Psychiatric-Mental Health Nursing

Scope and Standards of Practice

3rd Edition

ANA
AMERICAN NURSES ASSOCIATION

American Psychiatric Nurses Association

ISPN

The Standards of Practice for Psychiatric-Mental Health Nursing describe a competent level of nursing practice demonstrated by the critical thinking model known as the nursing process. The nursing process encompasses significant actions completed by registered nurses and forms the foundation of the nurses' decision-making.

Standards of Practice

Standard 1. Assessment

The psychiatric-mental health registered nurse collects and synthesizes comprehensive health data that are pertinent to the patient's/client's health and/or situation.

Standard 2. Diagnosis

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

Standard 3. Outcomes Identification

The psychiatric-mental health registered nurse identifies expected outcomes based on the patient's/client's goals and their individual circumstances.

Standard 4. Planning

The psychiatric-mental health registered nurse develops a patient/client-centered plan that prescribes strategies and alternatives to attain expected outcomes.

Standard 5. Implementation

The psychiatric-mental health registered nurse implements the patient/client-centered plan.

Standard 5A. Coordination of Care

The psychiatric-mental health registered nurse coordinates care delivery.

Standard 5B. Health Teaching and Health Promotion

The psychiatric-mental health registered nurse employs strategies to promote health and a safe environment.

Standard 5C. Consultation

The psychiatric-mental health advanced practice registered nurse provides consultation to maximize outcomes from the identified plan, collaborate with other clinicians to provide services for patients/clients, and contribute to system change.

Standard 5D. Pharmacological/Biological Therapies and Prescriptive Authority

The psychiatric-mental health registered nurse incorporates knowledge of pharmacological and biological interventions with applied clinical skills to restore the patient's/client's health and prevent further disability.

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.

Standard 5E. Complementary/Integrative Therapies

The psychiatric-mental health registered nurse incorporates knowledge of complementary/integrative interventions (e.g., meditation, yoga, acupuncture, Reiki, Healing Touch, nutrition, physical exercises, dietary supplements, aromatherapy, herbology, art, and music) with applied clinical skills to restore the patient's/client's health and prevent further disability.

Standard 5F. Milieu Therapy

The psychiatric-mental health registered nurse (including the graduate-level prepared PMH-RN and PMH-APRN) provides a safe, therapeutic, recovery-oriented environment in collaboration with patients/clients, families, and other clinicians/ancillary staff/care partners.

Standard 5G. Therapeutic Relationship

The psychiatric-mental health registered nurse (including the graduate-level prepared PMH-RN and PMH-APRN) uses the therapeutic relationship as the basis for interactions and the provision of care.

Standard 5H. Counseling and Psychotherapy

The psychiatric-mental health registered nurse uses counseling interventions to assist patients/clients in their individual recovery journeys.

The psychiatric-mental health advanced practice registered nurse conducts individual, couples, group, and family psychotherapy, using evidence-based psychotherapeutic frameworks within the nurse–client therapeutic relationship.

Standard 6. Evaluation

The psychiatric-mental health registered nurse evaluates progress toward attainment of expected outcomes.

Source: American Nurses Association, American Psychiatric Nurses Association, & International Society of Psychiatric-Mental Health Nurses. (2022). *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (3rd Ed.). Silver Spring, MD. ANA (pgs. 59–92).

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The American Nurses Association (ANA), the American Psychiatric Nurses Association (APNA), and the International Society of Psychiatric-Mental Health Nurses (ISPN) are national and international professional associations. This joint publication reflects the position of ANA, APNA, and ISPN regarding the scope and standards of psychiatric-mental health nursing practice and should be reviewed in conjunction with state board of nursing regulations. State law, rules, and regulations govern the practice of nursing, while *Psychiatric-Mental Health Nursing: Scope and Standards of Practice, 3rd Edition* guides registered nurses in the application of their professional skills and responsibilities.

About the American Nurses Association
The American Nurses Association (ANA) is the only full-service professional organization representing the interests of the nation's 4.2 million registered nurses through its constituent/state nurses associations and its organizational affiliates. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying Congress and regulatory agencies on health care issues affecting nurses and the public.

American Nurses Association
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About the American Psychiatric Nurses Association (APNA)
The American Psychiatric Nurses Association (APNA) is your resource for psychiatric-mental health nursing. A professional organization with 15,000 members, APNA provides leadership to promote psychiatric-mental health (PMH) nurses, improve mental health care for culturally diverse individuals, families, groups, and communities, and shape health policy for the delivery of mental health services. To facilitate professional advancement, APNA provides quality psychiatric-mental health nursing continuing education; a wealth of resources for established, emerging, and prospective PMH nurses; and a community of dynamic collaboration. APNA champions psychiatric-mental health nursing and mental health care through the development of positions on key issues, the dissemination of current knowledge and developments in PMH nursing, and collaboration with stakeholders to promote advances in recovery-focused assessment, diagnosis, treatment, and evaluation of persons with mental health and substance use conditions. For more information go to www.apna.org.

About the International Society of Psychiatric-Mental Health Nurses (ISPN)
The International Society of Psychiatric-Mental Health Nurses exists to unite and strengthen the presence and the voice of specialty psychiatric-mental health nursing globally, while influencing healthcare policy to promote equitable, evidence-based and effective treatment and care for individuals, families, and communities.

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Scope of Practice of Psychiatric-Mental Health Nursing

INTRODUCTION

This document addresses the scope of practice and standards of practice specific to psychiatric-mental health (PMH) nursing. The scope statement defines psychiatric-mental health nursing and describes its evolution in nursing, the levels of practice based on educational preparation, current clinical practice activities and sites, and current trends and issues relevant to the practice of psychiatric-mental health nursing. The standards of psychiatric-mental health nursing practice are authoritative statements that describe the responsibilities for which its practitioners are accountable.

Definition of Psychiatric-Mental Health Nursing

> *Psychiatric-mental health (PMH) nursing promotes integrated and comprehensive health and wellness through prevention and education, as well as assessment, diagnosis, care, and treatment of the full range of psychiatric-mental health disorders, including substance use disorders, across the life span. Psychiatric nurses practice transpersonal caring to promote the health and healing of humanity. The practice of PMH nursing is a science and an art, based on evidence and the purposeful use of self and the therapeutic relationship. PMH nurses provide care at the individual, family/relationship, community, and societal levels to promote well-being and quality of life, as well as to sustain positive health outcomes.*

PMH nurses work with people who are experiencing physical, psychological, mental, and spiritual distress. They provide comprehensive, trauma-responsive, person-centered behavioral and psychiatric-mental

health care in a variety of settings across the continuum of care. Essential components of PMH nursing practice include health and wellness promotion through identification of mental health issues, prevention of mental health problems, care of mental health problems, and treatment of persons with psychiatric-mental health disorders, including substance use disorders. Due to the complexity of care in this population, the preferred entry-level educational preparation is at the baccalaureate level; credentialing by the American Nurses Credentialing Center (ANCC) or a recognized certification organization should also be highly encouraged once practice requirements are met.

The PMH nurse provides care and treatment for individuals with psychiatric/substance use disorders and mental health issues and develops partnerships to assist them with their individual recovery goals. The PMH nurse has the responsibility to do more for the individuals when they can do less for themselves and to do less for the individuals when they are able to do more for themselves. In this way, PMH nurses develop and implement nursing interventions to assist the person in achieving recovery-oriented outcomes (McLoughlin, 2011). This philosophy of directing and providing care when the person is in acute distress and eventually transferring the decision-making and self-care to the individual is based on Peplau's theory of Interpersonal Relations in Nursing (Peplau, 1952). Furthermore, psychiatric nurses are guided by the philosophy and science of caring (Watson, 2008, 2018), which highlights the importance of caring, respecting, nurturing, understanding, and assisting individuals from a moral foundation and with a holistic approach. Both Peplau and Watson emphasize the importance of interpersonal relationships as a foundation for caring, which can promote individual and family growth. These and other frameworks have guided the evolution of psychiatric nursing practice as trailblazing and inspirational for all health care professionals who aim to integrate authentic partnership to facilitate recovery and well-being among individuals and families.

Other nursing theories that provide organizing frameworks for psychiatric-mental health nursing practice include Orem's (1971) theory of self-care and Reed's (1991) theory of self-transcendence. The concept of cultural awareness was introduced with the seminal work of Leininger's

(1985) theory of culture care diversity and universality and further extended with Campinha-Bacote's (2018) theory of cultural competence and cultural humility. Furthermore, life span development interventions used by PMH nurses are guided by developmental psychology theories such as Piaget's (1928/2012) theory of causality, Bandura's (1977) theory of self-efficacy, and Bronfenbrenner's (1979) theory of social ecology. Specific practice interventions may also be generated through the use of Prochaska and DiClemente's (1983) theory of self-change as well as Miller and Rollnick's (2012) theory of motivational interviewing to guide individuals, families, and groups to make sustainable changes to enhance quality of life and well-being.

An important focus of PMH nursing involves individuals with substance use disorders (Finnell, Tierney, & Mitchell, 2019). The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*) identifies substance misuse and addictive behaviors as psychiatric disorders (American Psychiatric Association [APA], 2013). These disorders may be co-occurring. An individual may have a primary psychiatric disorder with a secondary substance use disorder (e.g., a person diagnosed with bipolar disorder with hypomanic symptoms who uses alcohol to slow down), a primary substance use disorder with a secondary mental disorder (e.g., a person who experiences substance use disorder and becomes suicidal as a result), or two primary disorders such as schizophrenia and alcohol use disorder. The Substance Abuse and Mental Health Services Administration (SAMHSA) has long advocated for integrated treatment of both psychiatric and substance use disorders (SAMHSA, 2020a). Thus, in the first example, if a patient was admitted to a hospital with symptoms of hypomania, the Psychiatric-Mental Health Registered Nurse (PMH-RN) would not only need to assess and treat the symptoms related to mania but would also assess the consumer for alcohol use and the possibility of treatment. Therefore, the role of the PMH-RN requires competency in the assessment and treatment of both disorders.

PMH nurses provide basic care and treatment, general health teaching, health screening, and appropriate referral for treatment of general or complex physical health problems. The PMH nurse's assessment synthesizes information obtained from interviews, behavioral observations,

and other available data. From these, the PMH nurse determines diagnoses or problems that are congruent with available and accepted classification systems.

Goals or outcomes for the recipient of PMH nursing care are established early in treatment, with the individual directing this process as much as possible. Through a process of shared decision-making, the individual works with the nurse and other members of the health care team to develop a treatment plan based on assessment data, identified resources, and the individual's strengths and priorities. The PMH nurse then selects and implements evidence-based or best-practice interventions to assist with the optimal achievement of the individual's recovery goals and periodically evaluates both the attainment of the goals and the effectiveness of the interventions. The 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 individuals designing their treatment goals with assistance from the PMH nurse (McLoughlin & Geller, 2010).

Psychiatric-mental health problems and disorders are addressed across the continuum of care by PMH nurses. A continuum of care consists of an integrated system of settings, services, health care clinicians, and care levels spanning health states from illness to wellness. The primary goal of a continuum of care is to provide treatment that allows individuals to achieve the highest level of functioning in the least restrictive environment.

Phenomena of Concern for Psychiatric-Mental Health Nurses

Phenomena of concern for PMH nurses are dynamic, exist in all populations across the life span, and include but are not limited to:

- Promotion of optimal mental, physical, and spiritual well-being
- Prevention of mental and behavioral distress and illness
- Promotion of social inclusion of mentally and behaviorally at-risk individuals

- Elimination of stigma for those living with a psychiatric/substance use disorder or a mental health issue
- Improvement in access to care for those living with a psychiatric/substance use disorder or a mental health issue
- Provision of evidence-based treatment for psychiatric/substance use disorders that promotes whole health
- Provision of effective integrated physical and mental health care
- Recognition of psychological and physiological distress resulting from physical, interpersonal, and/or environmental trauma or neglect (e.g., domestic violence, sex trafficking) and the provision of trauma-informed care
- Inclusion of genetics and genomics in assessing the vulnerability of individuals and populations and determining individualized medicine
- Inclusion of social determinants of health in assessment, diagnosis, and care of individuals with psychiatric/substance use disorders or mental health issues
- Establishment and ongoing review of patient-centered, trauma-responsive, recovery-oriented plans of care
- Incorporation of innovative and technology-driven models of PMH care
- Reduction of self-harm and self-destructive behaviors, including non-suicidal self-injury and suicide
- Reduction of harm and destructive behaviors toward others, including verbal threats, physical assault, and homicide
- Evidence-based responses to the impact of bullying, including cyberbullying
- Evidence-based responses to community-based trauma following disasters, global pandemics, violence, race-related trauma international conflicts, and war
- Recognition and elimination of harmful bias, discrimination, and oppressive systems that affect practitioners and the people they serve
- Recognition of secondary trauma and compassion fatigue, as well as facilitation of self-care practices and resilience among PMH nurses

- Improvement of low health literacy rates among recipients of PMH care
- Involvement in health care policy and advocacy to promote mental health throughout the life span
- Participation in large-scale public mental health promotion strategies, including implementation of public policy, creation of supportive environments, and execution of community-based action

Recipients of Psychiatric-Mental Health Nursing Care

PMH nurses care for individuals, families, groups, or communities who have current or potential mental health needs across the life span. They provide care in all settings, from hospitals to homes, clinics to schools, and prisons to churches. The terms used to identify the recipients of their care vary across settings and models of care. One of the most common terms is "patient," meaning "one who suffers." It is usually used to refer to individuals who need a higher level of care and are being treated in acute care settings.

Patient rights initiatives in the 1990s promoted the use of terms such as "client" or "consumer," indicating more of a partnership between the individual and their clinician. These terms are frequently employed when referring to individuals in community-based settings or private practice. Those who are currently living in transitional or clinician-supported housing are frequently referred to as "residents." More recently, an effort to support recovery and avoid defining individuals based on their illness has prompted the development of terms such as "person with lived experience" or "person who is the focus of care." More generic terms, such as "recipient of care" or "health care recipient," can also be found in the literature.

Labels themselves are of particular importance to PMH nursing. The process of selecting the best term(s) to use in this document was done carefully and thoughtfully, being sensitive to the need for inclusivity and in an effort to eliminate stigma. With respect for the dignity of individuals

who are the recipients of PMH nursing care and for the sake of clarity, the term "patient" will be used throughout this document to capture the scope and standards of practice in acute care settings, and "client" will be used to capture the scope and standards of practice in community-based settings or private practice. From this point forward, the combined term "patient/client" will be used to denote a recipient of PMH care.

Establishing the Scope and Standards of PMH Nursing Practice

By developing and articulating the scope and standards of professional nursing practice, the nursing profession both defines its boundaries and informs society about the parameters of nursing practice and the expectations of competencies to be demonstrated. The scope and standards also guide the development of state-level nurse practice acts and the rules and regulations governing nursing practice. Because each state develops its own regulatory language about nursing, the designated limits, functions, and titles for nurses, particularly at the advanced practice level, may differ significantly from state to state. Nurses must ensure that their practice remains within the boundaries defined by their state practice acts. Individual nurses are accountable for ensuring that they practice within the limits of their own competence, professional code of ethics, and professional practice standards.

Levels of nursing practice are differentiated according to the nurse's educational preparation. The nurse's role, position, job description, and work setting further define practice. The PMH nurse's role may be focused on direct care clinical practice, consultation, administration, education, policy/advocacy, or research. It is important to note that PMH nurses at both the Registered Nurse (RN) and Advanced Practice Registered Nurse (APRN) levels share a common history and foundation for their scope of practice, which has evolved over time. What follows is a description of the history and evolution of psychiatric-mental health nursing, including the span of years and pivotal events that have shaped the various levels of practice from the late 19th century to the early 21st century.

HISTORY AND EVOLUTION OF PSYCHIATRIC-MENTAL HEALTH NURSING

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

Training for psychiatric nurses was originally provided by physicians. Effie Jane Taylor insisted that nurses train other nurses, and she developed the first nurse-taught course for psychiatric nursing within a general nursing education program at Johns Hopkins Hospital in the early 1900s (Stewart, 1939). 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.

Under nursing leadership, psychiatric-mental health nursing developed a biopsychosocial approach with specific nursing interventions for individuals with mental disorders. Nursing leadership also began to identify the didactic and clinical components of education training needed to care for persons with mental disorders. In the post–World War I era, "nursing in nervous and mental diseases" was added to curriculum guides developed by the National League for Nursing Education and was eventually required in all educational programs for registered nurses (Church, 1985).

The next wave of mental health reform and expansion in psychiatric nursing began during World War II. The public health significance of mental disorders became widely apparent when a significant proportion of potential military recruits were deemed unfit for service as a result of

psychiatric disability. In addition, public attention and sympathy for the large number of veterans with combat-related neuropsychiatric casualties led to increased support for improving mental health services. The National Mental Health Act in 1946 resulted in the establishment of the National Institute of Mental Health (NIMH) and funding to develop advanced educational programs for the mental health professions, including nursing (Smith, 2018). Nurses played an active role in meeting the growing demand for psychiatric services that resulted from increasing awareness of postwar mental health issues. The American Psychiatric Association commissioned nursing consultant Laura Fitzsimmons (1944) to evaluate educational programs for psychiatric nurses and recommend specific standards of training. These recommendations were supported by professional organizations and backed with federal funding to strengthen educational preparation and standards of care for psychiatric nursing. 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 four 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 and led to a growth in university-level nursing education.

Hildegard Peplau's *Interpersonal Relations in Nursing*, first published in 1952, emphasized the importance of the therapeutic relationship in helping individuals to make positive behavior changes and articulated the predominant psychiatric-mental health nursing approach of the period. In 1954, Peplau established the first graduate psychiatric nursing program at Rutgers University. 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 diagnose psychiatric-mental disorders and provide individual, group, and family therapy. Funding provided by the NMHA also led to the start of psychiatric-mental health nursing research. In 1963, the first journals focused on psychiatric-mental health nursing were published. In 1973, the American Nurses Association (ANA) published the first *Standards of Psychiatric-Mental Health Nursing Practice* and began certifying generalists in psychiatric-mental health nursing.

The process of deinstitutionalization began in the late 1950s when the majority of care for persons with psychiatric illness began to shift away from hospitals and toward community settings. Contributing factors included the establishment of Medicare and Medicaid in 1965, changing rules governing involuntary confinement, and the passage of legislation supporting the construction of community mental health centers. The Community Mental Health Centers Act of 1963 facilitated the expansion of PMH Clinical Nurse Specialist (PMH-CNS) practice into community and ambulatory care sites. Traineeships to fund graduate education provided through the NIMH played a significant role in expanding the PMH-CNS workforce.

PMH-RNs prepared at the undergraduate level continued to work primarily in hospital-based and psychiatric acute care settings providing care for those bearing the deep-seated stigma associated with psychiatric diagnoses and being treated by medical interventions such as lobotomies, electroshock therapy, physical restraint, and isolation. By the 1980s, many also practiced in community-based programs such as day, partial, or intensive outpatient treatment programs, assertive community treatment (ACT), and residential treatment. Nurses held key roles in embracing and leading innovation, change, and the evolution of the science. Thus began a seismic shift in the field of PMH nursing from a custodial model of care to a patient-centered, recovery-focused model.

Mental health care in the United States underwent another transformation in the 1990s, which was designated the "Decade of the Brain" by the Library of Congress and the NIMH. At this time, recovery-oriented mental health systems began to take hold (Anthony, 1993). PMH nurses built on Peplau's theory of emphasizing relationship-based care and worked to develop comprehensive systems of care focused on the whole individual. These changing care models included the treatment of individuals with co-occurring psychiatric and substance use disorders. At the same time, the increase of medication to stabilize acute symptoms, combined with economic pressures to reduce hospital stays, and the advent of "managed care" resulted in briefer psychiatric hospitalizations. While maintaining the broader emphasis on patient safety, shorter hospital stays and higher acuity began to shift psychiatric nursing practice to include

interventions focused on symptom stabilization. PMH nursing education began to include more content on psychopharmacology and the pathophysiology of psychiatric-mental health disorders.

SAMHSA (2010) declared recovery as an important goal in the transformation of mental health care in America. By this time, PMH nursing had been integrating person-centered, recovery-oriented, and trauma-informed practice across the continuum of care, including settings such as community-based agencies, schools, hospitals, emergency rooms, jails and prisons, and homeless outreach services for over a decade. More recent trends include an emphasis on prevention, integrated physical, and mental health care (Shea, 2013; Soltis-Jarrett et al., 2017), the introduction of telemental health care, the essential role of PMH nurses in meeting the mental health needs of diverse, at-risk, underserved, and disenfranchised populations (Pearson et al., 2015), and the indispensable role mental health plays in achieving the ultimate goal of well-being (McLoughlin, 2017). To guide patients toward well-being requires PMH nurses to reconnect with core values of the discipline found in nursing theories, such as Caring Science (Rosa, Horton-Deutsch, & Watson, 2018), and the *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015a), which provide a path to care for the whole person—body, mind, and spirit.

Additionally, PMH nursing practice has been significantly impacted by the development of the Doctor of Nursing Practice (DNP) degree. As described by the American Association of Colleges of Nursing (AACN), a DNP graduate has advanced education in systems function, analysis, health policy, and advocacy (AACN, 2019). Nurses with the DNP degree may practice at the PMH-RN level (e.g., RN administrators or educators) or at the APRN level (e.g., clinical nurse specialists or nurse practitioners). The DNP-prepared PMH nurse incorporates leadership; improves the quality of nursing care and the profession of nursing through policy evaluation, development, and advocacy; and creates and maintains healthy work environments (AACN, 2019).

With a scope of practice that includes educational preparation at the undergraduate and graduate levels, current PMH nursing practice is

significantly influenced by both the biopsychosocial and the social-ecological models of health. Madeleine Leininger's (1991) nursing theory, Culture Care Diversity and Universality, calls upon nurses to understand the culture or way of life of the care recipient. This includes assessing how cultural factors such as norms, beliefs, and practices influence health and health behaviors and understanding the dynamic and interrelated nature of these factors. This knowledge should then be incorporated into the care approach used by the nurse. The value of these frameworks is that they take into consideration the whole person and their environment, including the individual, familial, social, community, and political factors that influence health and well-being. Guided by these frameworks, PMH nurses provide comprehensive and coordinated holistic care and facilitate self-management across all settings. Going forward, PMH nursing continues to expand the tradition of developing and applying innovative approaches to advance caring for historically underserved populations. This includes, but is not limited to, individuals from racial/ethnic minority groups; immigrants/refugee groups; those who identify as lesbian, gay, bisexual, transgender, queer/questioning, and so on (LBGTQIA+); and those who live in rural settings. A focus on care for military personnel and veterans experiencing service-related mental health conditions (including but not limited to post-traumatic stress disorder, major depressive disorder, anxiety, and substance use disorders) also continues to be a priority.

Efforts to address the complex PMH needs of patients, in the context of limited resources, can lead to provider burnout and distress. Achieving the Triple Aim of health care—improving quality, reducing costs, and improving the patient experience—significantly challenges PMH systems and providers (Institute for Healthcare Improvement, 2014). This work has been recently expanded to include improving the work experience of the health care provider and is referred to as the Quadruple Aim (Bodenheimer & Sinsky, 2014). This focus adds recognition of provider well-being, prevention of compassion fatigue, secondary trauma, and best practices to promote resilience. Advanced practice psychiatric-mental health nurses have taken the lead in implementing wellness initiatives among nurses and health care professionals (Melnyk, 2017; Woods-Giscombe, 2020). This

approach to quality improvement has also led to an emphasis on developing and implementing strategies to recruit, sustain, and retain additional members of the PMH nursing discipline.

Developments in the broader context of the nursing profession have a corresponding effect within PMH nursing. One of the key messages of the Institute of Medicine's (IOM) report, *The Future of Nursing: Leading Change to Advance Health,* 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 report also calls for nurses to take a leadership role in moving quality health care forward through policy. Similarly, the AACN (n.d.) recognizes the importance of policy work with its inclusion in the essential elements of all levels of nursing education. In addition, the National League for Nursing (2019) and ANA (n.d.) support nurses' involvement in policy work as part of their profession. This work can be done at the local, state, and national levels. PMH nurses have served as mental health policy and program development leaders in both national and international arenas (Robert Wood Johnson Foundation, 2020).

The 21st Century Cures Act of 2016 resulted in the creation of the U.S. Department of Health and Human Services (HHS) Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC). This group is charged with compiling a summary of advances in serious mental illness (SMI) and serious emotional disturbance (SED) research, evaluating federal programs and treatment services related to SMI and SED, and making specific recommendations to better coordinate the administration of mental health services. One of the 14 non-federally appointed members is a PMH-APRN and researcher (SAMHSA, 2017a). While strides have been made in mental health care (i.e., Mental Health Parity and Addiction Equity Act), much more needs to be accomplished. Specific areas to address include:

- Parity for mental health care
- Promotion of early identification and intervention for those at risk
- Promotion of access to care

- Promotion of integrated care and quality treatment for health to include physical, mental, spiritual, and social well-being
- Promotion of evidence-based interventions to improve mental health care
- Addressing stigma and discrimination toward mental health patients
- Identifying and advocating to reduce bias within policies, practice, and other organizational or structural processes

Furthermore, Algeria et al. (2021) recommend behavioral health system transformations that include the decriminalization of mental illness and substance use disorders, appreciation for and integration of treatment modalities that address social contextual factors and needs for successful and sustainable outcomes, and person-centered care that meets people where they are.

Of note, the recent report, *Future of Nursing 2020–2030: Charting a Path to Achieve Health Equity,* calls upon all nurses, including PMH nurses, to understand the social determinants of health factors such as socioeconomic status, level of educational attainment, health care access, food and housing insecurity, and neighborhood safety and how these factors drive inequities and contribute to poor mental health (National Academies of Sciences, Engineering, and Medicine, 2021). In their 2021 editorial, Yearwood and Hines-Martin remind us that both conditions where people find themselves and cumulative factors affect poor mental health outcomes. Nurses, as the largest group within the health care professions, are in a unique position to make positive contributions to improving health equity in their roles of advocates, leaders, direct care providers, and nurse scientists.

A timeline of major events in the evolution of PMH nursing is included in the Appendix.

LEVELS OF PMH NURSING PRACTICE

The history and evolution of PMH nursing has resulted in three major levels of practice. The first level of PMH practice is the PMH-RN. These

RNs have educational preparation with a baccalaureate degree, associate degree, or a diploma program, and either work in, or have certification in, PMH nursing. The next level of PMH practice includes those RNs who have graduate-level preparation and PMH-RNs with MSN, DNP, PhDs, JDs, and other graduate degrees that add to the expertise and breadth of knowledge of the PMH-RN. The third level is the PMH-APRN with educational preparation as an advanced direct care clinician. PMH-APRNs are board certified as either Clinical Nurse Specialists or Nurse Practitioners and have completed either a master's or doctoral degree program. In PMH nursing practice, there are additional competencies at each level.

Psychiatric-Mental Health Registered Nurse

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, 2015b).

The nursing process is meant to promote and foster health and safety; assess areas of individual strength and dysfunction; assist persons to achieve their own personal recovery goals by gaining, regaining, 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.

A 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. Based on the work of Peplau (1952) and others, the practice of PMH-RNs is accomplished through interpersonal relationships, therapeutic use of self, and professional attributes. These attributes include but are not limited to self-awareness, empathy, and

moral integrity, which enable PMH nurses to practice the artful use of self in therapeutic relationships. Some characteristics of artful therapeutic practice are respect for the person or family, availability, spontaneity, hope, acceptance, sensitivity, vision, accountability, advocacy, and spirituality.

PMH-RNs play a revolutionary role in the articulation and implementation of new paradigms of care and treatment that place the patient/client at the center of the care delivery system. They are key members of interdisciplinary teams in implementing initiatives such as the development of person-centered, trauma-informed care environments. These efforts promote recovery; reduce or eliminate the use of seclusion or restraints; facilitate individually driven, person-centered treatment planning processes; and develop skill-building programs to assist individuals in achieving their own goals. In addition, PMH-RNs incorporate current knowledge of genetics and neuroscience to their practice, recognizing their impact on psychopharmacology and other treatment modalities. In partnership with patients/clients, communities, and other health professionals, PMH nurses provide leadership in identifying mental health issues and in developing strategies to ameliorate or prevent them.

Psychiatric-Mental Health Registered Nurse with Advanced Degrees

The graduate-level prepared PMH-RN leverages their knowledge, skills, and abilities in psychiatric care delivery in combination with master's or doctoral degrees in areas such as nursing leadership, research, public policy, business management, law, and education. These nursing leaders and administrators hold roles in a variety of public and private settings that focus on design, implementation, evaluation, and operations of all levels of health care delivery (ANA, 2016). PMH-RNs with advanced degrees use their combined skills and resources to develop workforce, manage culture, ensure cost-effective access to care, maintain quality standards, ensure safe practice environments, and improve outcomes for individuals and communities. PMH-RNs who practice at this level are well positioned to establish partnerships with policymakers and leaders across the continuum to represent the needs of providers and receivers of psychiatric-mental health care.

Psychiatric-Mental Health Advanced Practice Registered Nurse

The ANA (2015b) defines APRNs as professional nurses who have successfully completed a graduate program of study in advanced direct care nursing practice. These individuals obtain specialized knowledge and skills that form the foundation for expanded roles in health care. Psychiatric nurses pioneered the development of the advanced practice nursing role and led efforts to establish national certification through ANA. The full scope and standards of practice for PMH advanced practice nursing are set forth in this document. While individual PMH-APRNs may implement portions of the full scope and practice based on their role, position description, practice setting, and state regulations, the full breadth of the knowledge base informs their practice.

The first certification of PMH-APRNs was that of Clinical Nurse Specialist (CNS) with a focus on children/adolescents or adults. Beginning in the 1960s, PMH-CNSs with master's or doctoral degrees fulfilled a crucial role in helping deinstitutionalized mentally ill persons adapt to community life. In roles that continue today, they provide individual, group, and family psychotherapy in a broad range of settings and are eligible for third-party reimbursement. They also function as educators, researchers, and managers and work in consultation-liaison positions.

A significant shift in the role of advanced practice PMH nurses occurred in the 1990s as research focused on the neurobiological basis of mental and substance use disorders. In response to the more central role of psychopharmacology in psychiatric treatment, the role of the PMH-CNS evolved to encompass the expanding biopsychosocial perspective and the use of prescriptive authority. Courses in neurobiology, advanced health assessment, pharmacology, pathophysiology, and the diagnosis and medical management of psychiatric illness were added to the curricula of PMH graduate nursing programs. Preparation for prescriptive privileges became an integral part of advanced practice PMH nursing graduate programs (Kaas & Markley, 1998).

Increased awareness of physical health problems in mentally ill individuals and a shift to primary care as a key point of entry for comprehensive

health care in the early 2000s led PMH graduate programs to include greater emphasis on comprehensive health assessment and referral and management of common physical health problems. There was also 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 led many in the general public—and some state nurse practice acts—to equate the term "nurse practitioner" (NP) with "advanced practice registered nurse." In response to the increasing public recognition of the role, market forces, and state regulations, PMH nursing began utilizing the Nurse Practitioner title and modifying graduate psychiatric nursing programs to conform to requirements for NP credentialing (Wheeler & Haber, 2004). The psychiatric-mental health nurse practitioner role was delineated by the publication of the *Psychiatric-Mental Health Nurse Practitioner Competencies* (Population-Focused Competency Task Force, 2003), the product of a panel with representation from a broad base of nursing organizations sponsored by the National Organization of Nurse Practitioner Faculties (NONPF).

Whether practicing under the title of PMH-CNS or PMH-NP, Psychiatric-Mental Health Advanced Practice Registered Nurses share the same core competencies of clinical and professional practice. The American Psychiatric Nurses Association (APNA) and the American Nurses Credentialing Center (ANCC) conducted a seminal logical job analysis that described the purpose, essential functions, setting, and qualifications needed to perform as a PMH-CNS or a PMH-NP (Rice, Moller, DePascale, & Skinner, 2007). This analysis confirmed that the vast commonalities in practice warranted the development of one advanced practice examination for both roles. Although psychiatric-mental health nursing has moved toward a single national certification for new graduates of advanced practice programs, titled *Psychiatric-Mental Health Nurse Practitioner Across the Lifespan*, individuals already credentialed as Psychiatric-Mental Health Clinical Nurse Specialists will continue to practice under this certification (National Council of State Boards of Nursing [NCSBN] Joint Dialogue Group Report, 2008).

Although frequently extending to the leadership, research, and policy realms, present-day PMH-CNSs and PMH-NPs fulfill three key roles in

a variety of clinical settings: provision of psychotherapy, provision of psychopharmacological interventions, and provision of clinical supervision. 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. These interventions use a range of therapy models including but not limited to psychodynamic, cognitive, behavioral, 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 patient/client for the explicit purpose of effecting negotiated outcomes. The psychotherapeutic contract with the patient/client is usually verbal but may be written. The contract includes well-accepted elements such as the purpose of the therapy, treatment goals, time, place, fees, confidentiality and privacy provisions, and emergency after-hours contact information.

For PMH-APRNs, psychopharmacological interventions include the prescribing or recommending of pharmacologic agents and the ordering and interpretation of diagnostic and laboratory testing in alignment with a thorough biopsychosocial history and assessment. Collaboration with the person seeking help is essential to promote adherence and recovery, including specific discussions about the barriers and facilitators to use of psychopharmacologic agents (e.g., cost, accessibility, cultural beliefs). 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 watches for unintended or toxic responses. Current technology and research, including advances in the availability and feasibility of pharmacogenomic testing, can help PMH-APRNs integrate comprehensive assessment and management strategies to effectively treat patients' symptoms through the use of psychoactive medications.

The PMH-APRN also provides clinical supervision to assist other mental health clinicians to evaluate their practice, expand their clinical practice skills, meet the standard requirement for ongoing peer consultation, and

fulfill the need for peer supervision. This process, aimed at professional growth and development rather than staff performance evaluation, may be conducted in an individual or group setting. As a clinical supervisor, the PMH-APRN is expected both to be involved in direct care and to serve as a clinical role model and a clinical consultant. Through educational preparation and clinical experience in individual, group, and family therapy, the PMH-APRN is qualified to provide clinical supervision at the request of other mental health clinicians and clinician-trainees.

Although clinical supervision is 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 health care consumers. The PMH-APRN nurse should avoid providing clinical supervision for people with whom they have preexisting relationships as that could hinder objectivity. Nurses who provide clinical supervision maintain confidentiality, except when disclosure is required for evaluation and necessary reporting.

Scope of Practice Based on the Consensus Model for Advanced Practice Registered Nurses

Examination of regulation—focusing on licensure, accreditation, certification, and education (LACE)—was completed in 2008 by the APRN Consensus Work Group and the NCSBN APRN Advisory Committee (NCSBN Joint Dialogue Group Report, 2008). Broadly, this 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 involves specialized graduate educational preparation that may be applied to a specific population. Within each role, nurses must demonstrate specific competencies as determined by their specialty area of practice. All APRNs are educationally prepared to provide a scope of services to a population across the continuum of care as defined by nationally recognized role and population-focused competencies; however,

the emphasis and implementation within each APRN role vary based on care needs.

The scope of advanced practice in PMH 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-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, based on either the client's need or the PMH-APRN's practice focus. PMH-APRNs are accountable for functioning within the parameters of their education and training as well as 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.

Historically, the specialty programs in advanced practice PMH nursing education generally have focused on adult or child-adolescent psychiatric-mental health nursing practice. However, with the ongoing national implementation of the APRN Consensus Model and LACE recommendations, advanced practice PMH nursing educational preparation has adopted a life span approach and prepares PMH-APRNs to care for individuals, families, groups, and communities from prebirth until death. Fortunately for consumers, this means the PMH-APRN can now provide a full range of specialized services, which contrasts vastly to many primary care clinicians who are only able to treat *some* symptoms of mental health problems and psychiatric disorders.

In summary, PMH-APRNs are accountable for their own practice and are prepared to provide services independent of other disciplines in the full range of delivery settings. The PMH-APRN may be self-employed or employed by an agency, practice autonomously or collaboratively, and may or may not bill clients for services provided. Functions of the PMH-APRN include prescribing or recommending psychopharmacological agents; providing integrative therapy interventions, various forms of psychotherapy and community interventions, case management,

consultation and liaison services, and clinical supervision; developing policy for programs and systems; and actively engaging in advocacy activities, education, and research. Depending upon state practice regulations, prescriptive authority may or may not be provided independent of a collaborating physician.

CONTEMPORARY FACTORS INFLUENCING PMH NURSING PRACTICE

The U.S. Healthy People 2030 Framework (Office of Disease Prevention and Health Promotion, 2018) and the United Nation's (2015) 2030 Sustainable Development Goals make it clear that the role of health care providers, including PMH nurses, is to improve health outcomes for individual patients, families, communities, and populations. For nurses, this means that effective treatment planning and intervention begin with a thorough assessment that is grounded in a holistic review of patient needs. Evidence-based practice further requires PMH nurses to include the Social Determinants of Health (e.g., housing, food, transportation, safety) in their assessment process (Centers for Disease Control and Prevention [CDC], 2018a; World Health Organization [WHO], 2020). These factors fit within the Social-Ecological Model (SEM), a population health framework on which PMH nurses can anchor their practice and from which patient health outcomes can be maximized. Evolving from an interdisciplinary perspective, the SEM addresses needs assessment at the individual, family/relationship, community, societal, and policy levels. In all settings, PMH nurses who incorporate an SEM approach can best support patient-centered and recovery-oriented care.

Since the publication of the landmark report *Achieving the Promise: Transforming Mental Healthcare in America* (U.S. Department of Health and Human Services [U.S. DHHS], 2003), mental health professionals have been sensitized to the need for a recovery-oriented mental health system. In SAMHSA's 2019 strategic plan, *Leading Change,* recovery is emphasized along with prevention and treatment to improve individual, community, and public health. SAMHSA's strategic approach to behavioral health is informed by the premise that behavioral health and freedom

from addiction are essential to overall health. Similar themes are echoed in reports from the National Academies of Science, Engineering, and Medicine, including improving treatment access (Knickman et al., 2016) and addressing discrimination and stigma toward those with mental and substance use disorders (National Academies of Sciences, Engineering, and Medicine, 2016).

Similarly, the United Nations General Assembly (2015) added noncommunicable illnesses, including mental health and substance use, to its Sustainable Development Agenda. By 2030, targets for improvement include a one-third reduction in premature mortality through prevention, treatment, and the promotion of mental health and well-being, and strengthening the prevention and treatment of substance use disorders, including opioid abuse and harmful use of alcohol. Suicide prevention is a leading indicator for improvement.

The mental health treatment landscape has also been profoundly shaped by federal policy initiatives, including the 2010 Affordable Care Act (ACA). Prior to the ACA, the federal House Bill 6983 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 prevented group health plans and insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations for MH/SUD benefits than on medical/surgical coverage. The ACA built on the promise of the MHPAEA by (1) including mental health and substance use disorder benefits as essential health benefits, (2) applying parity protections for mental health and substance use disorders in individual and small group insurance markets, and (3) providing more Americans with access to care for mental health and substance use disorders. With these MHPAEA extensions, the ACA extended parity protections to an estimated 62 million Americans (U.S. DHHS, Office of the Assistant Secretary for Planning and Evaluation, 2013).

Prevalence and Treatment of Mental Disorders

Mental illness is the leading cause of disability worldwide (NIMH, 2016). Globally, depression is the leading cause of morbidity, and among people

aged 15 to 29, suicide is the second leading cause of death (WHO, 2021). Furthermore, people around the world with psychiatric and mental health conditions have disproportionately higher rates of preventable chronic illness and decreased life expectancy (approximately 20-year shorter life span), compared to those without psychiatric and mental health conditions (WHO, 2021).

In the United States, more than one in five—over 51 million—adults had a mental illness in 2019 (SAMHSA, 2020b). This number represented 20.6% of all U.S. adults. Rates of psychiatric illness are highest in women (24.5%) compared with men (16.3%) (SAMHSA, 2020b). Adults who report being two or more races have the highest rate (31.7%) of any mental illness, followed by White (22.2%), American Indian/Alaskan Native (18.7%), Hispanic or Latinx (18.0%), Black (17.3%), Native Hawaiian and Other Pacific Islanders (16.6%), and Asian (14.4%).

Serious mental illness (SMI) is characterized by significant functional impairment and includes individuals with schizophrenia, severe major depressive disorder, and severe bipolar disorder. The rate of SMI for adults in 2019 was 5.2%, with more women (6.5%) than men (3.9%) being affected (SAMHSA, 2020b). Young adults aged 21 to 25 had the highest rates of SMI, followed by adults aged 26 to 29, and adults 18 to 20: 8.8%, 8.7%, and 8.2%, respectively. Adults of two or more races had the highest rates of SMI (9.3%), followed by American Indian/Alaskan Native adults (6.7%), White adults (5.7%), Hispanic adults (4.9%), Black or African American adults (4.0%), and Asian adults (3.1%).

Psychiatric disorders carry with them the deadly potential for suicide. Overall, the age-adjusted rate of suicide in 2017 was 14.2 per 100,000 (CDC, 2018b). White males account for nearly 70% of all suicides. The rate of suicide among females was 6.1 per 100,000 compared with 22.4 for males. The highest U.S. age-adjusted suicide rate was among Whites (15.85), and the second-highest rate was among American Indians and Alaska Natives (13.42). Much lower and roughly similar rates were found among Blacks (6.61) and Asians and Pacific Islanders (6.59) (American Foundation for Suicide Prevention, 2018).

Psychiatric conditions often begin in childhood. The most commonly diagnosed psychiatric problems in children are attention-deficit hyperactivity disorder, behavior problems (e.g., oppositional defiant disorder), anxiety, and depression (CDC, 2021). About 9% of children between the ages of 2 and 17 have received a diagnosis of attention-deficit hyperactivity disorder (Danielson et al., 2017), while about 7% have diagnosable behavioral problems such as oppositional defiant disorder or have been diagnosed with anxiety (Ghandour et al., 2018). Slightly more than 3% have been diagnosed with depression. The lifetime prevalence of bipolar disorder among adolescents ages 13 to 18 is about 3% (Merikangas et al., 2012). Rates of treatment vary by diagnosis for children and adolescents. However, in 2016, the majority (78.1%) of depressed children ages 6 to 17 received treatment (Ghandour et al., 2018). More than half of children diagnosed with anxiety (59.3%) or other behavioral disorders (53.5%) received treatment.

Children are vulnerable to adverse childhood experiences (ACEs), which are traumatic or stressful events such as abuse and neglect. ACEs significantly impact the well-being of the child into adulthood and may result in such problems as alcoholism, major depressive disorder, and obesity. Of particular concern is the accumulation of ACEs, which correlates with the worst outcomes (Sacks & Murphey, 2018). In 2016, 45% of U.S. children experienced at least one ACE. One in 10 children experienced three or more ACEs, which places them at the greatest risk. The highest rate of ACEs is among Black children (61%), followed by Hispanic (51%), White (40%), and Asian (23%).

Although mental health problems are not a normal part of aging, older adults do face specific risks for psychiatric-mental health disorders. Typical life changes that happen as we get older (e.g., retirement, loss of a loved one) may cause feelings of uneasiness, stress, and sadness; depression is a common problem. Medicare covers 80% of treatment for a physical health problem, but only 50% of a mental health problem, which is a huge barrier to care. Up to 63% of older adults with a mental disorder do not receive the services they need (Life Senior Services, 2019). Older adults may also face issues with neurocognitive disorders, from mild cognitive impairment to various forms of dementia. Alzheimer's disease is the sixth

leading cause of death in the United States, and one in three older adults die with some form of dementia. By 2050, the annual costs associated with Alzheimer's and other dementias could be as high as $1.1 trillion (Alzheimer's Association, 2020).

Besides children and older adults, other vulnerable populations include:

- Homeless individuals and refugees who experience post-traumatic stress disorder (PTSD), major depressive disorder, generalized anxiety disorder, panic disorder, adjustment disorder, and somatization.
- Active-duty military personnel and veterans who are frequently challenged by both psychiatric disorders and substance use conditions. In 2016, the suicide rate was 1.5 times greater for veterans than for nonveteran adults (U.S. Department of Veterans Affairs, 2018).
- LGBTQIA+ individuals who are twice as likely to experience a psychiatric condition or misuse substances (American Psychiatric Association, 2017).

Treatment for psychiatric conditions includes psychotherapy, prescription medication, and outpatient and inpatient care. Table 1 summarizes the

TABLE 1 Treatment for Mental Health Conditions

	Adults	Women	Men	White	Black	Asian	Two+ Races	Hispanic
Any mental illness	44.8%	49.7%	36.8%	50.3%	32.9%	23.3%	43%	33.9%
Serious mental illness	65.5%	70.5%	56.5%	70.5%	57.9%	No Data	No Data	52.8%

Source: SAMHSA (2020b).

percentage of adults 18 years and older with any mental health condition who received health care services in 2019.

Substance Use Disorders and Addiction: Prevalence, Comorbidities, and Treatment Needs

Substance use is endemic across most segments of the U.S. population and is associated with health and mental health risks, including the risk of developing a substance use disorder (SUD). Substance use and related health problems are identified and treated in many health care settings. However, the identification and treatment of SUDs always fall within the scope of PMH nursing. In other words, SUDs are psychiatric disorders.

People with mental illness use alcohol, tobacco, and illicit drugs at considerably higher rates than those who do not have mental illness, and they suffer related morbidities and mortality at higher rates as well. SAMHSA's (2019b) 2019 National Survey on Drug Use and Health (NSDUH) estimates 7.7% of adults without a mental illness had a past-year SUD, while 18.5% of those with any mental illness and 27.2% of those with serious mental illness had a past-year SUD (see NSDUH table 8.47B; SAMHSA, 2019b). Substance use of all kinds is common among people with mental illness. For example, an estimated 20.8% of adult Americans without mental illness used illicit drugs in the past year, while 38.8% of those with any mental illness and 49.4% of those with SMI used illicit drugs (see NSDUH table 8.42B; SAMHSA, 2019b). People who use substances or have SUDs are seen in all areas of health care, including primary care, long-term care, surgical settings, and PMH programs; thus, substance use competencies are important for all nurses and for PMH nurses in particular.

There are low treatment rates for those with substance use disorders just as there are low rates for mental health treatment generally. In 2019, among those classified as needing treatment for illicit substances, only 10.3% received treatment at any location. Among adults with both mental illness and substance use disorders, 51.4% received neither mental health nor specialty substance use treatment, and only 7.8% received both mental health and specialty substance use treatment.

According to the CDC, there was a 4.6% increase in drug overdose deaths in the United States in 2019 (CDC, 2020a). Furthermore, the decline in average U.S. life expectancy may be influenced by deaths related to drug overdose and suicide (Hedegaard, Miniño, & Warner, 2018). This is concerning, because life expectancy is illustrative of health status, and declining rates suggest the critical importance of focusing PMH nursing interventions to improve quality of life and prevent deaths related to these behavioral health conditions (Beeber, 2018).

The gap between treatment need and treatment receipt for substance-related problems has been acknowledged by the federal government, including the recognition that nurses can help fill the gap. In 2016, President Obama signed the bipartisan Comprehensive Addiction and Recovery Act (CARA), which improved access to opioid treatment and recovery by allowing NPs to receive the federal waiver to prescribe buprenorphine, a privilege that was granted only to MDs in the year 2000. In 2018, President Trump signed the bipartisan Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act). This legislation further expanded nursing treatment authority by permanently allowing NPs to prescribe buprenorphine and permitting other APRNs with prescriptive authority to treat opioid use using buprenorphine. While these changes have been slow and incremental, they acknowledge that nursing practice, which is commensurate with role preparation, is essential to addressing the unmet substance use treatment needs this nation faces.

Over 20 years ago, a SAMHSA consensus report on co-occurring substance use and mental health disorders emphasized that *comorbidity is an expectation, not an exception.* Accessible systems of care prepared to treat co-occurring disorders are essential to treatment. Plans can and should be individualized to address each person's specific needs, using staged interventions and motivational enhancement to support recovery and wellness. The good news is that people can and do improve their health related to substance use, as well as evidence-based therapies and medications provided by psychiatric nurses who encourage and promote wellness and recovery as health care professionals with expertise in the assessment and

treatment of substance use disorders, and in collaboration with their multidisciplinary health care and social services partners.

Disparities in Mental Health Treatment

Data from the U.S. Census Bureau (2021) indicate that non-Hispanic Whites are 60.7%, Hispanics/Latinos are 18.1%, Blacks/African Americans are 13.4%, and Asians are 5.8% of the U.S. population. It is estimated that before 2050, 50% of the U.S. population will be non-White (U.S. Census Bureau, 2018). Researchers have found significant differences in health outcomes based on racial or ethnic background. Unfortunately, these *preventable differences* are what the CDC identifies as drivers of the burden of disease in socially disadvantaged communities or minority populations (CDC, n.d.). Health and, by extension, mental health disparities are viewed as adverse differences in health and health outcomes experienced by individuals and groups. These differences impact longevity, productivity, and quality of life. Health inequities are caused by the absence of fair and just opportunities to be healthy, which lead to disparities. These inequities are attributed to complex and interrelated factors such as membership in racial/ethnic groups, socioeconomic status, age, gender, citizenship status, disability status, geographic/environmental location, and sexual orientation. Contributing aspects include policies (existing, lack of, or poorly enforced), level of service utilization, social exclusion, exposure to racism and discrimination-related stressors, quality of health care practice, challenges to accessing care, provider behaviors and biases, stigma, and linguistic and cultural barriers (American Psychological Association, APA Working Group on Stress and Health Disparities, 2017; Kaiser Family Foundation, 2022; McGuire & Miranda, 2008).

A principle identified in the upcoming Healthy People 2030 states that "achieving health and well-being requires eliminating health disparities, achieving health equity and attaining health literacy." Equity in health or mental health is the achievement of equitable and optimal health care for all (Braveman, Arkin, Proctor, & Plough, 2017; Jones, 2014). Achieving equity in treatment requires developing and adhering to goals and strategies that include community-engaged preventive services,

improved access, and availability of quality and culturally sensitive and congruent mental health services. Equity in treatment requires the use of multilevel intervention models that address social determinants of health, workforce training to increase mental health literacy of both consumers and nonmental health care providers, and an increase in racial/ethnic diversity among mental health care providers (Hines-Martin & Nash, 2017; Pearson, Hines-Martin, Evans, York, Kane, & Yearwood, 2015; Woods-Giscombe, 2017). In striving to meet the mental health needs of all people, protect human rights, reduce health disparities, and promote well-being and human flourishing, the PMH nurse is cognizant of incorporating principles of diversity, equity, and inclusion in all practice behaviors. Diversity, equity, and inclusion, identified as core values by the Association of American Colleges (AAMC), promote change within organizations and have been identified as foundational in achieving health equity (Moreno & Chhatwal, 2020).

The Health Equity and Accountability Act (HEAA), which has been introduced to Congress several times but has yet to be voted upon, supports expansion of mental health care access for racial and ethnic minorities, incentivizes research on social determinants of health, promotes culturally competent practices when delivering health care services, and strengthens civil rights enforcement and data collection, storage, and sharing. The HEAA specifically focuses on communities of color, those residing in rural areas, and other underserved populations. The Patient Protection and Affordable Care Act (PPACA), signed into law in 2010, supports parity for both medical and psychological health care needs and advocates for integrated care, care coordination, and medical homes (Adepoju, Preston, & Gonzales, 2015).

MEETING AND ANTICIPATING POPULATION HEALTH NEEDS: REINVENTING MENTAL HEALTH TREATMENT

The health disparities cited earlier, and the identified gap between the need and receipt of treatment for mental health and substance-related health problems, present opportunities for the creative development of PMH

nursing roles in care coordination, integration, and the development of service delivery models that align with larger health goals. Health care delivery and reimbursement models are moving toward a population-based focus, with systems and providers being tasked to manage population-specific health care needs and costs. PMH-RNs and APRNs are recognized as essential contributors to addressing the mental health needs of individuals, families, and communities. PMH-RNs and APRNs are increasingly called upon to identify populations at risk for developing mental health problems through prevention, health and wellness promotion, identification and amelioration of risk factors, screening, and early intervention.

Within the population health framework, systems and providers must design innovative ways to identify and treat health problems, including mental health and substance use disorders. A national survey of hospitals identified that nursing and behavioral health were, respectively, the second and third most needed skills and backgrounds in population health (Health Research & Educational Trust, 2015). PMH nurses increasingly play critical roles in the development of effective behavioral health service delivery programs and systems.

One approach to more effective behavioral/mental health service delivery that has garnered increasing support from policymakers is the integration of physical and mental health care. For example, under the Federal Support Act of 2018, the Children's Health Insurance Program (CHIP) must now cover mental health and substance use, Medicare must cover services provided at certified opioid-treatment programs, and the Centers for Medicare & Medicaid Services is required to demonstrate ways to increase provider treatment capacity for SUDs. Initiatives such as these that integrate coverage for physical and mental health create opportunities for PMH nurses to fill the gap between treatment needs and care delivery for mental health and substance use disorders. Benefits of integrated behavioral health include improved access to treatment, enhanced treatment adherence and retention, and a clear focus on patient-centered care (Prom et al., 2021).

Policymakers have also introduced legislation aimed at larger issues with access to care and communication between health care providers

and the criminal justice system. Division B of the Helping Families in Mental Health Crisis Reform Act of 2016 addresses the prevention and treatment of mental illnesses and substance abuse, treatment coverage, communication permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and interactions with law enforcement and the criminal justice system. The 21st Century Cures Act (2016) strengthens mental health parity regulation by requiring insurance companies to cover mental health treatments to the same extent and in the same way as medical treatments. Finally, the Comprehensive Addiction and Recovery Act of 2016 notes that the reimbursement shift away from fee for service and toward caring for populations creates incentives to develop nontraditional services that may have greater effectiveness in supporting the well-being of individuals, families, and communities.

The continued focus on recovery in mental health care occurs along a continuum, from individual, to family and community, and finally to the population levels. At the individual level, the focus is on the care and treatment of the *person* with the disorder, not the disorder itself. This focus is anchored in PMH nursing traditions of relationship-based care where nurses use psychiatric nursing theory-driven and evidence-based therapeutic interpersonal skills to assist persons with mental disorders in achieving their own individual recovery and wellness goals. In addition, PMH nurses are increasingly recognizing that there is no health without mental health (Cipriano, 2016). At the population level, PMH nursing practice must connect to policy to broadly promote recovery and improve health and must consider the issues of equity, access, and social determinants of health (CDC, 2018a; Pearson et al., 2015; WHO, 2020). Of rising importance, the problems of cultural trauma, socioeconomic barriers, and racism are part of population health. This is of critical importance in PMH nursing, given the gap between treatment need and provision. Population health considers far more than the relationship of disease and individual; rather, it considers the overall health of the population at large. As the focus on population health continues to develop, so will the complex relationships between data/research, policy, practice, costs, and patient experience.

Meeting Population Health Needs through Prevention

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

This revolutionary paradigm shift from treatment to prevention has had profound implications for PMH nurses, particularly regarding their work with children and adolescents and their families. Creating a prevention-oriented mental health system requires that PMH nurses, pediatric nurses, and family nurses collaborate and understand the science that supports prevention and evidence-based interventions that can effectively help children achieve emotional regulation and build resilience (Greenberg, 2006). Further, it is essential that nurses contribute to the refinement and implementation of interventions that are applicable in both primary care and mental health care (Yearwood, Pearson, & Newland, 2012). PMH-APRNs are expected to focus on 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 mental illnesses and co-occurring substance use disorders).

Understanding the environment-risk interplay has implications for prevention throughout the life span. Such an approach recognizes the

multiple social determinants of mental health, risks, and protective factors as described by the WHO and Healthy People 2030 initiatives (U.S. DHHS, 2019; WHO, 2014). In a report about global initiatives on prevention, the WHO carefully traced the relationship of SMI to social problems, particularly poverty, as well as the relationship of SMI to nutritional, housing, and occupational challenges. Prevention, therefore, relies on impacting social determinants of health and reducing the factors that increase risk, such as poverty, abuse, and other forms of trauma (Hines-Martin & Nash, 2017; Onie, Farmer, & Behforouz, 2012). In accordance with the ecological framework (Bronfenbrenner, 1999), an increasingly important emphasis is placed on developing systems and societies that promote population health, strengthening the health of communities, and empowering and supporting communities to build connections to protect their members.

Meeting Population Health Needs through Screening and Early Intervention

The impact of ACEs such as family dysfunction and abuse on an individual's mental and physical health throughout the life span is profound and informs innovative programs for addressing early trauma and its impact. Nurses who interface with children 0 to 3 and their caregivers have the responsibility to conduct developmentally informed behavioral screenings and health assessments. We must participate in interdisciplinary collaboration to identify children who are both at the greatest risk for mental health problems and in need of help in accessing services. Particularly vulnerable populations include children in foster care and the welfare system. Evidence that roughly half of all lifetime mental health disorders start in the mid-teens (Kessler et al., 2007) increases the need for screening and early intervention in children and adolescents. Missed opportunities to identify psychiatric-mental health disorders in youth have led to increasing rates of suicide, school dropout, homelessness, and involvement with the juvenile justice system.

The synergy of prevention and developmental neuroscience is progressing, particularly at the juncture where early intervention targets psychological processes relevant to the origins of particular mental disorders

(Davidson & McEwen, 2012). Evidence-based programs are increasingly emerging to address early signs of anxiety, depression, and behavioral issues in children, adolescents, and across the life span through prevention and early intervention (Mental Health America, 2021). Furthermore, for the approximately 100,000 adolescents and young adults in the United States who will experience first-episode psychosis each year (NIMH, 2015), early recognition and treatment of that first episode are key to minimizing relapse and increasing the chance of a successful recovery.

Screening and early intervention are critical throughout the life span and will require shifting attention away from pathology and dysfunction and toward prevention, early symptom identification, and maintenance of optimal functioning. The U.S. Preventive Services Task Force (USPSTF) recommends screening for depression in the general adult population, including older adults and pregnant and postpartum women. The recommendation further states that screening should be initiated with systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up (Siu, 2016). Psychiatric nurses will be pivotal in weaving together the emerging neuroscience that supports building resilience 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 and intervention efforts that span disciplinary silos.

An example of a structured approach to screening and intervention across the continuum of behavioral care is Screening, Brief Intervention and Referral to Treatment (SBIRT). SAMHSA (2020c) describes SBIRT as an approach to intervening early and treating people with substance use disorders and those people who are at risk of developing these disorders. In SBIRT, substance use screening is quick and universal across populations to identify both the potential for health problems related to substance use as well as actual health problems. The appropriate intervention is subsequently based on the determined level of need and may be brief and focused, short term, or long term or may involve provision of or referral to specialty care. SBIRT is one approach to behavioral health engagement and intervention, and outcomes are varied according to population and setting. Additionally, it can be a model for a wide range of behavioral

health interventions that can be incorporated into screening and early treatment efforts.

Meeting Population Health Needs through Integrated Care

Integrated care has been defined as the combination of mental or behavioral health care and primary health care in one setting (Soltis-Jarrett et al., 2017). While over 50% of mental health care takes place in primary care settings (Petterson, Miller, Payne-Murphy, & Phillips, 2014), that care is less likely to be effective. Major challenges exist with inadequate diagnosis, undertreatment, and inadequate follow-up for sustained care. Effective models of integrated care have been developed to address these issues.

Individuals with chronic physical health problems have a higher risk for mental health disorders. In addition, there is a higher rate of chronic health problems among individuals with psychiatric or substance use disorders (Baughman et al., 2016), and there are significant gaps in the physical health care of those with serious mental illness (Emerson, Williams, & Gordon, 2016). The life expectancy among adults with serious mental illness can be as much as 15 to 25 years shorter compared to those without severe mental illness (Walker, McGee, & Druss, 2015).

SAMHSA (2017b) has developed a framework to guide behavioral health integration. Systems of care fall across a continuum from basic coordination of care across settings, to colocation of primary and behavioral care providers, to fully integrated care. Integration of mental health care and primary health care in the same setting can help to increase access and decrease stigma, reduce costs, improve continuity of care, and produce better outcomes. Optimal integration requires interprofessional teamwork to promote comprehensive assessment, diagnosis, treatment planning, and recovery. Nurses, and specifically PMH nurses and PMH advanced practice nurses, are important contributors to successful behavioral and primary care integration teams (Delaney et al., 2018).

Nurses should be aware of how their strengths in nursing practice, including holistic assessment, diagnosis, care planning, psychoeducation, advocacy, and patient navigation, are integral to quality patient care. As

systems of integrated care are constructed, PMH nurses must maintain their focus on the needs of the consumer and ensure that individuals can access the systems, are not intimidated by them, and know how to make the most of the services offered (Soltis-Jarrett et al., 2017). Integration should also be supported by technological advancements and guided by the voice of consumers with an emphasis on collaboration, effective communication, use of peer navigators, and the critical support of family and community members (Soltis-Jarrett et al., 2017).

Meeting Population Health Needs through Technology and Innovation

Health care technology continues to expand via the increasing use of telehealth, electronic health records (EHRs), e-consults, internet-delivered services, the rising prevalence of health information technology (HIT) to connect service sectors and build care coordination, and the integration of data systems to track outcomes and engineer rapid quality improvement. SAMHSA (2020d) has encouraged the development of infrastructure to support the use of HIT and EHRs at the acute care level, while also emphasizing the importance of privacy, confidentiality, and data standards. Such information exchange has been a vehicle for integrating care, containing costs, and increasing consumers' control of their personal health care and health information.

The rapid development of internet-delivered behavioral health interventions, such as online cognitive-behavioral treatments for depression and anxiety, calls for the equally rapid clarification of their key elements and outcomes. Despite barriers such as differences in state practice acts or access to HIPAA-compliant platforms, growth in internet-based behavioral health treatment is likely to continue. Future challenges to be addressed include creating interventions with fidelity to the framework of the original intervention and the careful measurement of outcomes.

In 2009, the American Recovery and Reinvestment Act instituted meaningful use incentives across all sectors of health care (including behavioral health) to facilitate care coordination, improve population health, protect patient information, enhance patient engagement, and

improve quality, safety, efficiency, and health equity (U.S. Congress, 2009). These same privacy issues can limit access to the data needed for optimal coordination of care and for establishing evidence-based care, with long-term impacts on patients with psychiatric/substance use disorders (Rice et al., 2019).

PMH nurses can play a role in educating patients and provider teams about the long-term benefits of HIT. PMH nurses can also help to drive a broader adoption and use of HIT in the care of patients with psychiatric/substance use disorders. This technology can have long-term impacts on understanding patterns of these conditions across populations, identifying gaps in care, tracking treatment effects, and achieving population health goals.

Meeting Population Health Needs through Planning for Workforce Requirements

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. Recently, a special edition of the *Journal of the American Psychiatric Nurses Association* devoted to the PMH nursing workforce noted that "we are all faced with a psychiatric nursing workforce insufficient to meet the mental health needs of US populations" (Pearson, 2019). This is not surprising when we consider the aforementioned gap between mental health treatment needs and treatment delivery. Independent of health care reform and its potential to increase access through expansion of health insurance, less than 45% of the need for primary care services and approximately 27% of the need for mental health services are currently being met nationwide based on Health Provider Shortage Area designations by the Health Resources and Services Administration (HRSA) Bureau of Health Workforce (U.S. DHHS, 2020b). Resource-poor environments require service models that move clients into self-management and bridge systems so that medical issues are addressed.

The Association of American Medical Colleges (2019) estimates that by 2032, there will be a deficit of 20,600 to 39,100 physician specialists,

including psychiatrists. There is a great need for health care providers, especially in rural areas, who can deliver a range of services including psychotherapy, case management, and medication management. Because of their command of multiple bodies of knowledge (medical science, neurobiology of psychiatric disorders, treatment methods, and relationship science), PMH nurses are the health care professionals that are best suited to facilitate connections between mental health, primary care, acute care, and case management systems (Delaney, Drew, & Rushton, 2019). PMH-APRNs are educated to provide a full scope of behavioral health services, including both substance use and mental health services. Achieving access and quality goals requires PMH-APRNs to eliminate regulatory barriers that restrict scope of practice, as well as restrictive reimbursement policies that limit health care consumer access to APRNs. Additionally, PMH-APRNs provide outcome-related data to support efficacy and quality of care.

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). Additionally, the Association for Multidisciplinary Education and Research in Substance use and Addiction (AMERSA, 2020) has defined and published core competencies for specific health professions, including nursing, in identifying and addressing problematic substance use. The APNA Recovery to Practice (RTP) (n.d.) online curriculum is a certificate program that delivers foundational evidence-based knowledge for PMH nurse practice. A key aspect of this curriculum development, and of program development in general, is having consumers of these mental health services at the table and contributing to the development of these systems of care (SAMHSA, 2010). Curriculum models should also include the competencies promoted by the Quality and Safety Education for Nurses (QSEN) Institute, which provides "the knowledge, skills and attitudes necessary to continuously improve the quality and safety of the health care systems in which they work" (QSEN, n.d.).

Seminal work providing guidance for building the PMH-APRN workforce includes recommendations on how PMH nursing will increase its numbers and prepare practitioners with the specific competencies needed to build a transformed mental health system (Delaney & Vanderhoef, 2019; Hanrahan, Delaney, & Stuart, 2012). This workforce plan calls on PMH-APRNs to include the role of individuals in recovery in 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.

MEETING POPULATION HEALTH NEEDS: SETTINGS AND ROLES

PMH nurses function across all settings where individuals with mental health issues or psychiatric disorders are found. These settings include psychiatric inpatient units, emergency departments, medical-surgical units, outpatient clinics, community health care centers, primary care offices, schools, and jails and prisons. Throughout these settings, PMH nurses function in direct and indirect roles, providing face-to-face and telehealth services, as well as consulting or coordinating care wherever individuals are at risk or experiencing mental illness. Their skills extend to administrative, educational, and research roles as well. The broad scientific knowledge base and holistic approach to care that is the hallmark of PMH nursing allows them to adapt to new challenges and create new roles in meeting population health needs.

Acute Care

Individuals may require acute inpatient care to provide a safe, secure, recovery-oriented setting when they are experiencing an escalation in symptoms that place them at risk of harming themselves or others. Acute care inpatient units provide individuals with treatment while preparing for reintegration into the community (National Alliance on Mental Illness [NAMI], 2016). Unfortunately, the number of inpatient psychiatric

beds in the United States has declined over the years with state hospital beds reduced 17% since 2010 and 97% since 1955 (Treatment Advocacy Center, 2018). This reduction has contributed to furthering already long boarding periods of psychiatric patients in emergency rooms, as well as increases in homelessness and incarceration of individuals with mental illness who are unable to access treatment (Fuller, Sinclair, Geller, Quanbeck, & Snook, 2016).

In tandem with efforts to preserve needed inpatient beds, models are evolving to provide acute care services to individuals in crisis both within emergency departments and on small specialty units (Knox et al., 2012). Specialty units include crisis stabilization units, extended observation units, crisis respite centers, and mobile respite units (NAMI, 2019). These alternatives to inpatient care are targeted to individuals who need increased, 24-hour support due to their acute symptoms but may not require an intensive inpatient hospital setting.

The integration of quality improvement and mental health recovery components into all service systems, including acute care, is vital. Providers and receivers of care, the federal government, regulators, and advocacy groups believe that all psychiatric services must be recovery oriented and provide quality, evidence-based treatment delivered using a person-centered approach. Since the elements of the recovery framework mirror the Institute of Medicine's (IOM, 2001) indicators for quality in health services, PMH nurses have a platform for assessing quality in inpatient psychiatric care. The Joint Commission has a clear standard that calls for the use of restraints or seclusion only in situations involving imminent danger to patients, staff, or others (The Joint Commission, 2018), and PMH nurses have called for the reduction or elimination of seclusion or restraint (APNA, 2018). While restraint reduction is critical, this narrow focus on quality fails to recognize that in addition to a safe environment, individuals with SMI need services that are person centered and recovery oriented. In addition to efforts to reduce the use of restraint and seclusion, a great focus is placed on providing ligature-free environments, preventing deaths by suicide, and addressing the opioid epidemic. The Zero Suicide (n.d.) framework has been adopted by organizations as a

systemwide approach to improve the quality of care and identify suicidal individuals who previously may have fallen through the cracks.

Acute care units provide structured environments with intensive programming designed to develop individual skills, measure the effectiveness of treatment, and prepare the individual for return to the community. As the single largest professional group practicing in inpatient arenas, PMH nurses are uniquely responsible for maintaining a safe milieu, which involves constructing physically safe, trauma-informed, and recovery-oriented environments. These efforts can be measured with tools that capture the extent to which the type of help provided in inpatient care is seen as acceptable and having a positive impact in ways that are important to patients. PMH-APRNs are well prepared to assume the role of an attending provider for individuals in acute care and continuing (long-term) care units.

Psychiatric Consultation-Liaison Nursing

Psychiatric consultation-liaison nursing (PCLN) practice emphasizes the assessment, diagnosis, and treatment of behavioral, cognitive, developmental, emotional, and spiritual responses of individuals, families, and significant others with co-occurring (actual or potential) physical illness(es) and/or dysfunction (ANA, 1990). This advanced practice psychiatric-mental health nursing role is performed in settings other than traditional psychiatric settings—most often in medical hospitals and skilled nursing facilities. Additionally, practice settings have expanded to primary care, "health care homes," and community settings. As an APRN, the PCLN role requires expanded knowledge of complex psychiatric and medical disorders, the ability to complete diagnostic assessments leading to *DSM* diagnoses, and considerable expertise in care coordination and navigating intricate health systems.

Consultation is used as a modality to provide successful psychiatric and biopsychosocial treatment for health care consumers/families and to enable nonpsychiatric health care providers to provide such care. PMH-APRNs will often work as integral members of an interdisciplinary consultation-liaison team, as a psychosomatic service, on independent

liaison nursing teams, or as individual consultants within medical settings. PMH-APRNs provide highly specialized advanced assessments, diagnoses, and interventions with recommendations for effective behavioral health care planning and symptom management. With initiatives that integrate physical and mental health care, the specialty skills and knowledge inherent in PCLN will continue to be invaluable as new integrated care models are implemented.

Psychiatric-mental health consultation may be accomplished by either direct or indirect consultation models. In the direct model, the consultee is typically the health care consumer or family. Specific activities may include psychopharmacologic recommendations, prescriptions, and monitoring; behavioral care plan development; and implementation of stabilization-focused therapeutic interventions for individuals and families. It is the PCLN who has the expertise to differentiate between medication-induced psychiatric symptoms, primary psychiatric disorders, or a combination of both. In the event the patient/client is a child, the PCLN would work with the nursing staff and all others involved in the child's care to develop a plan focused on the child's safety and improving their mental status while continuing the medical treatment needed.

In the indirect model, the consultee is the care provider or organization. In this approach, best practices are applied to general and unique clinical scenarios to improve individualized care as well as to improve overall health systems. The goals of consultation and liaison are mutually complementary and interdependent. PCLN uses both processes in conjunction with specific theoretical knowledge, clinical expertise, and an ability to synthesize and integrate information to influence health care delivery systems (Gonzalez, Walker, & Krupnick, 1995; Lewis & Levy, 1982).

Care Coordination and Case Management

Two closely related roles for PMH-RNs are that of care coordinator and case manager. As a care coordinator, the PMH-RN focuses on organizing patient care and sharing information with all participants involved in a patient's care. Care coordination is based on confidentially communicating the patient's preferences and needs to the appropriate people. The

PMH-RN may provide care coordination as a nurse navigator who is responsible for the guidance of patients through the complex care process. This coordination is based on population-specific knowledge and expertise in the social and legal systems related to mental health care.

The PMH-RN or PMH-APRN case manager works one-on-one with patients to develop an organized, coordinated approach to care. The work of a case manager may focus on a single client or a designated family, group, or population. Case management interventions include identifying options and services to meet the comprehensive health needs of individuals and families. Nurses serving in this role assist individuals in finding appropriate providers and facilities in a timely and cost-effective way. The PMH-APRN case manager identifies and analyzes real or potential barriers to care. Interventions are aimed to provide access to appropriate levels and types of care and treatment to achieve optimum outcomes.

Community-Based Care

The focus of community-based efforts by psychiatric-mental health nurses has expanded to include a population health and prevention approach. Psychiatric-mental health nurses deliver both traditional community-based interventions at the individual or micro level but also at the group/population or macro level. A focus on the mental health of populations requires that nurses working in and with communities also look at upstream or root causes of mental health challenges and intentionally work to ameliorate the drivers of poor mental health outcomes and contributors to health disparities before they occur. Community-based care occurs outside of hospitals and traditional inpatient settings. It occurs in clinics, schools and colleges, homes, shelters, health maintenance organizations, crisis centers, senior centers, group homes, and businesses, among others. Community-based care can take the form of developing and advocating for policies, promoting mental health literacy, serving as a consultant to a variety of entities, screening for risk, treating a variety of psychiatric presentations, and advocating for services across primary, secondary, and tertiary levels of prevention. At times, providing community-based care challenges the psychiatric-mental health nurse to work within the various layers of the socioecological model and to pay attention to the social

determinants of health factors that pose barriers to overall well-being (Hines-Martin & Nash, 2017; Pearson et al., 2015). Addressing these factors at the individual and population levels supports empowerment and community member participation, and it ultimately improves mental health.

Integrated Primary and Behavioral Health Care

Approximately 20% of all primary care visits include assessment or intervention to address a behavioral health concern (Petterson, Miller, Payne-Murphy, & Phillips, 2014). The majority of individuals with a mental health issue are managed solely by their primary care provider. In addition, patients with severe mental illness are disproportionately affected by chronic illness and experience lower life expectancy compared to those without chronic illness (Gerrity, 2014). This presents a great challenge for primary care settings and providers; time, resource, and staffing limitations truncate the optimal provision of care to treat mental health conditions in primary care settings. This can result in unresolved symptoms for patients and dissatisfaction, as well as experiences of being overwhelmed among both patients and providers.

The U.S. Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, and other national stakeholder groups have prioritized the implementation of programming to integrate behavioral health care in primary care settings (Gerrity, 2014). Various models of integration have been proposed. However, provider, patient, and system factors continue to pose challenges to successful dissemination and sustainability of behavioral health in primary care settings. Primary care providers, including physicians, nurse practitioners, and physician assistants, need resources, standardized tools, and reinforcements to integrate optimal behavioral health strategies into an already full primary care visit effectively and efficiently. The roles for PMH-APRNs who practice in primary care settings include but are not limited to (a) collaboration and consultation with other primary care provider partners from other disciplines, (b) direct provision of behavioral health care in integrated primary care settings, and/or (c) direct provision of behavioral health care within health service sites that have been referred to as reverse colocation models (Brown, Moore, MacGregor, & Lucey, 2021).

These practice models are constantly evolving as health care reform, payment structures, and service delivery models continue to alter the nature of primary care and its relationship to mental health service delivery (Delaney & Kwasky, 2013). Health care consumers are more likely to see a primary care provider than connect with scarce mental health care. Additionally, health care consumers may prefer receiving services in less stigmatizing primary care. Thus, integrated care as a strategy has expanded and become recognized as a best practice (Brown et al., 2021). Evolving and diversifying models for integrated care is essential, especially with regard to the large number of people who will be seeking mental health services in primary care settings, the complexity of treating medical and wellness issues among the serious mentally ill (SMI) population, and the varying levels of mental health needs that must be addressed in primary care (Delaney, Robinson, & Chafetz, 2013).

To build these systems will require innovations in integrated service delivery models, as well as attention to how the various components of these systems fit together—that is, the workflow process, financial integration, the teams to build a culture of care, and the workforce to enact it (Delaney et al., 2013; Reiss-Brennan, Cannon, Briesacher, & Leckman, 2011). Effective integrated care models will necessitate that clinicians develop the knowledge and competencies to provide person-centered care and address the various levels of intensity of mental health needs, including individuals with complex comorbidities (Delaney et al., 2013).

An important issue related to building this workforce involves how primary care is currently conceptualized, which, in turn, influences how the integrated care workforce is defined and how its training is supported. This workforce crosses traditional primary care and behavioral health care lines. Restrictive definitions of primary care (e.g., primary care is the first point of contact residing in one of five specialty areas) limit the boundaries of the primary care workforce and perpetuates a mind-body split. A comprehensive conceptualization of primary care that fits with the current expansion of services is found in an earlier definition of primary care forwarded by the IOM (1994):

> Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. (p. 1)

This definition creates more appropriate boundaries for the integrated care models that reside in both traditional primary care and expanded behavioral health care settings. As the conceptualization of primary care broadens to accommodate integrated care, it is clear that PMH advanced practice nurses are, by this definition, already delivering primary care services, which includes the diagnosis and treatment of common health problems (APNA, 2020). Given their unique skill set and clinical training, PMH-APRN practice in primary care settings will only expand in the next decade. PMH-APRNs who are able to work at their full professional capacity will be invaluable resources for bridging the gap of needed behavioral health services in primary care settings.

Telehealthcare

Telehealth refers to the use of telecommunications technology to remove time and distance barriers from the delivery of health care services and related health care activities. Audio and video therapy is an expanded means of communication that promotes access to health care (Center for Substance Abuse Treatment, 2009). Traditionally, the use of telehealth and tele-mental health care was designed to meet the needs of rural populations and geographic areas with identified shortages of specialty health care professionals.

Since early 2020, in response to overwhelming public health issues related to the COVID-19 pandemic crisis, regulatory barriers to telehealth practice have been significantly reduced. Telehealth has become a familiar platform by which Americans receive their health care, including mental health care. Experts are predicting that most of the regulatory changes will be made permanent (Landi, 2020). In this newly expanded venue, PMH-RNs 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." PMH-APRNs can provide assessment, diagnosis, and therapy sessions in real time, as well as e-consultations through store-and-forward systems.

In telehealth, all PMH nursing care incorporates practice and clinical guidelines that are based on empirical evidence and professional consensus. The specific guidelines can vary from state to state. Telehealth encounters raise special issues related to confidentiality and regulation. The technology used allows providers to cross state and even national boundaries, and providers must practice in accordance with all applicable state, federal, and international laws and regulations. In the telehealth environment, particular attention must be directed to maintain confidentiality, informed consent, documentation, and the integrity of the transmitted information.

Forensic Mental Health Care

Estimates indicate that 64% of U.S. inmates have mental health concerns or disorders, and approximately 15% to 20% of inmates in jails and prisons suffer from serious mental illness (Treatment Advocacy Center, 2016). Over 90% of federal inmates with mental health conditions are without access to mental health treatment, and minoritized populations are more likely to experience morbidity (American Psychological Association, 2014; Office of the Inspector General, U.S. Department of Justice, 2017). Any cross between the criminal justice system and psychiatric nursing can be considered forensic mental health. Both 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 assertive community treatment and conditional-release teams) settings to jails, prisons, and state psychiatric hospitals. Forensic PMH-APRNs perform psychiatric assessments, prescribe and administer psychiatric medications, educate correctional officers about mental health issues, and provide therapeutic services to

witnesses and victims of crime. In addition, forensic PMH-APRNs co-coordinate planning and care for individuals who are in transition from correctional facilities to community settings.

Disaster Psychiatric-Mental Health Nursing Care

Disaster nurse competency categories include prevention, preparedness, response, and recovery/rehabilitation (International Council of Nurses, 2019). Functioning as first responders, PMH nurses provide psychological first aid and mental health clinical services through organizational systems in response to environmental and man-made disasters and throughout the continuum of the disaster event and recovery. In addition, PMH nurses can provide short- and long-term mental health clinical services to individuals, families, and groups struggling with anxiety, stress, depression, trauma, loss, and other psychiatric and behavioral symptoms associated with disaster recovery.

Psychiatric nurses responding to disaster situations must be prepared to monitor and ensure a safe environment while providing services to both victims and relief workers within potential resource-poor settings. PMH nurses must be aware of, assess, and address the potential for post-traumatic stress, increased risk of suicide, substance use, and withdrawal secondary to the inability of impacted individuals to access prior substances of abuse. Disaster psychiatric nursing, a growing field of practice, challenges the nurse to engage in a wide variety of activities, including public health preparation, triage, complex communication, navigating unknown and potentially unpredictable environments, ethical challenges, organization and management strategies, psychosocial and psychological interventions, consultation, and referrals. Both PMH-RNs and PMH-APRNs are uniquely positioned and prepared to provide psychological first aid, crisis management, community education, physical health care, and support for individuals and groups in promoting coping and resilience. After stabilization of the immediate crisis, PMH nurses must be aware of the potential for post-traumatic stress, increased risk of suicide, substance use, and withdrawal secondary to inability of impacted individuals to access prior substances of abuse.

Administration, Education, and Research Roles

PMH nurses make significant contributions in administrative, educational, and research arenas. As administrators, PMH nurses oversee the business operations of hospitals and health care systems to ensure optimal patient care. In addition, they focus on nursing workforce development and leadership succession at their institutions and across the nation. PMH nurse administrators must possess in-depth knowledge of clinical care, state and federal regulations, accrediting agency requirements, financial management, insurance reimbursement, and community needs. PMH nurses in administrative positions often hold advanced degrees in nursing, business, or education. In the area of education, PMH nurses prepare undergraduate and advanced practice nurses to address the mental health needs of individuals, families, groups, and populations. With a combination of extensive clinical experience and graduate education, PMH nurses in academia help future practitioners to navigate the complex landscape of health care, community resources, and co-occurring disorders. Finally, PMH nurses engaged in research contribute to evidence-based knowledge in the areas of biomedicine, education, psychiatric-mental health nursing science, and clinical practice, and they conduct translational research science with the ultimate goal of improving health behaviors, health care services, health care systems, and health policies for optimal population health.

Contemporary Topics and Future Trends

PMH-RNs and PMH-APRNs are constantly responding to new situations and trends that impact the mental health of individuals, families, groups, and communities. Now more than ever, their leadership is needed to identify factors that put a population's mental health at risk and to develop the evidence upon which best practices are based. While no discipline or organization has a crystal ball to predict what the next areas of need might be, the following are "hot topics" emerging in mental health care:

- The opioid epidemic, the changing environment of drug use, and changing patterns of drug delivery systems (e.g., vaping)
- Increased rates of suicide in children and adolescents

- Ketamine infusion
- Neuromodulation techniques
- Pharmacogenomic testing
- Genetic testing in the absence of counseling
- Immigration, policy issues related to migrants, refugees, asylum seekers, detention, and family separation
- Social media pressures and alienation
- Mass violence
- Exacerbation of mental health-related issues secondary to a global health crisis
- Psilocybin therapy
- Racial disparities and trauma
- Global health crisis, pandemics, and global climate change

Meeting the needs of current and future patients means utilizing cutting-edge treatments to improve outcomes and reduce potential side effects. For example, PMH nurses have recognized the neuropsychological impacts of the COVID-19 pandemic. As noted by Roy et al. (2021), policy-, socio-economic-, and psychosocial-related factors are important contributors to adverse pandemic sequelae. As such, PMH nurses will need evidence-based resources and skillsets to address these complex challenges.

ETHICAL ISSUES IN PSYCHIATRIC-MENTAL HEALTH NURSING

PMH nurses adhere to all aspects of the *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015a). A code of ethics educates and informs professionals regarding ethical behavior while mandating a minimal standard of practice. The nine provisions of the *Code of Ethics for Nurses* comprise three groupings: the first three describe the most fundamental values and commitments of each nurse, the next three address the boundaries of loyalty and duty, and the last three examine the duties beyond individual encounters with patients and health care consumers (ANA, 2015a, p. xiii). As providers of transpersonal care to the most vulnerable in society, PMH nurses face unique ethical dilemmas. The additional statements accompanying each of the provisions below are intended

to identify the important global perspectives applicable when addressing ethical concerns associated with PMH nursing practice.

Respect for the Individual

Provision 1: The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.

Compassion is a key value of PMH nursing. PMH nurses show compassion by recognizing the importance of helping others through transpersonal caring, instilling hope in those who feel hopeless, and empowering those who are powerless as a result of PMH disorders. Respect is another key value. PMH nurses respect the dignity and worth of every individual, based on the understanding that PMH disorders, like other chronic health problems, can be treated. Hence, PMH nurses are staunch advocates in helping to overcome negative attitudes and beliefs related to PMH disorders to ensure appropriate, compassionate, holistic, and respectful care that acknowledges the human rights of all individuals.

Commitment to the Patient

Provision 2: The nurse's primary commitment is to the patient, whether an individual, family, group, community, or population.

Personal behaviors and attitudes can conflict with ethical guidelines. PMH nurses must be open to exploring and reconciling their personal experiences. They must also have a keen awareness of boundary issues with clients, whether family, group, community, or population. PMH nurses are willing to participate in self, peer, and supervisory assessment of clinical skills and practice.

PMH nurses recognize that people with PMH disorders may have maladaptive coping behaviors that affect the individual, the family and other groups, and society as a whole. In addition, they understand that there are multiple biopsychosocial causes for the disorders. PMH nurses also understand the behavior change process and recognize that setbacks will occur during progress toward recovery and the initiation or maintenance of a behavior change goal.

The PMH nurse is always cognizant of the responsibility to balance human rights with safety and the potential need for restrictive measures (restraint or seclusion) or forced treatment (e.g., arrest/involuntary admission for an emergent psychiatric evaluation) when individuals lack the ability to maintain their own safety.

Advocacy for the Health Care Consumer

Provision 3: The nurse promotes, advocates for, and protects the rights, health, and safety of the patient.

The PMH nurse monitors and carefully manages confidentiality, therapeutic self-disclosure, and professional boundaries through all forms of interaction (i.e., face-to-face, electronic record, social media). These obligations are intensified in PMH nursing due to the vulnerability of the population, the complexity of clinical care, and legal issues that are dictated by government legislation and the criminal justice system.

HIPAA was enacted to help protect confidential information by dictating specific rules that outline how confidential information is shared. In order to protect the patient's rights and safety, the PMH nurse has an obligation to be aware of and enforce the rules regarding protected confidential information.

The PMH nurse understands that the therapeutic relationship between PMH nurse and health care consumer is unbalanced in nature. Formulating effective nursing interventions often necessitates gaining knowledge of the health care consumer's intimate thoughts, feelings, and behaviors. Therefore, any intimate relationships (physical, verbal, electronic, social media) that may contribute to boundary violations, with current clients, their close relatives, guardians, or significant others, are prohibited.

The PMH nurse takes action to protect patients through consulting with and serving on ethics committees, accessing and advocating for resources, and/or advocating for optimal psychiatric care through policy formation and political action.

Responsibility and Accountability for Practice

Provision 4: The nurse has authority, accountability, and responsibility for nursing practice; makes decisions and takes action consistent with the obligation to promote health and provide optimum patient care.

The population of PMH providers is quite diverse. Equally varied are the specific proficiencies, skills, levels of involvement with health care consumers, and scopes of practice among the health care disciplines (e.g., physicians, nurses, social workers, psychologists, counselors/therapists, case workers, mental health workers, peer counselors). These roles often become blurred with inappropriate functions subsumed by health care providers working outside their scope of practice (e.g., assessment or diagnosis by a nonlicensed provider and/or noncertified provider), academic preparation, training, or competency.

PMH nurses often work in settings where nursing administration may not be dominant or even present. Thus, PMH nurses must be able to articulate and demonstrate their competence within their scope of practice, be aware of the professional standards that guide other team members, and possess the knowledge, skills, and abilities that all PMH providers have in common in order to provide optimum care.

Duties to Self and Others

Provision 5: The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.

PMH nurses must accord moral worth and dignity to all human beings. This moral respect extends to oneself and to others, including nurse colleagues whose practice may be impaired as a result of substance use, PMH disorders, or other physical disorders. PMH nurses are in key roles to change prevailing negative perceptions and attitudes toward individuals with PMH disorders.

The PMH nurse demonstrates a commitment to practicing self-care, managing stress, nurturing self, and maintaining supportive relationships

with others so that the nurse is meeting his or her own needs outside of the therapeutic relationship. Moral distress, fatigue, and compassion fatigue affect performance; therefore, nurses must promote and maintain their health and well-being. PMH nurses address the whole person as an integrated being through reflection, discernment, engaging in lifelong learning, maintaining competence, and committing to professional growth.

Contributions to Health Care Environments

Provision 6: The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.

Given their knowledge, skills, and abilities, PMH nurses are often the first to recognize distress in the workplace (e.g., depression, anxiety, altered patterns of self-care, substance use). PMH nurses have an ethical obligation to report peer observations or concerns to their nurse leader. Further, they have a moral obligation to help address problems faced by colleagues with symptoms suggestive of mental distress and/or substance use that may potentially impact patient safety and violate public trust.

PMH nurses face situations of competing values, loyalties, and obligations that generate tension and conflict. Addressing the resulting cognitive dissonance preserves the integrity of nursing values while helping to maintain a safe environment for those receiving health care.

Advancement of the Nursing Profession

Provision 7: The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards of development, and the generation of both nursing and health policy.

PMH nurses have an ethical obligation to be knowledgeable of evidence-based practice guidelines and apply them accordingly, which includes risk assessment and management. PMH nurses engage in continuous improvement through scholarly inquiry and knowledge development to ensure the highest quality of care for individuals, families, and populations affected by PMH disorders. The PMH nurse seeks continuing education and service experiences and participates in health-related civic

activities through local, regional, state, national, or global initiatives to contribute to nursing and health policy development.

Building on the *Code of Ethics*, the PMH nurse is responsible for providing both supportive mentoring to others and receiving mentoring in order to continue personal growth and development for use in effectively and skillfully executing the role. Mentoring involves the process of teaching, guiding, supporting, challenging, reviewing, critiquing, and sharing knowledge (Eller, Lev, & Feurer, 2014; Gandhi & Johnson, 2016). The mentoring process occurs between a more experienced individual and a junior or novice colleague. It can be a formal or informal relationship in which learner goals are identified and periodically evaluated and should be grounded in respect, open communications, and trust.

Collaboration to Meet Health Needs

Provision 8: The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.

The nursing profession holds health as a universal human right. Therefore, PMH nurses must collaborate with other nursing specialties, other health professionals, government agencies (e.g., SAMHSA, National Institutes of Health [NIH], IOM), the larger nursing community (e.g., ANA, APNA, International Society of Psychiatric-Mental Health Nursing [ISPN], state nurses associations), and the public (e.g., NAMI, Mental Health America [MHA]) to promote individual and societal health and reduce disparities. Nurses must address social determinants of health (CDC, 2018a; WHO, 2020), bring attention to human rights violations, and preserve the rights of vulnerable populations (e.g., mentally ill, homeless, prisoners, refugees, children, women, and elderly and socially stigmatized groups).

Promotion of the Nursing Profession

Provision 9: The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

PMH nurses have a central role in advocating for environments where the human rights, values, customs, and spiritual beliefs of individuals, families, and communities are respected (ISPN, 2020). PMH nurses recognize the importance of direct human interactions, communication, and professional collaboration. These relationships may be with individuals, populations, and/or other health care professionals and health workers, both within and between nurses and public representatives. Through active engagement in professional nursing organizations, PMH nurses inform policy development and implementation in recognition that PMH disorders are treatable and that nursing service is delivered with respect for human needs and values and without prejudice to vulnerable populations.

Standards of Psychiatric-Mental Health Nursing Practice

The following Standards of Practice and Standards of Professional Performance include (1) a list of the minimum competencies that all PMH nurses must demonstrate, and (2) additional competencies for which PMH-APRNs and graduate-level prepared PMH-RNs are accountable.

STANDARD 1. ASSESSMENT

The psychiatric-mental health registered nurse collects and synthesizes comprehensive health data that are pertinent to the patient's/client's health and/or situation.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Collects comprehensive data, including, but not limited to, psychiatric, substance use, physical, family, functional, psychosocial, emotional, cognitive, sexual, sleep, nutrition, cultural, basic trauma, developmental, environmental, spiritual/transpersonal, and economic assessments.
- Collects data as a systematic and ongoing process while focusing on the uniqueness of the person.
- Elicits the patient's/client's values, preferences, strengths, knowledge of the health care situation, expressed needs, and recovery goals.

- Involves the patient/client, family, health care providers, and other patient/client-identified support systems (as appropriate) in holistic data collection.
- Demonstrates effective clinical interviewing skills that facilitate the development of a therapeutic relationship.
- Prioritizes data collection activities based on the patient's/client's immediate condition and the anticipated needs of the patient/client or situation.
- Uses appropriate evidence-based assessment techniques and instruments in collecting pertinent data.
- Uses analytical models and problem-solving techniques.
- Gathers data on the patient's/client's history of adverse experiences (e.g., neglect, substance use in a caregiver, physical or sexual abuse) and how those experiences have affected the patient's/client's health.
- Ensures that appropriate consents, as determined by regulations and policies, are obtained to protect confidentiality and support the patient's/client's rights in the process of data gathering.
- 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 patient's/client's emotions, thoughts, behaviors, and condition.
- 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 comprehensive psychiatric and mental health diagnostic evaluations.
- Initiates and interprets diagnostic tests and procedures relevant to the patient's/client's current status.

- Employs evidence-based clinical practice guidelines to guide screening (e.g., trauma, suicide, etc.) and diagnostic activities as available and appropriate.
- Conducts a multigenerational family assessment, including medical, psychiatric, and substance use history.
- Organizes (as needed) a comprehensive trauma assessment based on the patient's/client's history, attachment style, level of dissociation, avoidance behaviors, triggers, current resources, and skills.
- Completes a cultural formulation assessment.
- Assesses interactions among the patient/client, family, community, and social systems and their relationship to mental health functioning.
- Assesses for effectiveness of current and past nonpharmacological and pharmacological treatment strategies.

STANDARD 2. DIAGNOSIS

The psychiatric-mental health registered nurse analyzes the assessment data to determine diagnoses, problems, and 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 patient's/client's health and safety or barriers to mental and physical health, which may include, but are not limited to, cultural, interpersonal, systematic, or environmental circumstances.
- Identifies the nursing diagnoses, problems, or areas in need of care and treatment from the assessment data.
- Identifies nursing diagnoses for patients/clients who have experienced trauma.
- Validates the nursing diagnosis or problems with the patient/client, significant others, and other health care clinicians to the

greatest extent possible in concert with person-centered, recovery-oriented practice.
- Develops nursing diagnoses or problems that, to the greatest extent possible, are in the patients'/clients' words and congruent with available and acceptable 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):

- Develops standard psychiatric and substance use diagnoses (e.g., *DSM* or International Classification of Diseases).
- Formulates differential diagnoses.
- Considers the diagnosis of trauma-related disorders and co-occurring psychiatric disorders.
- 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.
- Identifies long-term effects of psychiatric disorders on mental, physical, and social health.
- Evaluates health as impacted by life stressors, traumatic events, and situational crises.
- Evaluates the impact of the course of psychiatric disorders and mental health problems on the path of recovery, including quality of life and functional status.
- Assists staff in developing and maintaining competency in the diagnostic process.

STANDARD 3. OUTCOMES IDENTIFICATION

The psychiatric-mental health registered nurse identifies expected outcomes based on the patient's/client's goals and their individual circumstances.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Involves the patient/client to the greatest extent possible in formulating mutually agreed-upon and positively stated outcomes and individualized goals.
- Involves the patient's/client's family, health care providers, and other significant supports in formulating expected outcomes when possible and as appropriate.
- Derives age and culturally appropriate expected outcomes from the identified diagnoses and problems.
- Considers associated risks, benefits, costs, current scientific evidence, and clinical expertise when formulating expected outcomes.
- Considers the effects of social determinants of health 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 patient/client, the patient's/client's values, ethical considerations, environment, or situation, with consideration of associated risks, benefits, costs, current scientific evidence, and personal recovery goals.
- Develops expected outcomes that provide direction for continuity of care.
- Documents expected outcomes as patient/client-focused measurable goals in language either developed by the patient/client or understandable to the patient/client.
- Includes a time estimate for attainment of expected outcomes.

- Modifies expected outcomes based on changes in the status of the patient/client or evaluation of the situation in partnership with the patient/client.

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

The psychiatric-mental health advanced practice nurse (PMH-APRN):

- Assists the PMH-RN in identifying expected outcomes that incorporate scientific evidence and are achievable through implementation of evidence-based practices.
- Identifies expected outcomes that incorporate cost and clinical effectiveness, patient/client satisfaction, and continuity and consistency among providers.
- Incorporates clinical guidelines linked to positive clinical outcomes.

STANDARD 4. PLANNING

The psychiatric-mental health registered nurse develops a patient/client-centered plan that prescribes strategies and alternatives to attain expected outcomes.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Recognizes the patient/client as the authority on their own health by honoring their care preferences.
- Develops an individualized plan in partnership with the patient/client, family, and others, considering the patient's/client's characteristics or situation.
- Includes values, beliefs, spiritual and health practices, preferences, choices, developmental level, strengths, coping style, culture, environment, available technology, and individual recovery goals in the plan.

- Establishes the plan's priorities with the patient/client, support system, health care providers, and others as appropriate.
- Prioritizes elements of the plan based on the assessment of the patient's/client's safety needs and level of risk for potential harm to self or others.
- Includes strategies in the plan that address each of the identified problems or issues, including strategies for the promotion of recovery, restoration of health, and prevention of illness, injury, and disease.
- Incorporates a strength-based approach in planning care for patients/clients, families, and communities.
- Addresses the economic impact of the plan.
- Assists patients/clients in securing treatment or services in the least restrictive environment.
- Includes an implementation pathway or timeline.
- Provides for continuity.
- Utilizes the plan to provide direction to other members of the health care team.
- Documents the plan using person-centered terminology.
- Develops the plan to reflect current statutes, rules and regulations, and standards.
- Integrates current scientific evidence, trends, and research.
- Modifies the plan (i.e., the goals/outcomes and interventions) based on ongoing assessment of the patient's/client'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 knowledge.
- Plans care to minimize complications and promote individualized recovery and optimal quality of life, using

treatment modalities, including, but not limited to, psychodynamic, cognitive-behavioral, supportive interpersonal therapies, and psychopharmacology.
- Includes education on self-regulation skills (e.g., grounding, somatic skills, and mindfulness) to enhance resilience in patients/clients.
- Selects or designs strategies to meet the multifaceted needs of complex health care consumers.
- Includes synthesis of patient's/client's values and beliefs regarding nursing and medical therapies.
- 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 patient/client-centered plan.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Partners with the patient/client, family, support system, health care providers, and others as appropriate to implement the plan in a safe, realistic, and timely manner.
- Utilizes evidence-based and best practice interventions specific to the problem or issue.
- Employs principles of mental health recovery and trauma-sensitive care.
- Utilizes the principles of cultural humility when working with a patient/client.
- Integrates traditional and complementary health care practices as appropriate.
- Utilizes technology to measure, record, and retrieve patient/client data and enhance nursing practice.
- Utilizes community resources and systems to implement the plan.

- Provides care and treatment related to psychiatric, substance use, and medical conditions.
- Provides holistic care that focuses on the person with the disease or disorder, not just the disease or disorder itself, to promote wellness and well-being.
- Advocates for the patient/client.
- Addresses the needs of diverse populations across the life span.
- Collaborates with nursing colleagues and other disciplines to implement the plan.
- Supervises ancillary staff in carrying out care interventions.
- Documents implementation and any modifications, including changes or omissions, of the plan.
- 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 registered nurse (PMH-APRN):

- Facilitates utilization of systems and community resources 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 patient's/client's care in order to maximize individual recovery, well-being, and quality of life.
- Assists the patient/client in identifying options for care.
- Communicates with the patient/client, family, and health care systems 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 Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level prepared psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Provides leadership in the coordination of interprofessional health care for integrated delivery of care and treatment services.
- Synthesizes data and information to prescribe necessary system and community support measures, including environmental modifications.
- Coordinates system and community resources that enhance quality and effectiveness across continua of care.

STANDARD 5B. HEALTH TEACHING, HEALTH LITERACY, 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) to promote stabilization of symptoms, the process of recovery, well-being, and mental health literacy. The teaching is related to the patient's/client's needs, individual goals, and the patient's/client's situation that may include, but is not limited to, mental and behavioral health problems, psychiatric and substance use disorders, treatment regimens and self-management of those regimens, coping skills, relapse prevention, self-care activities, resources, conflict management, problem-solving skills, stress management and relaxation techniques, and crisis management.
- Promotes health literacy by using health promotion activities and health teaching methods appropriate to the situation and the patient's/client's preferences, 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 patient/client alliances, such as peer specialists and advocacy groups, as appropriate, in health teaching and health promotion activities.
- Identifies community resources to assist and support health care consumers in using prevention and mental health care services.
- Seeks individual patient/client feedback and evaluation of the effectiveness of strategies utilized and learning achieved.
- 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 Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level prepared psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Synthesizes empirical evidence on risk behaviors, learning theories, behavioral change theories, motivational theories, culture, epidemiology, and other related theories and frameworks when designing health information and patient/client education.
- Educates patients/clients and significant others about intended effects and potential adverse effects of treatment options and regimens.
- Provides education to individuals, families, and groups to promote understanding and effective management of overall health maintenance, mental health and symptom challenges, and psychiatric and substance use 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 patient/client education appropriate to the patient's/client'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 patients/clients access quality health information.
- Engages with the PMH-RN in curriculum and program development in the areas of health teaching and health promotion in clinical practice settings.
- Engages in lifelong learning to remain current about psychiatric-mental health-related content and a variety of culturally congruent teaching strategies to support and promote effective patient/client learning.

STANDARD 5C. CONSULTATION

The psychiatric-mental health advanced practice registered nurse provides consultation to maximize outcomes from the identified plan, collaborate with other clinicians to provide services for patients/clients, and contribute to system 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 patient/client or consultee based on mutual respect and role responsibilities.
- Facilitates the potential 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, facilitates understanding by involved stakeholders, and enhances the work of others to promote wellness and effect change.
- Clarifies that the implementation of system changes or changes to the treatment plan remain the consultee's responsibility.
- Contributes to the interprofessional team to resolve complex situations through both direct care and systemic change.

STANDARD 5D. PHARMACOLOGICAL/ BIOLOGICAL THERAPIES AND PRESCRIPTIVE AUTHORITY

The psychiatric-mental health registered nurse incorporates knowledge of pharmacological and biological interventions with applied clinical skills to restore the patient's/client's health and prevent further disability.

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.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Applies current research findings to guide nursing actions related to pharmacology and other biological therapies.
- Assesses the patient's/client'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 patients/clients in managing their own medications and adhering to a prescribed regimen.
- Provides health teaching about the mechanism of action, intended effects, potential adverse effects of the proposed prescription, ways to cope with transitional side effects, and other treatment options, including lack of treatment.
- Communicates to other clinicians observations about the response of patients/clients to biological interventions.
- Collaborates with other members of the interprofessional team to address complex medical, environmental, or financial concerns related to pharmacological/biological treatment.

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, their side effects, efficacy, and health care consumer preference.
- Provides patients/clients with information about intended effects and potential adverse effects of proposed prescribed therapies.
- Provides information about pharmacologic agents, costs, and alternative treatments and procedures, as appropriate, for the patient to make an informed decision.

- Prescribes pharmacologic agents/biological therapy based on a current knowledge of pharmacology and physiology.
- Prescribes specific pharmacological agents and treatments in collaboration with the patient/client that are based on clinical indicators; the patient's/client's status, needs, and preferences; and the results of diagnostic and laboratory tests.
- Provides brain stimulation therapies such as electroconvulsive therapy and transcranial magnetic stimulation therapy.
- Evaluates therapeutic and potential adverse effects of pharmacological and nonpharmacological treatments.
- Evaluates pharmacological outcomes by utilizing standard symptom measurements and the patient's/client's reports to determine effectiveness.

STANDARD 5E. COMPLEMENTARY/ INTEGRATIVE THERAPIES

The psychiatric-mental health registered nurse incorporates knowledge of complementary/integrative interventions (e.g., meditation, yoga, acupuncture, Reiki, Healing Touch, nutrition, physical exercises, dietary supplements, aromatherapy, herbology, art, and music) with applied clinical skills to restore the patient's/client's health and prevent further disability.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Applies current research findings to guide nursing actions related to psychotherapeutic modalities and complementary/integrative therapies.
- Directs complementary/integrative interventions.
- Communicates to other clinicians observations about the response of patients/clients to complementary/integrative interventions.
- Collaborates with other members of the interprofessional team to address complex medical, environmental, or financial concerns related to complementary/integrative treatment.

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

The psychiatric-mental health advanced practice registered nurse (PMH-APRN):

- Educates and assists the patient/client in selecting the appropriate use of complementary/integrative therapies.
- Prescribes evidence-based treatments, therapies, and procedures considering the patient's/client's comprehensive health care needs.
- Evaluates therapeutic and potential adverse effects of complementary/integrative treatments.

STANDARD 5F. MILIEU THERAPY

The psychiatric-mental health registered nurse (including the graduate-level prepared PMH-RN and PMH-APRN) provides a safe, therapeutic, recovery-oriented environment in collaboration with patients/clients, families, and other clinicians/ancillary staff/care partners.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Orients the patient/client and family to the care environment, including the physical environment, the roles of different health care providers, how to be involved in the treatment and care delivery processes, schedules of events pertinent to the care, treatment, and expectations regarding safe and therapeutic behaviors among patients/clients.
- Orients patients/clients to their rights and responsibilities particular to the treatment or care environment.
- Establishes a welcoming, safe, trauma-sensitive environment, including the use of therapeutic interventions such as sensory or relaxation rooms.
- Conducts ongoing assessments of the patient/client in relation to the environment to guide nursing interventions.

- Encourages participation in activities (both individual and group) that meet the patient's/client's physical and mental health needs for meaningful participation in the milieu and promotion of personal growth.
- Advocates that the patient/client be treated in the least restrictive environment necessary to maintain the safety of the individual and others.
- Informs the patient/client, in a culturally sensitive manner, about the need for limits related to safety and the conditions necessary to remove the restrictions.
- Provides support and validation to patients/clients when they discuss their illness experience and seeks to prevent complications of illness.
- Collaborates effectively with the interprofessional team, including ancillary staff and care partners.

STANDARD 5G. THERAPEUTIC RELATIONSHIP

The psychiatric-mental health registered nurse (including the graduate-level prepared PMH-RN and PMH-APRN) uses the therapeutic relationship as the basis for interactions and the provision of care.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Uses interpersonal skills and personal strengths to develop, enhance, understand, and support a therapeutic relationship.
- Maintains well-defined professional boundaries in the context of the nurse-patient/client relationship.
- Uses a patient-centered and patient-focused approach in the nurse-patient/client relationship.
- Engages in the nurse-patient/client relationship to promote well-being and growth in the patient/client.
- Engages in interactions with patients that are culturally sensitive and age appropriate.

STANDARD 5H. COUNSELING AND PSYCHOTHERAPY

The psychiatric-mental health registered nurse (PHM-RN) uses counseling interventions to assist patients/clients in their individual recovery journeys.

The psychiatric-mental health advanced practice registered nurse conducts individual, couples, group, and family psychotherapy, using evidence-based psychotherapeutic frameworks within the nurse-client therapeutic relationship.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Uses therapeutic communication and counseling techniques to promote the patient's/client's stabilization of symptoms and personal recovery goals.
- Uses counseling techniques to reinforce healthy behaviors and interaction patterns and helps the patient/client discover individualized health care behaviors to replace unhealthy ones.
- Documents counseling interventions, including, but not limited to, crisis intervention, stress management, interpersonal skill building, relaxation techniques, assertiveness training, and conflict resolution.
- Utilizes interventions that promote mutual trust to build a therapeutic treatment alliance.
- Empowers patients/clients to be active participants in their treatment.
- Uses awareness of their own emotional reactions and behavioral responses to others to enhance the therapeutic alliance.

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

The psychiatric-mental health advanced practice registered nurse (PMH-APRN):

- Uses knowledge of relevant biological, psychosocial, and developmental theories, as well as best available research evidence, to select psychotherapeutic approaches based on patient/client needs.
- Applies therapeutic communication strategies based on theories and research evidence to reduce emotional distress, facilitate cognitive and behavioral change, and foster personal growth and resilience.
- Conducts evidence-based psychotherapy for trauma and co-occurring disorders.
- Analyzes the impact of the duty to report and other advocacy actions on the therapeutic alliance.
- Arranges for the provision of care in the therapist's absence.
- Makes referrals when it is determined that the patient/client will benefit from a transition of care or consultation due to change in clinical condition.

STANDARD 6. EVALUATION

The psychiatric-mental health registered nurse evaluates progress toward attainment of expected outcomes.

Competencies

The psychiatric-mental health registered nurse (RN-PMH):

- Conducts a systematic, ongoing, and criterion-based evaluation of the outcomes and goals in relation to the prescribed interventions by the plan and indicated timeline.
- Collaborates with the patient/client, family, significant others, and other clinicians in the evaluation process.
- Evaluates the impact of trauma on the family system.
- Documents results of the evaluation.
- Evaluates the effectiveness of the planned strategies in relation to patient/client responses and the attainment of the expected outcomes.

- Uses ongoing assessment data to revise the problems, diagnoses, and interventions as needed.
- Adapts the plan of care for the trajectory of treatment according to an evaluation of response.
- Disseminates the results to the patient/client and others involved in the care or situation, as appropriate, in accordance with state and federal laws and regulations.
- Participates in assessing the use of interventions to minimize unwarranted or unwanted treatment.
- Evaluates interventions to optimize wellness and quality of life.

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level prepared psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Evaluates the accuracy of the diagnosis and effectiveness of the interventions in relationship to the patient's/client's attainment of expected outcomes.
- Uses reliable and valid measures to evaluate treatment progress and attainment of patient's/client's identified goals.
- Synthesizes multiple data sources to determine the impact of the plan on the affected patients/clients, families, groups, communities, and institutions.
- Uses the results of the evaluation analysis to make or recommend process or structural changes, including policy, procedure, or protocol documentation, as appropriate.
- Assists the PMH-RN in the evaluation and reformulation of the plan in complex and dynamic situations.

Standards of Professional Performance

STANDARD 7. ETHICS

The psychiatric-mental health registered nurse practices ethically.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Uses *Code of Ethics for Nurses With Interpretive Statements* (ANA, 2015) to guide practice.
- Applies ethical and legal principles to the treatment of patients/clients with mental health problems and psychiatric disorders.
- Delivers care in a manner that preserves and protects patient/client autonomy, dignity, and rights.
- Avoids using the power inherent in the therapeutic relationship to influence the patient/client in ways not related to the treatment goals.
- Maintains patient/client confidentiality within legal and regulatory parameters.
- Serves as an advocate, protecting patient/client rights and assisting patients/clients in developing skills for self-advocacy.
- Maintains therapeutic and professional interpersonal relationships 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 patients/clients, colleagues, or systems through activities such as recommending ethics clinical consultations for specific patient/client situations and participating on ethics committees.

- Intervenes in cases of illegal, incompetent, or impaired practices.
- Promotes advanced care planning related to behavioral health issues, which may include behavioral health advanced directives.
- Assists patients/clients who may be facing concurrent medical illnesses to plan for and gain access to appropriate care.
- Promotes a system and climate that is conducive to providing ethical care.
- Advocates for patients/clients to protect them from harm and maximize their human rights and dignity.

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

The psychiatric-mental health advanced practice registered nurse (PMH-APRN):

- Informs the patient/client of the risks, benefits, and outcomes of health care regimens.
- Contributes to interprofessional teams that address ethical risks, benefits, and outcomes.
- Utilizes ethical principles to advocate for access and parity of services for mental health problems, psychiatric disorders, and addiction services.
- Analyzes the impact of the duty to report and other advocacy actions on the therapeutic alliance.
- Arranges for the provision of care in the therapist's absence.

STANDARD 8. CULTURAL HUMILITY

The psychiatric-mental health registered nurse practices from a perspective of cultural humility.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Engages in frequent self-reflection to assess for presence of personal biases when working with culturally diverse individuals, groups, and communities.
- Participates (intentionally) in interactions/activities with individuals, groups, and communities from diverse backgrounds.
- Strives to be open and curious about the experiences and treatment desires of patients/clients and families that come from and hold diverse health care perspectives.
- Advocates for integration of patient's/client's treatment wishes into the plan of care.
- Utilizes a relationship-based style of communication with patients/clients in their care.
- Promotes personal and staff behaviors/actions that support an inclusive work environment, being mindful to avoid marginalization.
- Participates in lifelong learning to continuously develop and reinforce skills for working effectively and inclusively with diverse individuals, ideas, beliefs, practices, and desires.

Additional Competencies for the Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN)

The psychiatric-mental health advanced practice registered nurse (PMH-APRN):

- Determines barriers and facilitators to culturally inclusive and responsive patient/client care.
- Monitors patient/client outcomes associated with practices grounded in cultural humility.
- Supports members of the treatment team as they strive to be more culturally aware and sensitive.
- Advocates for provider-patient relationships built on openness, respect, and awareness.
- Challenges provider-patient power imbalances that negatively impacts patient self-determinism and choice.

STANDARD 9. COMMUNICATION

The psychiatric-mental health registered nurse communicates effectively in all areas of practice.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Assesses communication preferences of patients/clients, families, and colleagues.
- Assesses one's own communication skills in encounters with patients/clients, families, and colleagues across a variety of care delivery environments.
- Seeks continuous improvement of his or her own communication and conflict resolution skills.
- Demonstrates communication competence with individuals across the life span.
- Ensures communication effectiveness by utilizing a variety of culturally appropriate strategies and tools.
- Conveys information to patients/clients, families, the interprofessional team, and others in communication formats that promote understanding.
- Advocates for the decisions of the patients/clients.
- Discloses observations or concerns related to hazards and errors in care or the practice environment to the appropriate level.
- Maintains communication with other members of the interprofessional team to minimize risks associated with transfers and transition in care delivery.
- Documents referrals, including provisions for continuity of care.
- Contributes his or her 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 nursing care.

STANDARD 10. PROFESSIONAL COLLABORATION

The psychiatric-mental health registered nurse collaborates with others.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Shares knowledge and skills with peers and colleagues in professional practice settings, at professional conferences, and at other professional meetings.
- Provides colleagues with feedback to enhance their practice and role performance.
- Interacts with 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 health care professionals.
- Contributes to a supportive and healthy work environment.

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Models expert practice to interprofessional team members and health care consumers.
- Mentors other registered nurses and colleagues as appropriate.
- Participates in interprofessional teams that contribute to role development and advancement of self and others to promote nursing practice and quality health care.
- Partners with other disciplines to enhance health care through interprofessional activities such as education, consultation,

management, technological development, or research opportunities.
- Facilitates an interprofessional process to patient/client care with other members of the health care team.

STANDARD 11. LEADERSHIP

The psychiatric-mental health registered nurse leads in the professional practice setting and the profession.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Oversees the provision of nursing care and is accountable for the quality of care given to the patient/client.
- Abides by the established vision, goals, and plan to measure progress of a patient/client or health care organization.
- Demonstrates a commitment to continuous lifelong learning and education for self and others.
- Provides mentorship to promote the advancement of nursing practice, the profession, and quality health care.
- Treats colleagues with respect, compassion, and dignity contributing to a safe and healthy environment.
- Develops and utilizes constructive communication and conflict resolution skills.
- Participates in professional associations.
- Communicates effectively with the patient/client and colleagues.
- Influences health care policy at the local, state, and/or national level by advocating for patients/clients and the profession of nursing.
- Actively engages in positions of influence at the local, state, and national levels in order to inform policies and guidelines that address health needs.

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Influences decision-making bodies to improve patient/client outcomes and advanced practice nursing.
- Provides expert guidance and support to the interprofessional team.
- Develops innovative strategies to improve health outcomes in patients/clients.
- Promotes advanced practice nursing to patients/clients, families, and others.
- Mentors colleagues in the acquisition of clinical knowledge, skills, and judgment.
- Provides leadership to patient care teams through roles such as the attending provider and expert consultant responsible for directing care throughout hospitalizations and in community settings.

STANDARD 12. EDUCATION

The psychiatric-mental health registered nurse attains knowledge and competencies that reflect current nursing practice.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Participates in ongoing educational activities related to clinical 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.
- Seeks formal and independent learning activities to maintain and develop clinical skills, knowledge, and competencies and maintains records of the same for relicensing and recertification purposes.

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level psychiatric-mental health registered nurse (including the PMH-APRN):

- Uses current 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 health care consumers.
- Mentors registered nurses, colleagues, and students as appropriate.
- Participates in interprofessional teams by contributing to role development and advanced nursing practice and health care.

STANDARD 13. EVIDENCE-BASED PRACTICE AND RESEARCH

The psychiatric-mental health registered nurse integrates evidence and 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.

- Participates in research activities appropriate to the nurse's level of education and position. Such activities may include:
  - Identifying clinical problems specific to psychiatric-mental health nursing research
  - Conducting data collection (surveys, pilot projects, and 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 and research
  - Critically analyzing and interpreting research for application to practice
  - Using research findings in the development of policies, procedures, and standards of practice in nursing care
  - Incorporating research as a basis for learning

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level psychiatric-mental health registered nurse, including the APRN (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 health care practice.
- Promotes a climate of research, practice improvement, 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.
- Contributes to the development of evidence-based practice through implementation and dissemination of results from quality improvement projects and research studies.

STANDARD 14. QUALITY OF PRACTICE

The psychiatric-mental health registered nurse systematically enhances the quality and effectiveness of safe 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 quality improvement process to initiate changes in nursing practice and in the health care 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 in interprofessional 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 Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Obtains and maintains professional certification at the advanced level in psychiatric-mental health nursing.
- Designs, implements, and evaluates quality improvement initiatives to advance nursing practice and health outcomes.
- Identifies opportunities for the generation and use of research and evidence.
- Evaluates the nursing practice environment and quality of nursing care rendered in relation to existing evidence.

STANDARD 15. PROFESSIONAL PRACTICE EVALUATION

The psychiatric-mental health registered nurse evaluates one's own and others' nursing practice.

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 health care consumers, peers, professional colleagues, and others to enhance psychiatric-mental health nursing practice or role performance.
- 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.
- 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 registered nurse (PMH-APRN):

- Models self-improvement by reflecting on and evaluating one's own practice and role performance and sharing insights with peers and professional colleagues.
- Demonstrates mindful and reflective practice through regular supervision, peer consultation, and other lifelong learning activities.
- Conducts their practice according to the state's Nurse Practice Act.

STANDARD 16. RESOURCE UTILIZATION

The psychiatric-mental health registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible.

Competencies

The psychiatric-mental health registered nurse (PMH-RN):

- Evaluates factors such as safety, effectiveness, availability, cost–benefit, efficiencies, and impact on care.
- Assists the patient/client and family in identifying and securing accessible, affordable, and high-quality services to address health-related needs.
- Assigns or delegates elements of care to appropriate health care workers, based on the needs and condition of the health care consumer, potential for harm, stability of the health care consumer's condition, complexity of the task, and predictability of the outcome.
- Advocates for human, community, and technological resources that promote quality care.
- Employs evidence-based and practice-informed strategies to evaluate resources for clinical decision-making.

Additional Competencies for the Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level prepared psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Utilizes organizational and community resources to formulate interprofessional plans of care and policy.
- Develops innovative solutions for patient/client problems that address effective resource utilization and maintenance of quality care.
- Designs evaluation strategies to demonstrate quality, cost-effectiveness, cost–benefit, and efficiency factors associated with nursing practice.
- Builds constructive relationships with hospital and community providers, organizations, and systems to promote collaborative decision-making and planning to identify and meet resource needs.

STANDARD 17. 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 environmental health assessment and implementation of environmental health strategies.
- Promotes a practice environment that reduces environmental health risks for colleagues and patients/clients.
- Advocates for the judicious use of products and technology in health care.
- Communicates environmental health risks and exposure reduction strategies to health care 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 Graduate-Level Prepared Psychiatric-Mental Health Registered Nurse, Including the APRN

The graduate-level prepared psychiatric-mental health registered nurse, including the APRN (PMH-APRN):

- Creates partnerships that promote sustainable, global 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 media and understood by the general public.
- Advocates and supports nurses in implementing environmental health principles.

Glossary

Adverse Childhood Experiences (ACEs). Include, but are not limited to, childhood abuse (psychological abuse, physical abuse, or contact sexual abuse) and exposure to household dysfunction during childhood (substance abuse, mental illness, violent treatment of parent or stepparent, or criminal behavior in the household). ACEs are strongly associated with long-term risk for social, emotional, and cognitive impairment; engagement in risky behaviors; disease; disability; social problems; and early death (Felitti et al., 1998).

Advocate. A person who supports a person(s), population, cause, or policy.

Age-Appropriate (Developmentally Appropriate) Activities. Activities that are generally accepted as suitable for patients' chronological age or maturity level, based upon the cognitive, emotional, physical, and behavioral capacities of the individual. Any mental health issues or an intellectual disability must also be considered when determining the capacity of the patient to participate in the activities.

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

Biopsychosocial Model. An interdisciplinary model for illness and health that looks at the interconnectedness between biology, psychology, and social environments. This model can be found in many indigenous and ancient societies but was introduced to modern medicine in the United States in the 20th century as the foundation for how biology, psychology,

and social environments intertwine to impact health and disease processes (Engel, 1977). It is currently the basis for the International Classification of Functioning (ICF), Disability, and Health Science, the framework for measuring health and disability at both population and individual levels (WHO, 2002).

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

Care Coordinator. A trained health professional who helps manage a patient's health care.

Client. The recipient of care.

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

Comorbidity. The simultaneous occurrence of more than one disease or condition in the same client. One condition may cause the other or make the client more vulnerable to it; the conditions may be induced by common factors or may be unrelated.

Community. A group of people having characteristics in common.

Continuity of Care. An interprofessional process that includes health care consumers, families, and significant others in the development of a coordinated plan of care. This process facilitates the health care consumer's transition between settings and health care providers and is based on changing needs and available resources.

Complementary/Integrative Health Practices. Integrative health practices emphasize a holistic, patient-focused approach to health care and wellness—often including mental, emotional, functional, spiritual, social, and community aspects—and treating the whole person rather than, for example, one organ system. It aims for well-coordinated care between different providers and institutions. Examples include integration of dietary supplements, meditation, yoga, acupuncture, Reiki, and other mind-body practices into care (National Center for Complementary and Integrative Health, 2020).

Counseling. "A nursing intervention defined as use of an interactive helping process focusing on the needs, problems, or feelings of the patient and significant others to enhance or support coping, problem solving, and interpersonal relationships" (Miller-Keane & O'Toole, 2003).

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

Cultural Humility. Lifelong commitment to self-evaluation and personal critique, to acknowledging and addressing power imbalances, and to developing mutually beneficial and nonpaternalistic partnerships with communities on behalf of individuals, groups, and populations. Components include commitment to lifelong learning and critical self-reflection, recognizing and challenging power imbalances in order to promote respectful relationships, and calling for institutional and individual accountability (Foronda, Baptiste, Reinholdt, & Ousman, 2016; Tervalon & Murray-Garcia, 1998).

Culturally Congruent Practice. The application of evidence-based nursing that agrees with the preferred cultural values, beliefs, worldview, and practices of the health care consumer and other stakeholders. Cultural competence represents the process by which nurses demonstrate culturally congruent practice. Nurses design and direct culturally congruent practice and services for diverse consumers to improve access, promote positive outcomes, and reduce disparities (ANA, 2015b, p. 31; Marion et al., 2016).

Culturally Informed Practice. The ability of health care professionals to provide assessments and interventions that acknowledge, respect, and integrate patients' and families' cultural values, beliefs, and practices in the plan of care with a focus on empowerment and true partnership between the patient and provider. It requires ongoing development of one's professional attitude and roles of cultural bearer and learner (Froyd et al., 2021; Leseth, 2015).

Cultural Sensitivity. Effective engagement (verbal and nonverbal) to promote equity in health care through intentions and demonstrations of respect and mutual understanding of values, beliefs, preferences, and culture (Brooks, Manias, & Bloomer, 2019).

Diagnosis. A clinical judgment about a health care consumer's response to actual or potential health conditions or needs. The diagnosis may be framed in terms of a problem, issue, or target behavior that provides the basis for determining a plan to achieve expected outcomes. Registered nurses utilize nursing and/or medical diagnoses depending on educational and clinical preparation and legal authority.

Environment. The atmosphere, milieu, or conditions in which an individual lives, works, or plays and the registered nurse practices.

Evaluation. The process of determining the health care consumer's progress toward attainment of expected outcomes and the effectiveness of the registered nurse's care and interventions.

Evidence-Based Practice. A lifelong problem-solving approach to clinical practice that integrates a systematic search for relevant research (i.e., external evidence) with a critical appraisal and synthesis of the effectiveness and significance of that research to answer a burning clinical question; one's own clinical expertise, which includes internal evidence generated from outcomes management or quality improvement projects, a thorough health assessment, and evaluation and use of available resources necessary to achieve desired health outcomes; and incorporation of the person's preferences and values.

Expected Outcomes. Behaviorally focused, measurable, individual, family, or community states or perceptions that indicate desirable results. Outcomes are measured along a continuum and are responsive to nursing interventions.

Family. Family of origin or significant others as identified by the health care consumer.

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

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

Health Care Providers. Individuals with special expertise who provide health care services or assistance to health care consumers. They may include nurses, physicians, psychologists, social workers, nutritionists/dietitians, and various therapists.

Health Disparities. "[P]reventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other populations groups, and communities" (CDC, 2017).

Health Care Disparities. "[D]ifferences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention" (IOM, 2003, p. 32). Health care disparities are caused by provider and health care system-specific factors, versus patient factors, that directly contribute to disparities in health outcomes at the individual level, including provider biases, prejudices, and stereotyping that influence communication and clinical decision-making (IOM, 2003).

Health Inequities. An absence of fair and just opportunities to be healthy, which leads to disparities. Specific obstacles to health include, but are not limited to, poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care (Braveman, Arkin, Orleans, Proctor, & Plough, 2017; Jones, 2014). Attaining **Health Equity,** the "highest level of health for all people," must include "ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" (CDC, 2020b).

Holistic. Treatment based on an understanding that the parts of a health care consumer are interconnected and that physical, mental, social, and

spiritual factors all need to be included in an individual's treatment plan and nursing interventions.

Illness. The subjective experience of discomfort.

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

Individual. A single distinct being.

Integrated Care. Combines physical health care and mental health care in one setting. One model combines the expertise of mental health, substance abuse, and primary care clinicians in one setting to create a team-based approach with the patient and their support team. This holistic model improves health outcomes of the patient in a cost-effective manner (Soltis-Jarrett et al., 2017).

Interprofessional. 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 Disorder. Any condition of the brain that adversely affects a person's cognition, emotions, or behavior.

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

Milieu Therapy. A therapeutic milieu is a safe, welcoming, supportive, and functional physical treatment environment (McLoughlin & Geller, 2010). Milieu therapy includes the nursing interventions used to assist health care consumers to make positive change and promote recovery by providing empathy, assisting in problem solving, acting as a role model, demonstrating leadership, confronting discrepancies when necessary, encouraging self-efficacy, decreasing stimuli when necessary, and manipulating the environment such that the above interventions can be effective (Delaney, 2006; Yurkovich, 1989).

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

Nursing Process. A critical thinking model used by nurses that comprises the integration of the singular, concurrent actions of these six components: assessment, diagnosis, identification of outcomes, planning, implementation, and evaluation.

Outcomes Identification. The expected outcomes for a plan individualized to the recipient of care.

Patient. The recipient of care. (See Client)

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

Person-Centered. Valuing and incorporating the unique abilities, desires, and preferences of the receipt of care into the plan of care.

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

Population Health. Health status, outcomes, and distribution of outcomes within a group of people.

Primary Care. A level of care that provides entry to a health system with subsequent integration of patient-centered care over time.

Psychiatric Consultation-Liaison Nursing. A psychiatric nursing specialty for PMH-APRNs that involves direct or indirect care for patients with actual or potential physical dysfunction through prevention, intervention, rehabilitation, consultation, collaboration, and education relationships with nurses and other health care providers.

Psychiatric Disorder. Any condition of the brain that adversely affects a person's cognition, emotions, or behavior.

Psychiatric-Mental Health Nursing. Psychiatric-mental health (PMH) nursing promotes integrated and comprehensive health and wellness

through prevention and education, as well as assessment, diagnosis, care, and treatment of the full range of psychiatric-mental health disorders, including substance use disorders, across the life span. Psychiatric nurses practice transpersonal caring to promote the health and healing of humanity. The practice of PMH nursing is a science and an art, based on evidence and the purposeful use of self and the therapeutic relationship. PMH nurses provide care at the individual, family/relationship, community, and societal levels to promote well-being and quality of life, as well as to sustain positive health outcomes.

PMH nurses work with people who are experiencing physical, psychological, mental, and spiritual distress. They provide comprehensive, trauma-responsive, person-centered behavioral and psychiatric-mental health care in a variety of settings across the continuum of care. Essential components of PMH nursing practice include health and wellness promotion through identification of mental health issues, prevention of mental health problems, care of mental health problems, and treatment of persons with psychiatric-mental health disorders, including substance use disorders.

Psychotherapy. Psychotherapy is a general term used to describe the process of treating health care consumers with mental health issues or psychiatric disorders. A variety of professionals engage in psychotherapy, including psychiatric-mental health advanced practice nurses, clinical psychologists, psychiatrists, and clinical social workers. There are many specific types of psychotherapy, including cognitive-behavioral therapy, dialectical behavior therapy, group therapy, psychoanalytic therapy, and client-centered therapy.

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

Recovery. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery implies the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms (U.S. DHHS, 2003, p. 7).

Recovery Oriented. Recovery-oriented care is what psychiatric caregivers and practitioners offer in support of the health care consumer's recovery. It embeds the language, spirit, and culture of recovery with the caregivers themselves and with the health care consumers and their families. Recovery-oriented interventions focus on the health care consumer's goals as they define them and on the health care consumer as a leader or guide of the care process to the fullest extent possible. Recovery-oriented care focuses on utilizing strengths of the health care consumer in identifying and addressing barriers to wellness and gaining health.

Relationship. The state of being connected.

Resilience. Dynamic process encompassing positive adaptation within the context of significant adversity (Luther, Cicchetti, & Becker, 2000). A continuum that may present in differing degrees across multiple domains (biological, psychological, social, and cultural) (Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014).

Reverse Colocation. When primary care services are located in a mental health clinic.

Scope. The scope of practice describes the services that an RN or APRN is deemed competent to perform, and is permitted to undertake, in keeping with the terms of their professional license.

Social Determinants of Health. Social determinants of health included interrelated social structures and economic systems that shape health conditions (CDC, 2018a). They are "conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels. The social determinants of health are mostly responsible for health inequities—the unfair and avoidable differences in health status seen within and between countries" (WHO, 2020). The U.S. Department of Health and Human Services (2020a) has highlighted the term ***Determinants of Health*** to indicate the contribution of social, as well as other factors, to outcomes. Determinants of Health include the range of personal, social, economic, and environmental factors that influence health status are known as determinants of health, including policymaking,

social factors, health services, individual behavior, biology, and genetics. Complex relationships between these factors influence or determine health at individual and population levels (U.S. DHHS, 2020a). Furthermore, ***Structural Determinants*** specifically operate through intermediary determinants of health to produce health outcomes. Intermediary determinants are distributed according to the social stratification and determine differences in exposure and vulnerability to harmful conditions for health, including, but not limited to, social position, gender, race and ethnicity, and access to resources. Intermediate determinants include material circumstances (e.g., housing, neighborhood quality, and physical work environment), psychosocial circumstances (e.g., stressors, relationships, social support, and networks), behavioral and biological factors (nutrition, physical activity, consumption of substances), social cohesion, and the health system (Pan American Health Organization, 2012).

Social-Ecological Model. An approach that considers the interplay between and the overlapping influence of the individual, relationship, community, and societal factors.

Society/Societal. People living together in a community.

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 society. Stigma may be attached to a person who differs from social or cultural norms. Social stigma can result from the perception or attribution, rightly or wrongly, of mental disorder, physical disabilities, diseases, illegitimacy, sexual orientation, gender identity, skin tone, nationality, ethnicity, religious practice, and criminality, thus promoting a negative stereotype about a group of people.

Substance Use Disorder. Recurrent use of alcohol and/or drugs causing clinical impairment, which includes health issues, disability, and failure to meet life responsibilities at work, home, or life (SAMHSA, 2020e).

Telehealth. The use of electronic information and telecommunications technologies to support and promote clinical health care, patient and professional health-related education, and public health and health administration (HRSA, 2019).

Therapeutic Relationship. The collaborative alliance between a nurse and a patient/client/family established to support the patient's/client's/family's therapeutic goals through care, boundaries, and professionalism.

Transpersonal Care. Involves bringing our authentic presence to the care of another human being. Transpersonal care is rooted in the foundation of our intention and honed through attention. This form of caring conveys a concern for the inner life world of another and nurtures healing and wholeness in mind, body, and spirit.

Trauma. A response to an event or circumstance experienced by the individual as physically or emotionally harmful or threatening with lasting adverse effects on the individual's functioning or physical, emotional, social, or spiritual well-being.

Well-being. The presence of positive emotions, the ability to cope with difficult emotions, satisfaction with life, fulfillment, and positive functioning.

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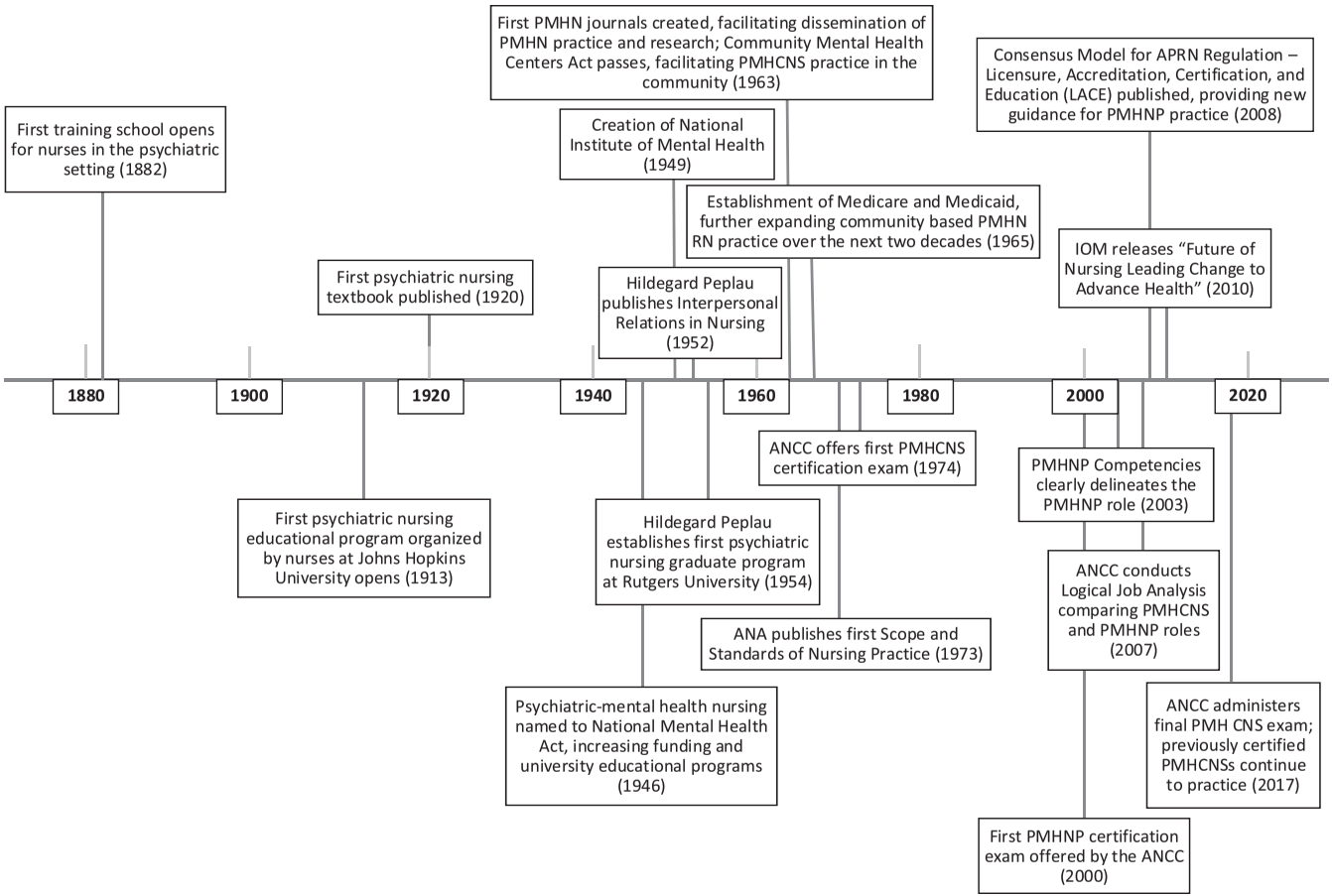
Abbreviations & Acronyms

AACN	American Association of Colleges of Nursing
ACEs	Adverse childhood experiences
ACT	Assertive Community Treatment
ANA	American Nurses Association
ANCC	American Nurses Credentialing Center
APRN	Advanced Practice Registered Nurse
APNA	American Psychiatric Nurses Association
CBT	Cognitive-behavioral therapy
CDC	Centers for Disease Control and Prevention
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CNP	Certified Nurse Practitioner
CNS	Clinical Nurse Specialist
CRNA	Certified Registered Nurse Anesthetist
DHHS	Department of Health and Human Services
DNP	Doctor of Nursing Practice
DSM-IV	*Diagnostic and Statistical Manual IV*
DSM-5	*Diagnostic and Statistical Manual, 5th Edition*
EHR	Electronic health record
HIPAA	Health Insurance and Accountability Act of 1996
ICD-10	International Classification of Diseases (10th Revision)
IOM	Institute of Medicine
ISPN	International Society of Psychiatric-Mental Health Nurses
LACE	Licensure, accreditation, certification, and education
MHPAEA	Mental Health Parity and Addiction Equity Act of 2008
NACHC	National Association of Community Health Centers

NAMI	National Alliance on Mental Health
NCSBN	National Council of State Boards of Nursing
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NMHA	National Mental Health Act of 1946
NONPF	National Organization of Nurse Practitioner Faculties
NP	Nurse Practitioner
PCLN	Psychiatric consultation-liaison nurse or nursing
PMH	Psychiatric-mental health
PMH-APRN	Psychiatric-Mental Health Advanced Practice Registered Nurse
PMH-CNS	Psychiatric-Mental Health Clinical Nurse Specialist
PMH-NP	Psychiatric-Mental Health Nurse Practitioner
PMH-RN	Psychiatric-Mental Health Registered Nurse
PPACA	Patient Protection and Affordable Care Act
PTSD	Post-traumatic stress disorder
QSEN	Quality and Safety Education for Nurses
RTP	Recovery to Practice
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious mental illness
SUD	Substance use disorder
WHO	World Health Organization

Appendix

Psychiatric-Mental Health Nursing Timeline: 1882–2021


First PMHN journals created, facilitating dissemination of PMHN practice and research; Community Mental Health Centers Act passes, facilitating PMHCNS practice in the community (1963)
Consensus Model for APRN Regulation – Licensure, Accreditation, Certification, and Education (LACE) published, providing new guidance for PMHNP practice (2008)
First training school opens for nurses in the psychiatric setting (1882)
Creation of National Institute of Mental Health (1949)
Establishment of Medicare and Medicaid, further expanding community based PMHN RN practice over the next two decades (1965)
IOM releases "Future of Nursing Leading Change to Advance Health" (2010)
First psychiatric nursing textbook published (1920)
Hildegard Peplau publishes Interpersonal Relations in Nursing (1952)
1880
1900
1920
1940
1960
1980
2000
2020
ANCC offers first PMHCNS certification exam (1974)
PMHNP Competencies clearly delineates the PMHNP role (2003)
First psychiatric nursing educational program organized by nurses at Johns Hopkins University opens (1913)
Hildegard Peplau establishes first psychiatric nursing graduate program at Rutgers University (1954)
ANCC conducts Logical Job Analysis comparing PMHCNS and PMHNP roles (2007)
ANA publishes first Scope and Standards of Nursing Practice (1973)
Psychiatric-mental health nursing named to National Mental Health Act, increasing funding and university educational programs (1946)
ANCC administers final PMH CNS exam; previously certified PMHCNSs continue to practice (2017)
First PMHNP certification exam offered by the ANCC (2000)

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Standards of Professional Performance

Standard 7. Ethics
The psychiatric-mental health registered nurse practices ethically.

Standard 8. Cultural Humility
The psychiatric-mental health registered nurse practices from a perspective of cultural humility.

Standard 9. Communication
The psychiatric-mental health registered nurse communicates effectively in all areas of practice.

Standard 10. Professional Collaboration
The psychiatric-mental health registered nurse collaborates with others.

Standard 11. Leadership
The psychiatric-mental health registered nurse leads in the professional practice setting and the profession.

Standard 12. Education
The psychiatric-mental health registered nurse attains knowledge and competencies that reflect current nursing practice.

Standard 13. Evidence-Based Practice and Research
The psychiatric-mental health registered nurse integrates evidence and research findings into practice.

Standard 14. Quality of Practice
The psychiatric-mental health registered nurse systematically enhances the quality and effectiveness of safe nursing practice.

Standard 15. Professional Practice Evaluation
The psychiatric-mental health registered nurse evaluates one's own and others' nursing practice.

Standard 16. Resource Utilization
The psychiatric-mental health registered nurse utilizes appropriate resources to plan, provide, and sustain evidence-based nursing services that are safe, effective, and fiscally responsible.

Standard 17. Environmental Health
The psychiatric-mental health registered nurse practices in an environmentally safe and healthy manner.

The Standards of Professional Performance for Psychiatric-Mental Health Nursing describe a competent level of behavior in the professional role. All registered nurses are expected to engage in professional role activities, including leadership, reflective of their education, experience, and position. The competencies accompanying each standard may be evidence of demonstrated compliance with the corresponding standard. The list of competencies is not exhaustive. Whether a particular standard or competency applies depends on the context, circumstances, or situation. Registered nurses are accountable for their professional actions to themselves, health care consumers, peers, and ultimately to society.

Source: American Nurses Association, American Psychiatric Nurses Association, & International Society of Psychiatric-Mental Health Nurses. (2022). *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (3rd Ed.). Silver Spring, MD. ANA (pgs. 59–92).

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