-making and self-care to the individual is rooted in Peplau's theory of Interpersonal Relations in Nursing (Peplau, 1991).

An important focus of PMH nursing involves substance disorders. Just as Schizophrenic Spectrum and Other Psychotic Disorders are described in the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5), Substance-Related and Addictive Disorders are also described in the DSM as Mental Disorders (American Psychiatric Association, 2013). For example, a healthcare consumer may have a primary mental disorder with a secondary substance-related disorder (e.g., a person diagnosed with bipolar disorder with

hypomanic symptoms who uses alcohol to slow down); or, a person may have a primary substance disorder with a secondary mental disorder, (e.g., a person who is addicted to cocaine and becomes suicidal as a result of the cocaine use), or a person may have two primary disorders such as schizophrenia and alcohol addiction. The Substance Abuse and Mental Health Services Administration (SAMHSA) has long advocated for integrated treatment of both mental and substance disorders (U.S. Health and Human Services, 2005). Thus, in the first example, if a healthcare consumer was admitted to a hospital with symptoms of hypomania, the PMH-RN would not only need to assess and treat the symptoms related to mania, but would also need to assess the consumer for alcohol use and treatment that might include detoxification. Therefore, the PMH-RN requires competency in assessment and treatment of both disorders.

Further, PMH nurses provide basic care and treatment, general health teaching, health screening, and appropriate referral for treatment of general or complex physical health problems (Kane & Brackley, 2011; Haber & Billings, 1995). The PMH nurse's assessment synthesizes information obtained from interviews, behavioral observations, and other available data. From these, the PMH nurse determines diagnoses or problems that are congruent with available and accepted classification systems. This synthesis and development of a problem or area of focus differentiates the PMH nurse from others who work as nursing staff who may gather data for the PMH nurse.

Next, personal goals or outcomes are established, with the individual directing this process as much as possible. Finally, the nurse and the healthcare consumer develop a treatment plan based on assessment data and the healthcare consumers' goals. The PMH nurse then selects and implements interventions to assist a person in achieving their recovery goals and periodically evaluates both attainment of the goals and the effectiveness of the interventions. Use of standardized classification systems enhances communication and permits the data to be used for research. However, in keeping with person-centered, recovery-oriented practice, the goal/outcome development must be individualized as much as possible, ideally with the consumer developing her or his own goals with assistance from the PMH nurse (Adams & Grieder, 2005; McLoughlin & Geller, 2010).

Mental health problems and psychiatric disorders are addressed across a continuum of care. A continuum of care consists of an integrated system of settings, services, healthcare clinicians, and care levels spanning health states from illness to wellness. The primary goal of a continuum of care is to provide

treatment that allows the individual to achieve the highest level of functioning in the least restrictive environment.

Phenomena of Concern for Psychiatric-Mental Health Nurses

Phenomena of concern for psychiatric-mental health nurses are dynamic, exist in all populations across the lifespan and include but are not limited to:

- Promotion of optimal mental and physical health and well-being
- Prevention of mental and behavioral distress and illness
- Promotion of social inclusion of mentally and behaviorally fragile individuals
- Co-occurring mental health and substance use disorders
- Co-occurring mental health and physical disorders
- Alterations in thinking, perceiving, communicating, and functioning related to psychological and physiological distress
- Psychological and physiological distress resulting from physical, interpersonal, and/or environmental trauma or neglect
- Psychogenesis and individual vulnerability
- Complex clinical presentations confounded by poverty and poor, inconsistent, or toxic environmental factors
- Alterations in self-concept related to loss of physical organs and/or limbs, psychic trauma, developmental conflicts, or injury
- Individual, family, or group isolation and difficulty with interpersonal relations
- Self-harm and self-destructive behaviors including mutilation and suicide
- Violent behavior including physical abuse, sexual abuse, and bullying
- Low health literacy rates contributing to treatment non-adherence