PSYCHIATRIC–MENTAL HEALTH NURSING:

SCOPE AND STANDARDS OF PRACTICE

American Nurses Association
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DRAFT for public comment

CONTENTS

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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 the *Scope and Standards of Psychiatric–Mental Health Nursing Practice* published in 2007 by the American Nurses Association (ANA, 2007). The taskforce members represented psychiatric–mental health nursing clinical administrators, staff nurses, nursing faculty, and psychiatric advanced practice 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* (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) on 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 the specialty of psychiatric–mental health 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 assisting persons with mental illness in their own recovery process are major priorities for this nursing specialty in an environment of fiscal constraints and disparities in reimbursement for mental health services.

Development of *Psychiatric–Mental Health Nursing: Scope and Standards of Practice* includes 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 http://www.ISPN-psych.org with links from the ANA website, http://nursingworld.org, and

the APNA website, http://www.apna.org. Notice of the public comment period will be distributed to nursing specialty organizations, state boards of nursing, schools of nursing, faculty groups, and state nurses associations. All groups will be encouraged to disseminate notice of the postings to all of their members and other stakeholders. The feedback will be carefully reviewed and integrated as appropriate.

PSYCHIATRIC–MENTAL HEALTH NURSING:

SCOPE OF PRACTICE

Psychiatric–mental health nursing is a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, psychiatric disorders and comorbid conditions. 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 research evidence to produce effective outcomes.

Introduction

The nursing profession, by developing and articulating the scope and standards of professional nursing practice, 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 practice 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 the specialty practice of psychiatric–mental health nursing. The scope statement defines psychiatric–mental health nursing and describes its evolution as a nursing specialty, its 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 by which the psychiatric–mental health nursing specialty describes the responsibilities for which its practitioners are accountable.

History and Evolution of the Specialty

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 illness could be ameliorated or cured with proper treatment. The McLean nurse training school was the first in the US to allow men the opportunity to become trained nurses (Boyd, 1998). Eventually, asylum nursing programs established affiliations with general hospitals so that training in general nursing skills 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 approaches to mental illness and began to identify the didactic and clinical components of training needed to care for persons with mental illness. 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 WWII. The public health significance of mental disorders became widely

apparent as 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 followed by 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 in graduate programs, psychiatric-mental health nursing research was begun, and 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*, 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, when the majority of care for persons with psychiatric illness began to shift away from hospitals and toward community settings, began in the late 1950s. 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 teams.

Mental health care in the US 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 forced by managed care, resulted in briefer psychiatric hospitalizations characterized by use of medication to stabilize acute symptoms. Shorter hospital stays and higher acuity began to shift psychiatric nursing practice away from the emphasis on relationship-based care advocated by Peplau, moving 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 disorder are primary and must be treated as such.

Also, 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 called on to develop and apply innovative approaches in carefor the large population of military personnel, veterans and their families experiencing war-related mental health conditions as a result of recent conflicts in Iraq and Afghanistan.

Major developments in the nursing profession have 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 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 Advanced Practice Health 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 incidence of “battle fatigue” led to the recognition of the need for more mental health professionals.

The first specialty 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 in establishing national specialty 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. These master’s and doctorally prepared PMHCNSs 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 were providing individual, group, and family psychotherapy in a broad range of settings and were obtaining third-party reimbursement. PMHCNSs were also functioning as educators, researchers, and managers, and were working 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 illness and addiction. 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 embedded in advanced practice psychiatric–mental health nursing graduate programs (Kaas & Markley, 1998).

Other trends in mental health and the larger healthcare system sparked other 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);
- The shift to primary care as a primary point of entry for comprehensive health care, including psychiatric specialty care;
- 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 and 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 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 title Nurse Practitioner and modifying graduate psychiatric nursing programs to conform with 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.

Psychiatric–Mental Health Advanced Practice Nurses, whether they practice under the title of CNS or NP, 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.

Current Issues and Trends

Since the arrival 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, The Substance Abuse and Mental Health Services Administration (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 Patient Protection and Affordable Care Act (PPACA) brought, among other transformational changes, the promise of expanded health care coverage, and with it an assessment of the current system's capacity to address anticipated demand. In the midst of launching this landmark policy, the economic downtown reverberated through federal and state budgets creating 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 co-morbidities and decreased life expectancy of individuals with serious mental illness (McGuire et al., 2002) These data hastened the movement towards integrated behavioral/primary care with the Center for Medicaid and Medicare 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 re-imbursement 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 its members. This 21st Century mental health care 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 illness continues to impose a significant burden on individuals. According to 2008 SAMSHA data, during the preceding year an estimated 9.8 million adults aged 18 and older in the United States had a serious mental illness and 2 million youth aged 12 to 17 had a major depressive episode. More recent incidence data (CDC, 2011) indicates that that 6.8% of U.S. adults had a diagnosable episode of depression as measured by the PHQ-9 during the 2 weeks before the survey was administered. In a multi-state survey spanning two year collection points, the reported rates of lifetime depression were similar in 2006 (15.7%) and 2008 (16.1%) and 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 illness remains high, treatment rates are distressingly low. In 2010, fewer than 40% of the 45.9 million adults with mental illness had received any mental health services. The figure only improved slightly for those individuals with Serious Mental Illness (SMI)-approximately 60 percent of the 11.4 million adults with SMI in the past year received treatment (SAMHSA, 2012).

In 2006, health professionals were shaken by data demonstrating the increased mortality and high prevalence of chronic medical conditions in individuals with mental health issues (Parks, Svendsen, Singer, & Forti, 2006). The shocking statistic that, on

average, people with serious mental illness (SMI) die 25 years earlier than those without these illnesses, and little of that increased mortality is accounted for by direct effects of the severe mental illness (Prince et al., 2007), has lent increased urgency to the call for integration of medical and mental health services (Manderscheid, 2010). In addition to premature mortality, co-morbidity of chronic physical and mental illness creates a synergistic impact on disability: individuals coping with these co-morbid conditions are more likely to be have scores that place them in the top 10% of persons challenged by disability (Scott et al, 2009). These co-morbidities significantly increase healthcare costs (Melek & Norris, 2008) with only a small fraction of those costs (16%) attributable to mental health services.

Substance abuse disorders: prevalence and co-morbidities

Estimates are that 2.8 million citizens in the US are dealing with problems related to substance use. This figure is expected to double in 2020, particularly with adults over 50, casting particular concerns for the older adult population (Han, Gfroerer, Colliver, & Penne, 2009).

High rates of substance use disorders (SUD) and co-occurring serious mental illness are also of great concern. The National Drug Use and Health survey estimates that 25.7 percent of adults with SMI had co-occurring dependence or abuse of either illicit drugs or alcohol (SAMSHA, 2009). This figure puts co-occurring substance dependency or abuse among individuals with SMI at a rate nearly four times higher than SUD in the general population (SAMSHA, 2012). These individuals, particularly persons dealing with co-occurring SUD and major depression or post traumatic stress disorder (PTSD), demonstrate poorer outcomes (Najt, Fusar-Poli, & Brambilla, 2011) such as increased disability and 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 percent 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 estimates of any DSM-IV disorder among adolescents are 40.3% at 12 months (79.5% of lifetime cases), the most common disorders among adolescents being 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 does not include cognitive impairments and dementias, the most common being Alzheimer's disease (New Freedom Commission on Mental Health, 2003). Considering that in 2030 one in five US residents will be 65 years or older (Vincent & Velkoff, 2010), the need for mental health services in this population is great and will increase (SAMSHA 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 Hispanic or Latino population rising from 12.6% in 2000 to 30.2% in 2050 (Shrestha & Heisler, 2011). Although rates of mental illness in minority populations are estimated to be similar to those in the white population, minorities are less likely to receive mental health services for a myriad of 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 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, and 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 and number of covered inpatient days, and high co-pays for services. The payment changes anticipated by the PPACA, particularly Medicaid expansion to 133% of persons above the poverty level, are likely to bring more individuals into the mental health system. However, 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, and stigma associated with mental illness, also constitute barriers to seeking help for mental health problems. These disparities occur at a time of growing evidence regarding the effectiveness of treatment for behavioral problems and psychiatric disorders.

Opportunities to Partner with Consumers for Recovery and Wellness

The growing demand for coordinated, cost-effective mental health psychiatric-mental health nursing the opportunity to be creative in developing PMH-RN roles in care coordination, enhancing 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 towards caring for populations creates incentives to develop non-traditional services that may have greater effectiveness in supporting individuals' and family's movement towards mental health and building healthy communities.

The focus on recovery is an opening to re-vitalize 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 their therapeutic interpersonal skills, PMH-RNs are able assist persons with mental illness 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 health care 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 health care 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 illness. Such a vision will require unifying nurses from a wide range of specialties to create the structure for integrated care and constructing patient-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 illness, risk, environmental influences and how prevention is possible through strengthening protective factors and reducing risk factors. The report also provided a systematic review of the science of mental illness prevention. 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 emotional skills, and scaffolding social supports within communities (Beardslee, Chien, & Bell, 2011).

This paradigm shift has profound implications for PMH nurses, particularly 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 building resiliency (Greenberg, 2006).

Further, it is essential that nurses promulgate how a shared science base will help nurses refine interventions that are applicable in both care primary and specialty mental health care (Yearwood, Pearson & Newland, 2012).

Understanding the environment-risk interplay has implications for prevention throughout the lifespan. Such an approach recognizes the multiple determinants of mental health, risk and protective factors (WHO, 2004). Reporting global initiatives on prevention, WHO carefully traced the relationship of serious mental illness to social problems, particularly poverty, and the relationship 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 strengthening the health of communities, which is seen to both empower and support individuals as well as build protective connectivity.

Screening and early intervention

Evidence that roughly half of all lifetime mental health disorders start by the mid-teens (Kessler et al., 2007) increases the need for screening and early intervention in child and adolescent mental distress. 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 illnesses (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 life span and will require shifting attention away from pathology and dysfunction and towards optimal functioning. Recent recommendations include depression screening in primary care when the practice has the capacity for depression care support (USPSTF, date). 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 towards 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 intervention early 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. evaluate the accuracy of the thought, the evidence to support it and then devise an alternate response. This program has been implemented in a variety of settings, including schools. In program outcomes across 13 studies, data demonstrate that the intervention prevents symptoms of anxiety and depression (Gillham & Reivich, nd). Health care systems such as Intermountain Healthcare have developed scales for systematically screening health care consumers and then, based on the scale scores, professionals complete a Mental Health Integration form. The health care consumer is then assigned a level of treatment that matches his/her 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 brings 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 US healthcare system have

provided momentum to the movement to 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 co-location 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). Evolving models are diverse and increasingly rely on technology and the innovations such as the health care home to integrate services (Collins, Hewson, Munger, & Wade, 2010). Psychiatric nurses, who always remain close to the needs of the consumer, must assure that as systems of integrated care are constructed, there is a parallel effort to assure that individuals can access them, are not intimated by them, and know how to make the most of the serviced 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 drawing upon the family/community as critical supports (CalMed, 2011).

Technology of a Public Health Model of Mental Health Care

Health care technology will be expanded in the coming decade via increasing use of tele-health and internet delivered services, Health Information Technology (HIT) to connect service sectors and build care coordination, and in data systems to track outcomes and engineer rapid quality improvement. In their vision for the use of health information technology, SAMSHA (2011) plans innovation support of HIT and the Electronic Health Record (EHR) to reach a 2014 goal of specialty 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 being rapidly developed and their key elements and outcomes increasingly clarified (Bastelaar et al., 2011; Bennett & Glassgow, 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 careful measurement of outcomes.

Emerging models of acute care

While there is widespread agreement among mental health providers and consumers agree 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 has resulted by some estimates in a deficit of nearly 100,000 inpatient beds; causing increases in homelessness, emergency room use, and use of jails and prisons as de-facto psychiatric inpatient treatment (Bloom, Krishnan, & Lockey, 2008; Treatment Advocacy Center, nd). 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 all forms of acute treatment, is now considered vital. This includes all forms of acute treatment. Persons in crisis need a safe environment and then, 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 which in the last decade have centered on limiting restraint and seclusion use (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 serious mental illness need services that are person-centered and recovery-oriented. PMH nurses, as the single largest professional group practicing in inpatient arenas, must provide leadership in constructing recovery oriented environments and measuring these efforts with tools that capture the social validity of the services provided; i.e., the extent to which the type of help provided in inpatient care is seen as acceptable and having a positive impact in ways important to consumers (Ryan et al., 2008).

Workforce needed to construct a Public Health Model of Mental Health Care, Build recovery oriented inpatient units, and innovate with Health IT

Availability of a mental health workforce with the appropriate skills to implement necessary changes in the health care 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 (SAMSHA 2012).Independent of health care reform and its potential to increase access through expansion of health insurance, an estimated 56 million individuals nationally will face difficulties assessing 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 are specifically designed to address the interplay of poverty, mental illness, and social issues (Hauenstein, 2008). 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).

PMH-APRNs are trained and educated to provide a full scope of behavioral health services, including both substance abuse and mental health services (Funk et al, 2005). Particularly in rural areas, there is a great need for providers who can provide such a range of services, including medication management, given that the supply of psychiatrists is showing only modest increases (Vernon, Salsberg, Erikson, & Kirch, 2009). Achieving access and quality goals will demand that regulatory barriers that restrict scope of practice and restrictive reimbursement policies that limit healthcare consumer access to APRNs are addressed. PMH-APRNs will also need to enhance systematic data collection on practice and outcomes to document their contribution to quality healthcare.

Several curriculum frameworks have been developed to prepare nurses with the appropriate knowledge and skills to meet future health care 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). A curriculum to integrate recovery into PMH nursing practice is being produced by the APNA Recovery to Practice (RTP) curriculum committee and will be disseminated by SAMSHA as part of the Recovery to Practice initiative. A key aspect of this curriculum development and program development in general is having consumers of these mental health services at the table and contributing toward the development of these systems of care (SAMHSA, 2010).

A comprehensive blueprint for building the PMH-APRN workforce has been suggested which includes recommendations for how the specialty 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 to be 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. Key to 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 understand systems and 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 a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of

behavioral problems and psychiatric disorders. 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 research evidence to produce effective outcomes.

PMH nurses work with people who are experiencing physical, psychological, mental and spiritual distress. They provide comprehensive, person-centered mental health and psychiatric care in a variety of settings across the continuum of care. Essential components of this specialty 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 specialty, the preferred educational preparation is at the baccalaureate level with credentialing by the American Nurses Credentialing Center (ANCC).

The role of the PMH nurse is to not only provide care and treatment for the healthcare consumer, but to develop partnerships with healthcare consumers to assist them with their individual recovery goals. These goals may include: renewing hope, redefining self beyond the illness, incorporating the illness, becoming involved with meaningful activities, overcoming barriers to social inclusion, assuming control, becoming empowered and 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 s/he is able to do more for her/his self. 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 transferring the decision-making and self-care to the individual as her/his condition improves is rooted in Peplau's theory of Interpersonal Relations in Nursing (Peplau,1991).

An important focus of PMH nursing is substance use 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

(Psychiatric Mental Health Substance Abuse Essential Competencies Taskforce of the American Academy of Nursing Psychiatric Mental Health Substance Abuse Expert Panel, 2012; 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 problem statements 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, a treatment plan based on assessment data and theoretical premises is developed. 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/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 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:

- Promotion of optimal mental and physical health and well-being ~~and~~
- Prevention of mental and behavioral distress/illness
- Promotion of social inclusion of mentally and behaviorally fragile individuals

- Co-occurring mental health and substance use treatment
- Co-occurring mental health and medical illness
- 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
- 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 relatedness
- 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

Levels of Psychiatric–Mental Health Registered Nurse Practice.

There are three levels of Practice: The first level of PMH Practice is the Psychiatric–Mental Health Registered Nurse (PMH-RN), with educational preparation within a Bachelor's Degree, Associates' Degree, or a Diploma program. The next level of PMH Practice is the Psychiatric–Mental Health Advanced Practice Registered Nurse (PMH-APRN) with educational preparation within a Masters' Degree program. Two categories of practice exist in this advanced practice level, the PMHCNS and the PMHNP. The third level of practice is the Doctor of Nursing Practice (DNP) with educational preparation within a Clinical Doctoral Degree program as described by the American Association of Colleges of Nursing (AACN, 2004). The PMH-APRN and the DNP-PMH

have the same clinical scope of practice. The DNP-PMH has advanced education in systems function and analysis.

Psychiatric–Mental Health Registered Nurse (PMH-RN)

A Psychiatric–Mental Health Registered Nurse (PMH-RN) is a registered nurse who demonstrates competence, including specialized knowledge, skills, and abilities, obtained through education and experience in caring for persons with mental health issues, mental health problems, psychiatric disorders, and co-occurring psychiatric and substance use disorders.

The science of nursing is based on a critical thinking framework, known as the nursing process, composed of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. These steps serve as the foundation for clinical decision making and are used to provide an evidence base for practice (ANA, 2004).

Psychiatric–mental health registered nursing practice is characterized by the use of the nursing process to treat people with actual or potential mental health problems, psychiatric disorders, and co-occurring psychiatric and substance use disorders to: promote and foster health and safety; assess dysfunction and areas of individual strength; assist persons achieve their own personal recovery goals by gaining, re-gaining or improving coping abilities, living skills and managing symptoms; maximize strengths; and prevent further disability. Data collection at the point of contact involves observational and investigative activities, which are guided by the nurse's knowledge of human behavior and the principles of the psychiatric interviewing process.

The data may include but is not limited to the healthcare consumer's:

- Central complaint, focus, or concern and symptoms of major psychiatric, substance related, and medical disorders.
- Strengths, supports, and individual goals for treatment.
- History and presentation regarding suicidal, violent, and self-mutilating behaviors.
- History of ability to seek professional assistance before engaging in behaviors dangerous to self or others.

- History of reasons why it may have been difficult in the past to follow-through with suggested or prescribed treatment.
- Pertinent family history of psychiatric disorders, substance abuse, and other mental and relevant physical health issues.
- Evidence of abuse, neglect, or trauma.
- Stressors, contributing factors, and coping strategies.
- Demographic profile and history of health patterns, illnesses, past treatments, and difficulties and successes in follow-through.
- Actual or potential barriers to adherence to recommended or prescribed treatment.
- Health beliefs and practices.
- Methods of communication.
- Religious and spiritual beliefs and practices.
- Cultural, racial, and ethnic identity and practices.
- Physical, developmental, cognitive, mental status, emotional health concerns, and neurological assessment.
- Daily activities, personal hygiene, occupational functioning, functional health status, and social roles.
- Work, sleep, and sexual functioning.
- Economic, political, legal, and environmental factors affecting health.
- Significant support systems and community resources, including those that have been available and underutilized.
- Knowledge, satisfaction, and motivation to change, related to health.
- Strengths and competencies that can be used to promote health.
- Current and past medications, both prescribed and over-the-counter, including herbs, alternative medications, vitamins, or nutritional supplements.

- Medication interactions and history of side effects and past effectiveness.
- Allergies and other adverse reactions.
- History and patterns of alcohol, substance, and tobacco use, including type, amount, most recent use, and withdrawal symptoms.
- Complementary therapies used to treat health and mental illness and their outcomes.

The work of psychiatric–mental health registered nurses is accomplished through the interpersonal relationship, therapeutic intervention skills, and professional attributes. These attributes include but are not limited to self-awareness, empathy, and moral integrity, which enable psychiatric–mental health nurses to practice the artful use of self in therapeutic relationships. Some characteristics of artful therapeutic practice are respect for the person / family, availability, spontaneity, hope, acceptance, sensitivity, vision, accountability, advocacy, and spirituality.

Psychiatric–mental health registered nurses play a significant role in the articulation and implementation of new paradigms of care and treatment that place the healthcare consumer at the center of the care delivery system. PMH-RNs are key members of interdisciplinary teams in implementing initiatives such as: fostering the development of person-centered, trauma informed care environments in an effort to promote recovery and reduce or eliminate the use of seclusion or restraints; promoting individually-driven, person-centered treatment planning processes; and, the development of skill-building programs to assist individuals to achieve their own goals.

Psychiatric–mental health registered nurses maintain current knowledge of advances in genetics and neuroscience and their impact on psychopharmocology and other treatment modalities. In partnership with healthcare consumers, communities, and other health professionals, psychiatric–mental health nurses provide leadership in identifying mental health issues, and in developing strategies to ameliorate or prevent them.

Psychiatric–Mental Health Nursing Clinical Practice Settings

Psychiatric–mental health registered nurses practice in a variety of clinical settings across the care continuum and engage in a broad array of clinical activities including, but not limited to, health promotion and health maintenance; intake screening, evaluation, and triage; case management; provision of therapeutic and safe environments; promotion of self-care activities; administration of psychobiological treatment regimens and monitoring response and effects; crisis intervention and stabilization; and psychiatric rehabilitation, or interventions that assist in a person's recovery. PMH nurses may be paid for their services on a salaried, contractual, or fee-for-service basis.

In the 21st century, advances in the neurosciences, genomics and psychopharmacology, as well as evidenced based practice and cost-effective treatment, enable the majority of individuals, families and groups who are in need of mental health services to be cared for in community settings. Acute, intermediate, and long-term care settings still admit and care for healthcare consumers with behavioral and psychiatric disorders. However, lengths of stay, especially in acute and intermediate settings, have decreased in response to fiscal mandates, the availability of community-based settings, and consumer preference.

Crisis Intervention and Psychiatric Emergency Services

One of the most challenging clinical environments in psychiatric nursing is the psychiatric emergency department. Emergency departments are fast paced, often over stimulating environments, with typically limited resources for those individuals with a psychiatric and/or substance related emergencies. Psychiatric emergency service can be hospital or community based. The specific models of care continue to evolve and develop based on identified local health care needs. The current models in dealing with psychiatric emergencies include consultative services in a medical center or hospital emergency department (these psychiatric services may either be internally based or externally contracted); an enhanced, autonomous psychiatric emergency department; extended observation units; crisis stabilization units; respite services; and, mobile crisis teams (Glick, Berlin, Fishkind, & Zeller, 2008). Extended observation units, crisis stabilization units, respite service and mobile crisis teams are alternative treatment

options for individuals with a psychiatric emergency or crisis that does not require inpatient psychiatric treatment.

Acute Inpatient Care

This setting involves the most intensive care and is reserved for acutely ill patients who are at imminent risk for harming themselves or others, or are unable to care for their basic needs because of their level of impairment. This treatment is typically short-term, focusing on crisis stabilization. These units may be in a psychiatric hospital, a general care hospital, or a publicly funded psychiatric facility.

Intermediate and Long-Term Care

Intermediate and long-term care facilities may admit patients but more often they receive patients transferred from acute care settings. Intermediate and long-term care provides treatment, habilitation and rehabilitation for patients who are at chronic risk for harming themselves or others due to mental illness or who are unable to function with less intense supervision and support. Long-term inpatient care usually involves a minimum of three months. Both public and private psychiatric facilities provide this type of care. Long-Term care hospitals also include those state hospitals that admit patients through the criminal justice system. Often these forensic patients must remain in locked facilities for long periods of time related to state statues and legal statuses rather than clinical status.

Partial Hospitalization and Intensive Outpatient Treatment

The aim of partial hospitalization and intensive outpatient programs is acute symptom stabilization with safe housing options. Partial hospitalization and Intensive Outpatient programs admit patients who are in acute need of treatment, however, do not require 24 hour medical management or 24 hour nursing care. These programs function as free-standing programs as well as serve as step-down programs for patients discharged from inpatient units.

Residential Services

A residential facility provides twenty-four-hour care and housing for an extended period period. Services in typical residential treatment facilities include psychoeducation for symptom management and medications, assistance with vocational training, and, in the case of the severely and persistently mentally ill, may include training for activities of daily living. Independent living is often a goal for residential treatment facilities.

Community-Based Care

Psychiatric–mental health registered nurses provide care within the community as an effective method of responding to the mental health needs of individuals, families, and groups. Community-based care refers to all non-hospital/facility based care, and therefore may include care delivered in partnership with patients in their homes, worksites, mental health clinics and programs, health maintenance organizations, shelters and clinics for the homeless, crisis centers, senior centers, group homes, and other community settings. Schools and colleges are an important site of mental health promotion, primary prevention, and early intervention programs for children and youth that involve psychiatric–mental health registered nurses. Psychiatric–mental health registered nurses are involved in educating teachers, parents, and students about mental health issues and in screening for depression, suicide risk, post-traumatic stress disorder, alcohol, substance, and tobacco use.

Assertive Community Treatment (ACT)

ACT is a team treatment approach designed to provide comprehensive, community-based psychiatric treatment, rehabilitation, and support to persons with serious and persistent mental illnesses (Assertive Community Treatment Association, 2012). An ACT team is comprised of a group of professionals whose background and training include social work, rehabilitation, peer counseling, nursing and psychiatry. The ACT approach provides highly individualized services directly to consumers 24 hours a day, seven days a week, 365 days. A 2003 study on ACT teams found that having a full-time nurse on the team was rated as the most important ingredient on an ACT team (McGrew, Pescosilido & Wright, 2003).

Definition of Psychiatric–Mental Health Advanced Practice Nursing (PMH-APRN).

The American Nurses Association (ANA) defines Advanced Practice Registered Nurses (APRNs) as professional nurses who have successfully completed a graduate program of study in a nursing specialty that provides specialized knowledge and skills that form the foundation for expanded roles in health care.

The psychiatric–mental health advanced practice nurse is educated at the master's or doctoral level with the knowledge, skills and abilities to provide continuous and comprehensive mental health care, including assessment, diagnosis, and treatment across settings. Psychiatric-mental health advanced practice nurses (PMH-APRN) include both nurse practitioners (PMH-NP) and clinical nurse specialists (PMH-CNS). Psychiatric-mental health advanced practice nurses are clinicians, educators, consultants and researchers who assess, diagnose, and treat individuals and families with behavioral and psychiatric problems/disorders or the potential for such disorders. Psychiatric–mental health nursing is necessarily holistic and considers the needs and strengths of the individual, family, group, and community.

"Advanced Practice Registered Nurses play a pivotal role in the future of health care. APRNs are often primary care providers and are at the forefront of providing preventive care to the public" (ANA, 2012). Demand for health care services will continue to grow, as millions of Americans gain health insurance under the Affordable Care Act and Baby Boomers dramatically increase Medicare enrollment. The nation increasingly will call upon advanced practice registered nurses (APRNs) to meet these needs and participate as key members of health care teams (ANA, 2012).

Consensus Model- LACE [Licensure, Accreditation, Certification and Education]

The Consensus Model for Advanced Practice Registered Nurse (APRN) Regulation – focusing on licensure, accreditation, certification and education (LACE) was completed in 2008, by the APRN Consensus Work Group & the National Council of State Boards of Nursing APRN Advisory Committee. Broadly, the model identifies four APRN roles for which to be certified –clinical nurse specialist (CNS), certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA) and certified nurse midwife (CNM).

Each of these roles is further specified by a focused population for which they have specialized graduate educational preparation. Finally, a nurse must demonstrate specific competencies as outlined by their specialty practice area (NCSBN Joint Dialogue Group Report, 2008).

All APRNs are educationally prepared to provide a scope of services to a population across the lifespan as defined by nationally recognized role and population-focused competencies; however, the emphasis and implementation within each APRN role varies. The emphasis and implementation of services or care provided by APRNs varies based on care needs (NCSBN Joint Dialogue Group Report, 2008)

The full scope and standards of practice for psychiatric–mental health advanced practice nursing is set forth in this document. While individual PMH-APRNs may actually implement portions of the full scope and practice based on their role, position description, and practice setting, it is, importantly, the full breadth of the knowledge base that informs their practice.

PMH-APRN practice focuses on the application of competencies, knowledge, and experience to individuals, families, or groups with complex psychiatric–mental health problems. Promoting mental health in society is a significant role for the PMH-APRN, as is collaboration with and referral to other health professionals, as either the individual need or the PMH-APRN's practice focus may dictate.

The scope of advanced practice in psychiatric–mental health nursing is continually expanding, consonant with the growth in needs for service, practice settings, and the evolution of various scientific and nursing knowledge bases. PMH-APRNs are accountable for functioning within the parameters of their education and training, and the scope of practice as defined by their state practice acts. PMH-APRNs are responsible for making referrals for health problems that are outside their scope of practice. Although many primary care clinicians treat some symptoms of mental health problems and psychiatric disorders, the PMH-APRN provides a full range of comprehensive services that constitute primary mental health and psychiatric care and treatment.

PMH-APRNs are accountable for their own practice and are prepared to perform services independent of other disciplines in the full range of delivery settings. Additional functions of the PMH-APRN include prescribing psychopharmacological agents, integrative therapy interventions, various forms of psychotherapy, community interventions, case management, consultation and liaison, clinical supervision, program, system and policy development, expanded advocacy activities, education, and research.

The settings and arrangements for psychiatric–mental health nursing practice vary widely in purpose, type, and location, and in the auspices under which they are operated. The PMH-APRN may be self-employed or employed by an agency, practice autonomously or collaboratively, and bill clients for services provided.

Psychotherapy

Psychotherapy interventions include all generally accepted and evidence based methods of brief or long-term therapy, specifically including individual therapy, group therapy, marital or couple therapy, and family therapy using a range of therapy models including, but not limited to, dynamic insight-oriented, Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and supportive interpersonal therapies to promote insight, produce behavioral change, maintain function and promote recovery.

Psychotherapy denotes a formally structured relationship between the therapist (PMH-APRN) and the healthcare consumer for the explicit purpose of effecting negotiated outcomes. This treatment approach to mental disorders is intended to alleviate emotional distress or symptoms, to reverse or change maladaptive behaviors, and to facilitate personal growth and development. The psychotherapeutic contract with the consumer is usually verbal but may be written. The contract includes well accepted elements such as purpose of the therapy, treatment goals, time, place, fees, confidentiality and privacy provisions, and emergency after-hours contact information.

Psychopharmacological Interventions

Psychopharmacological interventions include the prescribing or recommending of pharmacologic agents and the ordering and interpretation of diagnostic and laboratory

testing. Collaboration with the person seeking help is essential to promote adherence and recovery. In utilizing any psychobiological intervention, including the prescribing of psychoactive medications, the PMH-APRN intentionally seeks specific therapeutic responses, anticipates common side effects, safeguards against adverse drug interactions, and is alert for unintended or toxic responses. Current technology and research are utilized, including genomic testing, to help understand medication efficacy.

Case Management

Case Management by the PMH-APRN involves population specific nursing knowledge coupled with research, knowledge of the social and legal systems related to mental health, and expertise to engage a wide range of services for the consumer regardless of their age or the healthcare setting. The PMH-APRN is the point person, responsible for the integration of all care and decision-making around that care. The PMH-APRN case manager designates an organized, coordinated approach to care by overseeing or directly engaging in case management activities. The PMH-APRN, case manager identifies and analyzes real or potential barriers to care and intervenes to help provide access to appropriate levels and types of care and treatment to achieve optimum outcomes. Case manager interventions may be with a single client, a designated family, group or population.

Program, System and Policy Development and Management

The PMH-APRN may focus on the mental health needs of the population as a whole on various levels including; community, state, national or international. This focus involves the design, implementation, management and evaluation of programs and systems to meet the mental health needs of a general population (e.g. persons with serious mentally illnesses and co-occurring substance use disorders) or target a population at risk for developing mental health problems through prevention, health and wellness promotion, identification and amelioration of risk factors, screening, and early intervention. These activities are informed by the full range of nursing knowledge which includes a holistic approach to individuals, families, and communities that is cognizant and respectful of cultural and spiritual norms and values. Additionally, policy, practice,

program management, quality management, and data analysis knowledge and skills are essential for success in this arena. This area of practice has taken on a greater importance since the 2010 Institute of Medicine's (IOM), consensus report on the future of nursing. One of the key messages of this report is that "Nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States" (IOM, 2010, p.3). The PMH-RN with advanced education and experience may assume these responsibilities in select instances.

Psychiatric Consultation-Liaison Nursing (PCLN)

Psychiatric consultation-liaison (PCLN) nursing, is part of a PMH-APRN's practice that emphasizes the assessment, diagnosis and treatment of behavioral, cognitive, developmental, emotional and spiritual responses of individuals, families and significant others with actual or potential physical illness(es) and/or dysfunction. Psychiatric consultation-liaison practice, by definition encompasses both consultation and liaison activities that occur in settings other than traditional psychiatric settings, most often in medical settings.

Consultation is an interactive process between a consultant, who possesses expertise and a consultee, who is seeking advice and knowledge. It is an interpersonal educational process in which the consultant collaborates with an individual or a group that influences and participates in healthcare delivery and has requested assistance in problem-solving (Blake, 1977; Lippitt & Lippitt, 1978). The recipient of PCLN consultation service may be the individual, family member(s), health care provider(s), groups and/or organizations. The term *liaison* is used to describe the linkage of healthcare professionals to facilitate communication, collaboration, and establishing partnerships (Robinson, 1987). The liaison process is often used to explicate the teaching or educative component of PCLN practice. The goals of consultation and liaison are mutually complimentary and interdependent. PCLN uses both processes in conjunction with specific theoretical knowledge, clinical expertise and an ability to synthesize and integrate information to influence healthcare delivery systems (Krupnick, 2003; Lewis & Levy, 1982; Robinson, 1987).

Development of the PCLN role continues, as does international expansion of the role (Sharrock, 2011). The PCLN uses consultation as a modality to provide effective psychiatric and psychosocial care for healthcare consumer/families and enhance the abilities of non-psychiatric healthcare providers to provide such care. Psychiatric-mental health consultation may be accomplished by either direct consultation or indirect consultation models. In the direct model the consultee is typically the healthcare consumer or family, whereas in the indirect model, the consultee and focus of interventions is the care provider or organization.

Clinical Supervision

The PMH-APRN provides clinical supervision to assist other mental health clinicians to evaluate their practice, expand their clinical practice skills, to meet the standard requirement for ongoing peer consultation, and for essential peer supervision. This process is aimed at professional growth and development rather than staff performance evaluation, and may be conducted in an individual or group setting. As a clinical supervisor, the PMH-APRN is expected to both be involved in direct care and to serve as a clinical role model and a clinical consultant.

Through educational preparation in individual, group and family therapy, and clinical experience, the PMH-APRN is qualified to provide clinical supervision at the request of other mental health clinicians and clinician-trainees. Although not exactly the same as a therapy relationship, the PMH-APRN uses similar theories and methods to assist clinicians in examining and understanding their practices and developing new skills. PMH-APRN nurses providing clinical supervision must be aware of the potential for impaired professional objectivity or exploitation when they have dual or multiple relationships with supervisees or healthcare consumers. The nurse should avoid providing clinical supervision for people with whom they have pre-existing relationships that could hinder objectivity. Nurses who provide clinical supervision maintain confidentiality, except when disclosure is required for evaluation and necessary reporting.

Ethical Issues in Psychiatric–Mental Health Nursing

Psychiatric–mental health registered nurses adhere to all aspects of the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001). While psychiatric-mental health registered nurses have the same goals as all registered nurses, there are unique ethical dilemmas in psychiatric –mental health nursing practice.

The PMH-RN monitors and carefully manages confidentiality, therapeutic self-disclosure and professional boundaries. These obligations are intensified in psychiatric-mental health nursing due to the vulnerability of the population, the complexity of clinical care and legal issues which are dictated by legislation and the criminal justice system.

The nurse demonstrates a commitment to practicing and maintaining self-care, managing stress, nurturing self, and maintaining supportive relationships with others so that the nurse is meeting their own needs outside of the therapeutic relationship. Moral distress (Jameton,1993) is identified, addressed, and an appropriate action plan iscreated and carried out (Epstein & Delgado, 2010; Lachman, 2010)

The psychiatric–mental health registered nurse is always cognizant of the responsibility to balance human rights with safety and the potential need for coercive practices (e.g., restrictive measures such as restraint or seclusion), or forced treatment (e.g., court-mandated treatment, mental hygiene arrest/involuntary admission for an emergent psychiatric evaluation) when the individual lacks the ability to maintain their own safety. The PMH-RN helps resolve ethical issues by participating in such activities as consulting with and serving on ethics committees, or advocating for optimal psychiatric care through policy formation and political action.

Specialized Areas of Practice

Specialty programs in advanced psychiatric–mental health nursing education generally have focused on adult or child-adolescent psychiatric–mental health nursing practice. However, with the ongoing implementation of the APRN Consensus Model and Licensure, Accreditation, Certification & Education (LACE) recommendations nationally, advanced psychiatric-mental health nursing educational preparation has adopted a

lifespan approach which includes preparing PMH-APRN to care for individuals, families, groups and communities from pre-birth until death.

Primary Care

Because the lack of access to mental health care and the lack of policy related to healthcare reform have increased over the past several decades, studies have found that approximately 70% of all individuals who present to a primary care setting have a psychiatric illness and/or mental health problem (Blount et al, 2007). Without access to care, individuals and their families seek mental health assessment and treatment with a primary care provider and/or frequent the already over burgeoning emergency departments nation-wide. Not only are depression and anxiety now more likely to be treated in primary care, the increase demand for assessment and management of complex, dual diagnoses and psychotic disorders has surfaced with ill-prepared primary care clinicians.

PMH-APRNs provide mental health services in primary care using several models. Models of integrated care fall into a continuum across a variety of settings (Blunt, 2003). Examples of how PMH-APRNs practice in primary care settings includes but is not limited to: (a) improving collaboration by consulting with a primary care provider, (b) providing medically based behavioral health care and/or (c) unifying primary care and behavioral health as an integrated process.

Integrative Programs

Integrative programs provide simultaneous care and treatment for co-occurring substance use disorders and serious mental health disorders by a team of trained professionals. These programs exist across the care continuum. According to the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association, substance use disorders are Axis I disorders (American Psychiatric Association, 2000). As such, providers of psychiatric services, including PMH-RNs and PMH-APRNs must be well-versed in the assessment, care and treatment of those with co-occurring psychiatric and substance disorders. In a 1998 SAMHSA consensus report on co-occurring disorder standards, practice, competencies, and training curricula, the

following principle was emphasized: *Comorbidity should be expected, not considered an exception*. Consequently, the whole system must be designed to be welcoming and accessible to healthcare consumers with all types of dual diagnoses; and, whenever possible, treatment of persons with complex comorbid disorders should be provided by individuals, teams, or programs with expertise in mental health and substance use disorders (SAMHSA, 1998). Further, individuals with co-occurring disorders present complicated, chronic, interrelated conditions that often require personalized solutions for the specific set of symptoms, level of severity, and other psychosocial and environmental factors. Thus, treatment plans must be individualized to address each person's specific needs using staged interventions and motivational enhancement to support recovery (SAMHSA, 2002).

Telehealth

Telehealth is the use of telecommunications technology to remove time and distance barriers from the delivery of healthcare services and related healthcare activities. Electronic therapy is an expanded means of communication that promotes access to health care (Center for Substance Abuse Treatment, 2009). The psychiatric–mental health registered nurse may use electronic means of communication such as telephone consultation, computers, electronic mail, image transmission, and interactive video sessions to establish and maintain a therapeutic relationship by creating an alternative sense of the nursing presence that may or may not occur in “real time.” Psychiatric–mental health nursing care in telehealth incorporates practice and clinical guidelines that are based on empirical evidence and professional consensus. Telehealth encounters raise special issues related to confidentiality and regulation. Telehealth technology can cross state and even national boundaries and must be practiced in accordance with all applicable state, federal, and international laws and regulations. Particular attention must be directed to confidentiality, informed consent, documentation, maintenance of records, and the integrity of the transmitted information.

Self-Employment

Self-employed PMH-APRNs offer direct services in solo private practice and group practice settings, or through contracts with employee assistance programs, health maintenance organizations, managed care companies, preferred provider organizations, industry health departments, home healthcare agencies, or other service delivery arrangements. In these settings, the PMH-APRN provides comprehensive mental health care to clients. In the consultation and liaison role, the PMH-APRN may also provide consultative services at the organization, state and national levels. This type of consultation includes the provision of clinical or system assessment, development, implementation and evaluation. Further, Psychiatric Nurse consultants have independent practices as legal consultants or experts for both individual legal actions and systemic actions or litigations. Self-employed nurses may be sole-proprietors or form nurse-owned corporations or organizations that provide mental health service contracts to industries or other employers.

Forensic Mental Health

PMH-RN and the PMH-APRN levels of practice are found within forensic mental health settings. Roles include working with victims and offenders across the continuum of care from community (forensic ACT and conditional-release teams) settings to jails, prisons, and state psychiatric hospitals. In essence any cross between the criminal justice system and psychiatric nursing can be considered forensic mental health. Estimates indicate that one-third of persons in jails and prisons have mental illnesses, and most admissions to inpatient care are court-ordered (Torrey, Kennard, Eslinger, Lamb & Pavle, (2010). Forensic PMH-APRNs perform psychiatric assessments, prescribe and administer psychiatric medications, and educate correctional officers about mental health issues. Forensic PMH-APRNs also provide therapeutic services to witnesses and victims of crime.

Disaster Psychiatric Mental Health Nursing

Psychiatric–mental health nurses provide psychological first aid and mental health clinical services as first responders through organizational systems in response to environmental and man-made disasters. Disaster psychiatry and mental health is a

growing field of practice designed to facilitate effective coping by disaster victims and relief workers as they experience extreme stresses in the aftermath of a disaster. The mental health problems experienced by disaster survivors are typically stress-induced symptoms that are precipitated by numerous and simultaneous practical problems that they encounter secondary to the disaster. Disaster psychiatry and mental health services encompass a wide range of activities, including public health preparations, early psychological interventions, psychiatric consultation to surgical units, relief units to facilitate appropriate triage, and psychotherapeutic interventions to alleviate stress to individuals, families and children. Both PMH-RNs and PMH-APRNs may be actively engaged in the practical work of providing Psychological First Aid (Young, 2006) and community education networking to assist in building community resilience. The APRN–PMH also engages in psychiatric triage and referral, crisis stabilization and addressing specific health issues with individuals who have pre-existing psychiatric-mental health and/or substance use disorders (Stoddard, Pandya, & Katz, 2011; Ursano, Fullerton, Weisaeth, & Raphael, 2007).

Psychiatric mental health nurses care for persons with psychiatric, behavioral health and co-morbid conditions across the lifespan. Using therapeutic interpersonal and/or pharmacological interventions, PMH nurses promote recovery for countless persons afflicted with the debilitating effects of behavioral, psychiatric and substance use disorders.

STANDARDS OF PRACTICE

The standards of psychiatric-mental health nursing practice are authoritative statements of the duties that psychiatric-mental health registered nurses are expected to perform competently. The standards published herein may be utilized as evidence of the standard of care, with the understanding that application of the standards is context dependent. Specific conditions and clinical circumstances may affect the application of the standards at a given time. The standards are subject to formal, periodic review and revision. These practice and performance standards are written in such a way that each standard and competency listed for the psychiatric–mental health registered nurse also apply to the advanced practice psychiatric–mental health registered nurse. In several instances additional standards and measurement are only applicable to the advanced practice registered nurse.

Standard 1. Assessment

The Psychiatric–Mental Health Registered Nurse collects and synthesizes comprehensive data that is pertinent to the healthcare consumer's health and/or situation.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Collects comprehensive data including, but not limited, to psychiatric, substance, physical, functional, psychosocial, emotional, cognitive, sexual, cultural, age-related, environmental, spiritual/transpersonal, and economic assessments in a systematic and ongoing process while focusing on the uniqueness of the person.
- Elicits the healthcare consumer’s values, preferences, knowledge of the healthcare situation, expressed needs and recovery goals.
- Involves the health care consumer, family, other identified support persons, and healthcare providers, as appropriate, in holistic data collection.

- Identifies barriers (e.g., psychosocial, literacy, financial, cultural) to effective communication and makes appropriate adaptations.
- Incorporates effective clinical interviewing skills that facilitate development of a therapeutic relationship.
- Recognizes the impact of personal attitudes, values, and beliefs.
- Assesses family dynamics and impact on the healthcare consumer's immediate condition, or the anticipated needs of the consumer's of the situation.
- Prioritizes data collection activities based on the healthcare consumer's immediate condition, anticipated needs or situation.
- Uses appropriate evidence-based assessment techniques, instruments and tools in collecting pertinent data.
- Uses analytical models and problem-solving techniques.
- Synthesizes available data, information, and knowledge relevant to the situation to identify patterns and variances.
- Uses therapeutic principles to understand and make inferences about the consumer's emotions, thoughts, behaviors and condition.
- Applies ethical, legal, and privacy guidelines and policies to the collection, maintenance, use, and dissemination of data and information.
- Recognizes the healthcare consumer as the authority on her or his own health by honoring their care preferences.
- Documents relevant data in a retrievable format.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric–Mental Health Advanced Practice Registered Nurse (PMH- APRN)

- Performs a comprehensive psychiatric and mental health diagnostic evaluation.
- Initiates and interprets diagnostic tests and procedures relevant to the person's current status.
- Employs evidence-based clinical practice guidelines to guide screening and diagnostic activities related to psychiatric and medical co-morbidities.

- Conducts a multigenerational family assessment, including medical, psychiatric and substance use history.
- Assesses the effect of interactions among the individual, family, community, and social systems and their relationship to mental health functioning, health and illness.

Standard 2. Diagnosis

The psychiatric–mental health registered nurse analyzes the assessment data to determine diagnoses, problems or areas of focus for care and treatment, including level of risk.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Identifies actual or potential risks to the healthcare consumer's health and safety or barriers to mental and physical health which may include but are not limited to interpersonal, systematic, or environmental circumstances.
- Derives the diagnosis, problems or areas in need of care and treatment from the assessment data.
- Develops the diagnosis or problems with the healthcare consumer, significant others, and other healthcare clinicians to the greatest extent possible in concert with person-centered, recovery-oriented practice.
- Develops diagnoses or problem statements that, to the greatest extent possible, are in the health care consumer's words and congruent with available and accepted classification systems.
- Documents diagnoses or problems in a manner that facilitates the determination of the expected outcomes and plan.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN):

- Systematically compares and contrasts clinical findings with normal and abnormal variations and developmental events in formulating a differential diagnosis.
- Utilizes complex data and information obtained during interview, examination, and diagnostic procedures in identifying diagnoses.

- Incorporates standard psychiatric and substance use diagnoses (e.g. DSM, IDC-9).
- Identifies long-term effects of psychiatric disorders on mental, physical, and social health.
- Evaluates the health impact of life stressors, traumatic events, and situational crises within the context of the family cycle.
- Evaluates the impact of the course of psychiatric disorders and mental health problems on a healthcare consumer's individual recovery course, including quality of life and functional status.
- Assists the PMH-RN and other staff in developing and maintaining competency in problem identification and the diagnostic process.

Standard 3. Outcomes Identification

The Psychiatric–Mental Health Registered Nurse identifies expected healthcare consumer outcomes / goals for a plan individualized to the consumer or to the situation.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Involves the healthcare consumer to the greatest extent possible in formulating mutually agreed upon outcomes and individualized healthcare consumer goals.
- Involves the healthcare consumer's family, significant support persons, healthcare providers, and others in formulating expected outcomes when possible and as appropriate.
- Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise when formulating expected outcomes.
- Identifies expected outcomes that incorporate scientific evidence and are achievable through implementation of evidence-based practices.
- Defines expected outcomes in terms of the healthcare consumer, values, culture, ethical considerations, environment, or situation with consideration of associated risks, benefits, costs, current scientific evidence and healthcare consumer's individual recovery goals.
- Develops expected outcomes that provide direction for continuity of care.
- Documents expected outcomes as healthcare consumer-focused measurable goals in language either developed by or understandable to the healthcare consumer.
- Includes a time estimate for attainment of expected outcomes.
- In partnership with the healthcare consumer, modifies expected outcomes based on changes in status or evaluation of the situation.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN):

- Assists the PMH-RN in identifying expected outcomes that incorporate scientific evidence and are achievable through implementation of evidence-based practices.
- Develops, implements, supports and uses clinical guidelines to promote positive outcomes.
- Differentiates outcomes that require care process interventions from those that require system-level interventions.

Standard 4. Planning

The Psychiatric–Mental Health Registered Nurse develops a plan that prescribes strategies and alternatives to assist the healthcare consumer in attainment of expected outcomes.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Develops an individualized plan in partnership with the person, family, and others considering the person's characteristics or situation, including, but not limited to, values, beliefs, spiritual and health practices, preferences, choices, developmental level, coping style, culture and environment, available technology and individual recovery goals.
- Establishes the plan priorities with the healthcare consumer, family, and others as appropriate.
- Prioritizes elements of the plan based on the assessment of the health care consumer's level of risk for potential harm to self or others and safety needs.
- Includes strategies in the plan that addresses each of the identified problems or issues, including strategies for the promotion of recovery, restoration of health and prevention of illness, injury, and disease.
- Considers the economic impact of the plan.
- Assists healthcare consumers in securing treatment or services in the least restrictive environment.
- Includes an implementation pathway or timeline in the plan.
- Provides for continuity in the plan.
- Utilizes the plan to provide direction to other members of the healthcare team.
- Documents the plan using person-centered, non-jargon terminology.
- Defines the plan to reflect current statutes, rules and regulations, and standards.
- Integrates current scientific evidence, trends and research.

- Modifies the plan (goals / outcomes and interventions) based on ongoing assessment of the health care consumer's achievement of goals and responses to interventions.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Identifies assessment and diagnostic strategies and therapeutic interventions that reflect current evidence, including data, research, literature, and expert clinical mental health and medical knowledge.
- Plans care to minimize complications and promote individualized recovery, and optimal quality of life using treatment modalities such as, but not limited to, cognitive behavioral therapies, psychotherapy, and psychopharmacology.
- Selects or designs strategies to meet the multifaceted needs of complex healthcare consumers.
- Includes synthesis of healthcare Consumer's values and beliefs regarding nursing and medical therapies in the plan.
- Actively participates in the development and continuous improvement of systems that support the planning process.

Standard 5. Implementation

The Psychiatric–Mental Health Registered Nurse implements the identified plan.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Partners with the person, family, significant others, and caregivers as appropriate to implement the plan in a safe, realistic, and timely manner.
- Utilizes the therapeutic relationship and employs principles of mental health recovery.
- Utilizes evidence based interventions and treatments specific to the problem or issue.
- Utilizes technology to measure, record, and retrieve healthcare consumer data, implement the nursing process, and enhance nursing practice
- Utilizes community resources and systems to implement the plan.
- Provides age-appropriate care in a culturally and ethnically sensitive manner.
- Provides care and treatment related to psychiatric, substance, and medical problems.
- Provides holistic care that focuses on the person with the disease or disorder, not just the disease or disorder itself.
- Advocates for the healthcare consumer.
- Addresses the needs of diverse populations across the lifespan.
- Collaborates with nursing colleagues and others to implement the plan.
- Supervises non-RN nursing staff in carrying out nursing interventions.
- Integrates traditional and complementary healthcare practices as appropriate.
- Documents implementation and any modifications, including changes or omissions, of the identified plan.
- Incorporates new knowledge and strategies to initiate change in nursing care practices if desired outcomes are not achieved.

- Manages psychiatric emergencies by determining the level of risk and initiating and coordinating effective emergency care.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Facilitates utilization of systems and community resources to implement the plan.
- Supports collaboration with nursing colleagues and other disciplines to implement the plan.
- Uses principles and concepts of project management and systems management when implementing the plan.
- Fosters organizational systems that support implementation of the plan.
- Provides Clinical Supervision to the PMH-RN in the implementation of the plan.
- Actively participates in the development and continuous improvement of systems that support the implementation of the plan.

Standard 5A. Coordination of Care

The Psychiatric–Mental Health Registered Nurse coordinates care delivery.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Coordinates implementation of the plan.
- Manages the healthcare consumer's care in order to maximize individual recovery, independence and quality of life.
- Assists the healthcare consumer to identify options for alternative care.
- Communicates with the healthcare consumer, family, and system during transitions in care.
- Advocates for the delivery of dignified and humane care by the interprofessional team.

- Documents the coordination of care.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Provides leadership in the coordination of multidisciplinary team for integrated delivery of services.
- Functions as the single point of accountability for all medical / psychiatric services.
- Synthesizes data and information to prescribe necessary system and community support measures, including environmental modifications.
- Coordinates system and community resources that enhance delivery of care across continuums.

Standard 5B. Health Teaching and Health Promotion

The Psychiatric–Mental Health Registered Nurse employs strategies to promote health and a safe environment.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Provides health teaching in individual or group settings related to the healthcare consumer's needs, recovery goals, and situation that may include, but is not limited to: mental health problems, psychiatric and substance use disorders, medical disorders, treatment regimen and self-management of those regimens, coping skills, relapse prevention, self-care activities, healthy living skills, resources, conflict management, problem-solving skills, stress management and relaxation techniques, and crisis management.

- Uses health promotion and health teaching methods appropriate to the situation and the healthcare consumer's values, beliefs, health practices, developmental level,

learning needs, readiness and ability to learn, language preference, spirituality, culture, and socioeconomic status.

- Integrates current knowledge, evidence-based practices and research regarding psychotherapeutic educational strategies and content.
- Engages consumer alliances, such as peer specialists, and advocacy groups, as appropriate, in health teaching and health promotion activities.
- Identifies community resources to assist and support consumers in using prevention and mental healthcare services.
- Seeks opportunities from the individual health care consumer for feedback and evaluation of the effectiveness of strategies utilized.
- Provides anticipatory guidance to individuals and families to promote mental health and to prevent or reduce the risk of psychiatric disorders.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Synthesizes empirical evidence on risk behaviors, learning theories, behavioral change theories, motivational theories, epidemiology, and other related theories and frameworks when designing health information and consumer education.
- Educates healthcare consumers and significant others about intended effects and potential adverse effects of treatment options and regimes.
- Provides education to individuals, families, and groups to promote knowledge, understanding, and effective management of overall health maintenance, mental health problems, and psychiatric / substance disorders.
- Uses knowledge of health beliefs, practices, evidence-based findings, and epidemiological principles, along with the social, cultural, and political issues that affect mental health in the community, to develop health promotion strategies.
- Designs health information and educational programs appropriate to the healthcare consumer's developmental level, learning needs, readiness to learn, and cultural values and beliefs.

- Evaluates health information resources, such as the Internet, in the area of practice for accuracy, readability, and comprehensibility to help healthcare consumers access quality health information.
- Assists the PMH-RN in curriculum and program development in the areas of health teaching and health promotion.

Standard 5C. Milieu Therapy

The Psychiatric–Mental Health Registered Nurse provides, structures, and maintains a safe, therapeutic, recovery-oriented environment, in facilities and in the community in collaboration with healthcare consumers, families, and other healthcare clinicians.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Orients the healthcare consumer and family to the care environment, including the physical environment, the roles of different healthcare providers, how to be involved in the treatment and care delivery processes, schedules of events pertinent to their care and treatment, and expectations regarding safe and therapeutic behaviors.
- Orients the healthcare consumer to their rights and responsibilities particular to the treatment or care environment.
- Establishes a welcoming, trauma-informed environment.
- Conducts ongoing assessments of the healthcare consumer in relationship to the environment to guide nursing interventions in maintaining a safe environment and healthcare consumer safety.
- Selects specific activities, both individual and group, that meet the healthcare consumer's physical and mental health needs for meaningful participation in the milieu and promoting personal growth.

- Advocates that the healthcare consumer is treated in the least restrictive environment necessary to maintain the safety of the healthcare consumer and others.
- Informs the healthcare consumer in a culturally competent manner about the need for external structure or support and the conditions necessary to remove the external restrictions.
- Provides support and validation to healthcare consumers when discussing their illness experience, and seeks to prevent complications of illness.

Standard 5D. Pharmacological, Biological, and Integrative Therapies

The Psychiatric–Mental Health Registered Nurse incorporates knowledge of pharmacological, biological, and complementary interventions with applied clinical skills to restore health and prevent further disability.

Measurement Criteria

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Applies current research findings to guide nursing actions related to pharmacology, other biological therapies and integrative therapies.
- Assesses healthcare consumer's response to biological interventions based on current knowledge of pharmacological agents' intended actions, interactive effects, potential untoward effects, and therapeutic doses.
- Includes health teaching for medication management to support consumers in managing their own medications and following prescribed regimen.
- Provides health teaching about mechanism of action, intended effects, potential adverse effects of the proposed prescription, ways to cope with transitional side effects, and other treatment options, including no treatment.
- Directs interventions toward alleviating untoward effects of biological interventions.
- Communicates observations about the healthcare consumer's response to biological interventions to other health clinicians.

Standard 5E. Prescriptive Authority and Treatment

The Psychiatric–Mental Health Advanced Practice Registered Nurse uses prescriptive authority, procedures, referrals, treatments, and therapies in accordance with state and federal laws and regulations.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN):

- Conducts a thorough assessment of past medication trials, side effects, efficacy, and consumer preference.
- Educates and assists the healthcare consumer in selecting the appropriate use of complementary and alternative therapies.
- Provides healthcare consumers with information about intended effects and potential adverse effects of proposed prescriptive therapies.
- Provides information about pharmacologic agents, costs, and alternative treatments and procedures as appropriate.
- Prescribes evidence-based treatments, therapies, and procedures considering the individual's comprehensive healthcare needs.
- Prescribes pharmacologic agents based on a current knowledge of pharmacology and physiology.
- Prescribes specific pharmacological agents and treatments in collaboration with the healthcare consumer, based on clinical indicators, the healthcare consumer's status, needs and preferences, and the results of diagnostic and laboratory tests.
- Evaluates therapeutic and potential adverse effects of pharmacological and non-pharmacological treatments.
- Evaluates pharmacological outcomes by utilizing standard symptom measurements and reports to determine efficacy.

Standard 5F. Psychotherapy

The Psychiatric–Mental Health Advanced Practice Registered Nurse conducts individual, couples, group, and family psychotherapy using evidence-based psychotherapeutic frameworks and therapeutic relationships.

Competencies

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Uses knowledge of relevant biological, psychosocial, and developmental theories, as well as best available research evidence, to select therapeutic methods based on individual needs.
- Utilizes interventions that promote mutual trust to build a therapeutic treatment alliance.
- Empowers healthcare consumers to be active participants in treatment.
- Applies therapeutic communication strategies based on theories and research evidence to reduce emotional distress, facilitate cognitive and behavioral change, and foster personal growth.
- Uses awareness of own emotional reactions and behavioral responses to others to enhance the therapeutic alliance.
- Analyzes the impact of duty to report and other advocacy actions on the therapeutic alliance.
- Arranges for the provision of care in the therapist's absence.
- Applies ethical and legal principles to the treatment of healthcare consumers with mental health problems and psychiatric disorders.
- Makes referrals when it is determined that the healthcare consumer will benefit from a transition of care or consultation due to change in clinical condition.
- Evaluates effectiveness of interventions in relation to outcomes using standardized methods as appropriate.
- Monitors outcomes of therapy and adjusts the plan of care when indicated.
- Therapeutically concludes the interpersonal relationship and transitions the healthcare consumer to other levels of care, when appropriate.

- Manages professional boundaries in order to preserve the integrity of the therapeutic process.

Standard 5G. Consultation

The Psychiatric–Mental Health Advanced Practice Registered Nurse provides consultation to influence the identified plan, enhance the abilities of other clinicians to provide services, and effect positive change.

Competencies

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Initiates consultation at the request of the consultee.
- Establishes a working alliance with the healthcare consumer or consultee based on mutual respect and role responsibilities.
- Facilitates the effectiveness of a consultation by involving the stakeholders in the decision-making process.
- Synthesizes clinical data, theoretical frameworks, and evidence when providing consultation.
- Communicates consultation recommendations that influence the identified plan, facilitate understanding by involved stakeholders, enhance the work of others, and effect change.
- Clarifies that implementation of system changes or changes to the plan of care remain the consultee's responsibility.
- Assists the PMH-RN and other members of the multidisciplinary team with complex situations, both direct-care and systemically.

Standard 6. Evaluation

The Psychiatric–Mental Health Registered Nurse evaluates progress toward attainment of expected outcomes.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Conducts a systematic, ongoing, and criterion-based evaluation of the outcomes / goals in relation to the prescribed interventions, by the plan and indicated timeline.
- Collaborates with the healthcare consumer, family or significant others, and other healthcare clinicians in the evaluation process.
- Documents results of the evaluation.
- Evaluates the effectiveness of the planned strategies in relation to healthcare consumer's responses and the attainment of the expected outcomes.
- Uses ongoing assessment data to revise the diagnoses / problems, outcomes, and interventions, as needed.
- Adapts the plan of care for the trajectory of treatment according to evaluation of response.
- Disseminates the results to the healthcare consumer and others involved in the care or situation, as appropriate, in accordance with state and federal laws and regulations.
- Participates in assessing and assuring the responsible and appropriate use of interventions in order to minimize unwarranted or unwanted treatment and healthcare consumer suffering.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Evaluates the accuracy of the diagnosis and effectiveness of the interventions in relationship to the healthcare consumer's attainment of expected outcomes.

- Synthesizes the results of the evaluation analyses to determine the impact of the plan on the affected individuals, families, groups, communities, and institutions.
- Uses the results of the evaluation analyses to make or recommend process or structural changes, including policy, procedure, or protocol documentation, as appropriate
- Assists the PMH-RN in the evaluation and re-formulation of the plan in complex situations.

STANDARDS OF PROFESSIONAL PERFORMANCE

Standard 7. Ethics

The Psychiatric–Mental Health Registered Nurse integrates ethical provisions in all areas of practice.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Uses *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) to guide practice.
- Delivers care in a manner that preserves and protects healthcare consumer autonomy, dignity, and rights.
- Is aware of and avoids using the power inherent in the therapeutic relationship to influence the healthcare consumer in ways not related to the treatment goals.
- Maintains confidentiality within legal and regulatory parameters.
- Serves as a consumer advocate protecting patient's rights and assisting consumers in developing skills for self-advocacy.
- Maintains a therapeutic and professional interpersonal relationship with appropriate professional role boundaries.
- Demonstrates a commitment to practicing self-care, managing stress, and connecting with self and others.
- Contributes to resolving ethical issues of consumers, colleagues, or systems as evidenced in such activities as recommending ethics clinical consultations for specific healthcare consumer situations and participating on ethics committees.
- Reports illegal, incompetent, or impaired practices.
- Promotes advance care planning related to behavioral health issues which may include behavioral health advance directives.
- Assists healthcare consumer s who are facing life threatening medical illnesses or aging to plan for and gain access to appropriate palliative and hospice care.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Informs the healthcare consumer of the risks, benefits, and outcomes of healthcare regimens.
- Participates in interdisciplinary teams that address ethical risks, benefits, and outcomes.
- Promotes and maintains a system and climate that is conducive to providing ethical care.
- Utilizes ethical principles to advocate for access and parity of services for mental health problems, psychiatric disorders, and substance use disorder services.

Standard 8. Education

The Psychiatric–Mental Health Registered Nurse attains knowledge and competency that reflect current nursing practice.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Participates in ongoing educational activities related to appropriate knowledge bases and professional issues.
- Participates in interprofessional educational opportunities to promote continuing skill-building in team collaboration
- Demonstrates a commitment to lifelong learning through self-reflection and inquiry to identify learning needs.
- Seeks experiences that reflect current practice in order to maintain skills and competence in clinical practice or role performance.
- Acquires knowledge and skills appropriate to the specialty area, practice setting, role, or situation.
- Maintains professional records that provide evidence of competency and lifelong learning.
- Seeks experiences and formal and independent learning activities to maintain and develop clinical and professional skills and knowledge.
- Seeks experiences and formal and independent learning activities to maintain and develop skills in and knowledge of electronic health care media.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Uses current healthcare research findings and other evidence to expand clinical knowledge, enhance role performance, and increase knowledge of professional issues.
- Contributes to an environment that promotes interprofessional education.

- Models expert practice to interprofessional team members and healthcare consumers.
- Mentors registered nurses and colleagues as appropriate.
- Participates in interprofessional teams contributing to role development and advanced nursing practice and health care.

Standard 9 Evidence-Based Practice and Research

The Psychiatric–Mental Health registered nurse integrates research findings into practice.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Utilizes evidence-based nursing knowledge, including research findings, to guide practice decisions.
- Actively participates in research activities at various levels appropriate to the nurse's level of education and position. Such activities may include:
    - Identifying clinical problems specific to psychiatric–mental health nursing research).
    - Participating in data collection (surveys, pilot projects, formal studies).
    - Assisting with informed consent process.
    - Participating in a formal committee or program.
    - Sharing research activities and findings with peers and others.
    - Conducting Evidence-Based Practice Projects.
    - Conducting research.
    - Critically analyzing and interpreting research for application to practice.
    - Using research findings in the development of policies, procedures, and standards of practice in healthcare.
    - Incorporating research as a basis for learning.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Contributes to nursing knowledge by conducting, critically appraising, or synthesizing research that discovers, examines, and evaluates knowledge, theories, criteria, and creative approaches to improve healthcare practice.
- Promotes a climate of research and clinical inquiry.

- Formally disseminates research findings through activities such as presentations, publications, consultation, and journal clubs.
- Promotes a culture that consistently integrates the best available research evidence into practice.
- Educates PMH-RNs on the conduct of research and Evidence-based Practice Projects

Standard 10. Quality of Practice

The Psychiatric–Mental Health Registered Nurse systematically enhances the quality and effectiveness of nursing practice.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Demonstrates quality by documenting the application of the nursing process in a responsible, accountable, and ethical manner.
- Uses the results of quality improvement activities to initiate changes in nursing practice and in the healthcare delivery system.
- Uses creativity and innovation in nursing practice to improve care delivery.
- Incorporates new knowledge to initiate changes in nursing practice if desired outcomes are not achieved.
- Participates in quality improvement activities. Such activities may include:
    - Identifying aspects of practice important for quality monitoring.
    - Using indicators developed to monitor quality and effectiveness of nursing practice.
    - Collecting data to monitor quality and effectiveness of nursing practice.
    - Analyzing quality data to identify opportunities for improving nursing practice.
    - Formulating recommendations to improve nursing practice or outcomes.
    - Implementing activities to enhance the quality of nursing practice.
    - Developing, implementing, and evaluating policies, procedures and guidelines to improve the quality of practice.
    - Participating on interdisciplinary teams to evaluate clinical care or health services.
    - Participating in efforts to minimize costs and unnecessary duplication.
    - Analyzing factors related to safety, satisfaction, effectiveness, and cost–benefit options.
    - Analyzing organizational systems for barriers.

- Implementing processes to remove or decrease barriers within organizational systems.

Additional Measurement Criteria for the Psychiatric–Mental Health Advanced Practice Nurse

The PMH-APRN:

- Obtains and maintains professional certification at the advanced level in psychiatric–mental health nursing.
- Designs quality improvement initiatives to improve practice and health outcomes.
- Educates the PMH-RN and other colleagues in the conduct of quality and performance improvement projects.
- Identifies opportunities for the generation and use of research and evidence.
- Evaluates the practice environment and quality of nursing care rendered in relation to existing evidence.
- Collaborates with healthcare consumers, families, groups and communities in identifying and working on quality improvement initiatives.

Standard 11. Communication

The Psychiatric–Mental Health Registered Nurse

- Assesses communication format preferences of healthcare consumers, families, and colleagues.*
- Assesses her or his own communication skills in encounters with healthcare consumers, families, and colleagues.*
- Seeks continuous improvement of her or his own communication and conflict resolution skills.*
- Conveys information to healthcare consumers, families, the interprofessional team, and others in communication formats that promote accuracy.
- Questions the rationale supporting care processes and decisions when they do not appear to be in the best interest of the healthcare consumer.*
- Discloses observations or concerns related to hazards and errors in care or the practice environment to the appropriate level.
- Maintains communication with other providers to minimize risks associated with transfers and transition in care delivery.
- Documents referrals, including provisions for continuity of care.
- Contributes her or his own professional perspective in discussions with the interprofessional team.
- Documents plan of care communications, rationales for plan of care changes, and collaborative discussions to improve care.

*(BHE.MONE, 2006)

Standard 12. Leadership

The Psychiatric–Mental Health Registered Nurse provides leadership in the professional practice setting and the profession.

Measurement Criteria

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Engages in teamwork as a team player and a team builder.
- Works to create and maintain healthy work environments in local, regional, national, or international communities.
- Displays the ability to define a clear vision with associated goals and a plan to implement and measure progress.
- Demonstrates a commitment to continuous lifelong learning for self and others.
- Teaches others to succeed by mentoring and other strategies.
- Exhibits creativity and flexibility through times of change.
- Demonstrates energy, excitement, and a passion for quality work.
- Uses mistakes by self and others as opportunities for learning so that appropriate risk-taking is encouraged.
- Inspires loyalty by valuing people as the most precious asset in an organization.
- Directs the coordination of care across settings and among caregivers, including oversight of licensed and unlicensed personnel in any assigned or delegated tasks.
- Serves in key roles in the work setting by participating on committees, councils, and administrative teams.
- Promotes advancement of the profession through participation in professional organizations.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Influences health policy and promotes recovery orientation in services for prevention and treatment of mental health problems, psychiatric disorders, co-occurring psychiatric and substance related disorders, and co-occurring psychiatric and medical disorders.
- Works to influence decision-making bodies to improve healthcare.
- Provides direction to enhance the effectiveness of the healthcare team.
- Initiates and revises protocols or guidelines to reflect evidence-based practice, to reflect accepted changes in care management, or to address emerging problems.
- Promotes communication of information and advancement of the profession through writing, publishing, and presentations for professional or lay audiences.
- Designs innovations to effect change in practice and improve health outcomes.

Standard 13. Collaboration

The Psychiatric–Mental Health Registered Nurse collaborates with the healthcare consumer, family, and others in the conduct of nursing practice.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Shares knowledge and skills with peers and colleagues as evidenced by such activities as healthcare conferences or presentations at formal or informal meetings.
- Provides peers with feedback regarding their practice and role performance.
- Interacts with peers and colleagues to enhance one's own professional nursing practice and role performance.
- Maintains compassionate and caring relationships with peers and colleagues.
- Contributes to an environment that is conducive to the education of healthcare professionals.
- Contributes to a supportive and healthy work environment.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Models expert practice to interdisciplinary team members and healthcare consumers.
- Mentors and provides clinical supervision to other registered nurses and colleagues as appropriate.
- Participates in interdisciplinary teams that contribute to role development and advanced nursing practice and health care.
- Partners with other disciplines to enhance healthcare through interprofessional activities such as education, consultation, management, technological development, or research opportunities.

1871 • Facilitates an interprofessional process with other members of the healthcare
1872 team.
1873

Standard14. Professional Practice Evaluation

The Psychiatric–Mental Health Registered Nurse evaluates one's own practice in relation to the professional practice standards and guidelines, relevant statutes, rules, and regulations.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Applies knowledge of current practice standards, guidelines, statutes, rules, and regulations.
- Engages in self-evaluation of practice on a regular basis, identifying areas of strength as well as areas in which professional development would be beneficial.
- Obtains informal feedback regarding practice from healthcare consumers, peers, professional colleagues, and others.
- Participates in systematic peer review as appropriate.
- Takes action to achieve goals identified during the evaluation process.
- Provides rationale for practice beliefs, decisions, and actions as part of the informal and formal evaluation processes.
- Seeks formal and informal constructive feedback from peers and colleagues to enhance psychiatric-mental health nursing practice or role performance.
- Provides peers with formal and informal constructive feedback to enhance psychiatric-mental health nursing practice or role performance.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Engages in a formal process seeking feedback regarding one's own practice from healthcare consumers, peers, professional colleagues, and others.
- Models self-improvement by reflecting on and evaluating one's own practice and role performance, and sharing insights with peers and professional colleagues.

Standard 15. Resource Utilization

The Psychiatric–Mental Health Registered Nurse considers factors related to safety, effectiveness, cost, and impact on practice in the planning and delivery of nursing services.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Evaluates factors such as safety, effectiveness, availability, cost–benefit, efficiencies, and impact on practice when choosing practice options that would result in the same expected outcome.
- Assists the healthcare consumer and family in identifying and securing appropriate and available services to address health-related needs.
- Assists the healthcare consumer and family in factoring in costs, risks, and benefits in decisions about treatment and care.
- Assigns or delegates elements of care to appropriate healthcare workers, based on the needs and condition of the consumer, potential for harm, stability of the condition, complexity of the task, and predictability of the outcome.
- Assists the healthcare consumer and family in becoming informed about the options, costs, risks, and benefits of treatment and care.
- Advocates for resources, including technology, that promote quality care.
- Identifies the evidence when evaluating resources.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Utilizes organizational and community resources to formulate multidisciplinary or interprofessional plans of care.
- Formulates innovative solutions for healthcare problems that address effective resource utilization and maintenance of quality.

- Designs evaluation strategies to demonstrate quality, cost effectiveness, cost–benefit, and efficiency factors associated with nursing practice.
- Builds constructive relationships with community providers, organizations and systems to promote collaborative decision-making and planning to identify and meet resource needs.

Standard 16. Environmental Health

The Psychiatric–Mental Health Registered Nurse practices in an environmentally safe and healthy manner.

Competencies

The Psychiatric–Mental Health Registered Nurse (PMH-RN):

- Attains knowledge of environmental health concepts, such as implementation of environmental health strategies.
- Promotes a practice environment that reduces environmental health risks for workers and healthcare consumers.
- Assesses the practice environment for factors such as sound, odor, noise, and light that threaten health.
- Advocates for the judicious and appropriate use of products in health care.
- Communicates environmental health risks and exposure reduction strategies to healthcare consumers, families, colleagues, and communities.
- Utilizes scientific evidence to determine if a product or treatment is an environmental threat.
- Participates in strategies to promote healthy communities.

Additional Competencies for the Psychiatric–Mental Health Advanced Practice Registered Nurse

The Psychiatric-Mental Health Advanced Practice Nurse (PMH-APRN):

- Creates partnerships that promote sustainable environmental health policies and conditions.
- Analyzes the impact of social, political, and economic influences on the environment and human health exposures. Critically evaluates the manner in which environmental health issues are presented by the popular media.
- Advocates for implementation of environmental principles for nursing practice.
- Supports nurses in advocating for and implementing environmental principles in nursing practice.

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Glossary

Assessment. A systematic, dynamic process by which the registered nurse, through interaction with the patient, family, groups, communities, populations, and healthcare providers, collects and analyzes data. Assessment may include the following dimensions: physical, psychological, socio-cultural, spiritual, cognitive, functional abilities, developmental, economic, and lifestyle.

Caregiver. A person who provides direct care for another, such as a child, dependent adult, the disabled, or the chronically ill.

Code of ethics. A list of provisions that makes explicit the primary goals, values, and obligations of the profession.

Co-morbidity. The simultaneous occurrence of more than one disease or condition in the same patient. One condition may cause the other or make the patient more vulnerable to it; they may be induced by common factors; or they may be unrelated.

Continuity of care. An interdisciplinary process that includes patients, families, and significant others in the development of a coordinated plan of care. This process facilitates the patient's transition between settings and healthcare providers, based on changing needs and available resources.

Contract.

Criteria. Relevant, measurable indicators of the standards of practice and professional performance.

Culture.

Diagnosis. A clinical judgment about the patient's response to actual or potential health conditions or needs. The diagnosis provides the basis for determination of a plan to achieve expected outcomes. Registered nurses utilize nursing or medical diagnoses depending upon educational and clinical preparation and legal authority.

Environment. The atmosphere, milieu, or conditions in which an individual lives, works, or plays.

Evaluation. The process of determining the progress toward attainment of expected outcomes, including the effectiveness of care, when addressing one's practice.

Expected outcomes. End results that are measurable, desirable, and observable, and translate into observable behaviors.

Evidence-based practice. A process founded on the collection, interpretation, and integration of valid, important, and applicable patient-reported, clinician-observed, and research-derived evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgments.

Family. Family of origin or significant others as identified by the patient.

Guidelines. Systematically developed statements that describe recommended actions based on available scientific evidence and expert opinion. Clinical guidelines describe a

process of patient care management that has the potential of improving the quality of clinical and consumer decision-making.

Health. An experience that is often expressed in terms of wellness and illness, and may occur in the presence or absence of disease or injury.

Healthcare consumer. The person, client, family, group, community, or population who is the focus of attention and to whom the registered nurse is providing services as sanctioned by the state regulatory bodies.

Healthcare providers. Individuals with special expertise who provide healthcare services or assistance to patients. They may include nurses, physicians, psychologists, social workers, nutritionist/dietitians, and various therapists.

Holistic. Based on an understanding that the parts of a patient are intimately interconnected and physical, mental, social, and spiritual factors need to be included in any interventions.

Illness. The subjective experience of discomfort.

Implementation. Activities such as teaching, monitoring, providing, counseling, delegating, and coordinating.

Interdisciplinary. Reliant on the overlapping skills and knowledge of each team member and discipline, resulting in synergistic effects where outcomes are enhanced and more comprehensive than the simple aggregation of the team members'individual efforts.

Knowledge. Information that is synthesized so that relationships are identified and formalized.

Mental health. Emotional and psychological wellness; the capacity to interact with others, deal with ordinary stress, and perceive one's surroundings realistically.

Multidisciplinary. Reliant on each team member or discipline contributing discipline-specific skills.

Nursing process. A nursing methodology based on critical thinking. The steps consist of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation.

Patient. The term *patient* has been purposively omitted from this document in favor of 'healthcare consumer' bearing in mind that other terms such as *client*, *individual*, *resident*, *family*, *group*, *community*, or *population* may be better choices in some instances. When the health care consumer is an individual, the focus is on the health state, problems, or needs of the individual. In the case of a family or group, the focus is on the health state of the unit as a whole or the reciprocal effects of the individual's health state on the other members of the unit. In the case of a community or population, the focus is on personal and environmental health and the health risks of the community or population.

Peer review. A collegial, systematic, and periodic process by which registered nurses are held accountable for practice and which fosters the refinement of one's knowledge, skills, and decision making at all levels and in all areas of practice.

Plan. A comprehensive outline of the steps that need to be completed to attain expected outcomes.

Psychiatric disorder. Any condition of the brain that adversely affects the patient's cognition, emotions, or behavior.

Psychiatric–mental health nursing. A specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders.

Quality of care. The degree to which health services for patients, families, groups, communities, or populations increase the likelihood of desired outcomes and are consistent with current professional knowledge.

Recovery Oriented.

Social Inclusion. Social inclusion is based on the belief that we all fare better when no one is left to fall too far behind and the social environment includes everyone. Social inclusion simultaneously incorporates multiple dimensions of well-being. It is achieved when all have the opportunity and resources necessary to participate fully in economic, social, and cultural activities which are considered the societal norm.

Standard. An authoritative statement defined and promoted by the profession, by which the quality of practice, service, or education can be evaluated.

Stigma. The extreme disapproval of, or discontent with, a person on the grounds of characteristics that distinguish them from other members of a society. Stigma may attach to a person, who differs from social or cultural norms. Social stigma can result from the perception or attribution, rightly or wrongly, of mental illness, physical disabilities, diseases, illegitimacy, sexual orientation, gender identity, skin tone, nationality, ethnicity, religion (or lack of religion) or criminality (see social inclusion).