Issues and Trends in Psychiatric-Mental Health Nursing

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**LEARNING OBJECTIVES**

After reading this chapter, you will be able to:

- Discuss the applicability of standards of practice to psychiatric-mental health nursing.
- Explain the differences in primary, secondary, and tertiary prevention in the field of mental health.
- Describe the application of the nursing process to psychiatric-mental health nursing.
- Defend the need for mental health parity in health care.
- Contrast the differences and similarities in the practice of psychiatric-mental health registered nurses and psychiatric-mental health advanced practice registered nurses.

**KEY TERMS**

- Advanced practice registered nurse (APRN)
- Behavioral health
- Case management
- Diagnostic and Statistical Manual of Mental Disorders, 4th ed., text revision (DSM-IV-TR)
- Evidence-based practice (EBP)
- Managed care
- Mental disorder or illness
- Mental health
- Mental health parity
- Neurosis
- Nurse practice acts
- Nursing diagnosis
- Nursing documentation
- Nursing process
- Outcomes of care
- Primary mental health care
- Primary, secondary, and tertiary prevention
- Psychosis
- Standards of practice
- Standards of professional performance
- Third-party reimbursement

Overview

Psychiatric-mental health nursing is an integral part of the continuum of nursing practice. The American Nurses Association (ANA) describes psychiatric-mental health nursing as “a specialized area of nursing practice committed to promoting mental health through the assessment, diagnosis, and treatment of human responses to mental health problems and psychiatric disorders” (ANA, 2007, p. 1). As a core mental health profession, psychiatric-mental health nursing “employs a purposeful use of self as its art and a wide range of nursing, psychosocial, and neurobiological theories and research evidence as its science” (ANA, 2007, p. 1). The practice of psychiatric-mental health registered nurses includes the provision of “comprehensive, patient-centered mental health and psychiatric care and treatment and outcome evaluation in a variety of settings across the entire continuum of care” (ANA, 2007, p. 14).

Mental Health Definitions

Karl Menninger described the state of mental health as “the adjustment of human beings to each other and to the world around them with a maximum of effectiveness and happiness” (1945, p. 1). Others see mental health as the individual’s ability to be, to act, to grow, to master, and to become whatever the person wants to be. The ANA views mental health as “emotional and psychological wellness; the capacity to interact with others, deal with ordinary stress, and perceive one’s surroundings realistically” (ANA, 2007, p. 67).

The ANA defines a mental disorder or illness as “a disturbance in thoughts or mood that causes maladaptive behavior, inability to cope with normal stresses, and impaired functioning.

Classification of mental disorders should not be seen as classification of people, but of the disorders that can affect people.

A mental disorder or illness is a disturbance in thoughts or mood that causes maladaptive behavior, inability to cope with normal stresses, and impaired functioning.

Nurse practice acts provide a general description of what constitutes the legally protected scopes of practice of the RN, the LPN, and, in some states, different categories of APRN.

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Critical Thinking Question

Describe how you think a person would feel and/or react to being labeled as “the schizophrenic,” “the case with meningitis,” “the manic nursing student,” or the “alcoholic mother.”

How does such labeling potentially impact upon an individual’s ability to function?

Nurse Practice Acts

Psychiatric-mental health nurses are directed in both general and specialty practice by individual state nurse practice acts that establish the authority
for professional nursing practice and the rules and regulations for each state. Most state nurse practice acts provide a general description of what constitutes the legally protected scope of practice in the state for registered professional nurses (RNs) and licensed practical nurses (LPNs). RNs are independent practitioners of nursing; whereas LPNs are dependent practitioners who deliver nursing care under the direction or supervision of a registered professional nurse, physician, or other legally authorized healthcare practitioner. Some states also describe the scope of practice of advanced practice registered nurses (APRNs) or advanced practice nurses (APNs) such as nurse practitioners (NPs), clinical nurse specialists (CNSs), certified nurse midwives (CNMs), and certified registered nurse anesthetists (CRNAs). The title APRN was suggested by the National Council of State Boards of Nursing as an umbrella classification (not a state title) to clarify the nomenclature in the regulation of advanced practice.

All nurses are responsible for knowing the statutes, rules, and regulations for nursing practice in the states in which they are licensed to practice. In specialties such as psychiatric-mental health nursing, nurses are responsible for acquiring and maintaining competency through appropriate education, knowledge, training, and experience.

**Scope and Standards of Practice**

Nurses receive direction for both general and specialty practice from such documents as the ANA’s *Nursing’s Social Policy Statement, Code of Ethics for Nurses, Nursing: Scope and Standards of Practice*, and various statements and standards related to psychiatric-mental health nursing, child and adolescent psychiatric nursing, psychiatric consultation liaison nursing, addictions nursing, and intellectual and developmental disabilities nursing. The phenomena of concern specific to psychiatric-mental health nursing (ANA, 2007, pp. 15–16) include actual or potential mental health problems pertaining to the following:

- The promotion of optimal health and well-being and the prevention of mental illness
- Impaired ability to function related to psychiatric, emotional, and physiological distress
- Alterations in thinking, perceiving, and communicating due to psychiatric disorders or mental health problems
- Behaviors and mental states that indicate potential danger to self or others
- Emotional stress related to illness, pain, disability, and loss
- Symptom management, side effects, and toxicities associated with self-administered drugs, psychopharmacological intervention, and other treatment modalities
- Barriers to treatment efficacy and recovery posed by alcohol and substance abuse and dependence
- Self-concept and body image changes, developmental issues, life process changes, and end of life issues
- Physical symptoms that occur along with altered physiological status
- Psychological symptoms that occur along with altered physiological status
- Interpersonal, organizational, sociocultural, spiritual, or environmental circumstances and events that affect the mental and emotional well-being of the individual, family, or community
- Elements of recovery including the ability to maintain housing, employment, and social support that help individuals re-engage in the seeking of meaningful lives

Critical Thinking Question: How are the psychiatric-mental health phenomena of concern manifested by clients in an in-patient psychiatric unit?

The ANA also states that standards are authoritative statements describing the responsibilities for which nurses are accountable, reflect the values and priorities of the profession, provide direction for professional nursing practice, provide a framework for the evaluation of nursing practice, define the profession’s accountability to the public, and identify the client outcomes for which nurses are responsible (ANA, 2003). ANA’s *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (2007) was collaboratively written by representatives of the American Nurses Association, American Psychiatric Nurses Association (APNA), and the International Society of Psychiatric-Mental Health Nurses (ISPN) and can be found in Appendix I.

Based on the generic *Nursing: Scope and Standards of Practice*, the specialty-specific *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* is divided into standards of practice and standards of professional performance. The standards...
of practice address the care that the client receives from the psychiatric-mental health registered nurse, and are based on the **nursing process.** These standards cover assessment, diagnosis, outcome identification, planning, implementation (coordination of care, health teaching and promotion, milieu therapy, and pharmacological, biological, and complementary interventions), and evaluation. Additional standards of practice for APRNs include prescriptive authority and treatment, psychotherapy, and consultation. The standards of professional performance address the psychiatric-mental health registered nurse’s professional functioning. These standards include quality of practice, education, evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership (ANA, 2007, p. vi).

In addition to standards, the ANA provides measurement criteria for each of the standards, which should be reviewed by all nurses interested in the specialty. For example, under the Diagnosis Standard, the psychiatric-mental health registered nurse “derives the diagnoses or problems from the assessment data,” and under the Quality of Practice Standard, the psychiatric-mental health registered nurse “incorporates new knowledge to initiate changes in nursing practice if desired outcomes are not achieved” (ANA, 2007, pp. 29, 45). These standards and accompanying measurement criteria apply to the practice of psychiatric-mental health registered nurses in all settings and with all clients—individuals, families, groups, communities, or populations.

### Psychiatric-Mental Health Registered Nurses

According to the Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN, 1996), a division of ISPN, psychiatric mental health nurses are registered nurses who are educationally prepared in nursing, are licensed to practice in their individual states, and are qualified to practice in the psychiatric-mental health nursing specialty at one of two levels: basic or advanced. These levels of practice are differentiated by the nurse’s level of educational preparation, the complexity of the nurse’s practice, and the performance of certain specialty nursing functions.

The psychiatric-mental health registered nurse, whose practice skills are more generalized, provides interventions such as health promotion and health maintenance, intake screening and evaluation, case management, provision of milieu therapy, promotion of self-care activities, assisting with psychobiological interventions, health teaching, counseling, crisis care, and psychiatric rehabilitation. These nurses combine unique skills to address the mental health client’s physical, mental, emotional, social, and spiritual needs and may work in many diverse settings such as hospitals, ambulatory clinics, walk-in clinics, residential settings, halfway houses, occupational health offices, EAPs, and schools (ANA, 2007). To achieve professional certification, in addition to meeting the educational requirements, the psychiatric-mental health registered nurse must have specific direct care experience, have spent a specified time in the practice of psychiatric-mental health nursing, have participated in clinical supervision, have participated in continuing education, and have successfully completed a national certifying examination administered by the American Nurses Credentialing Center (ANCC).

### Psychiatric-Mental Health Advanced Practice Nurses

APRNs in this specialty hold either master’s or doctoral degrees in a psychiatric-mental health nursing specialty. Early in the development of the specialty, some psychiatric nurses received advanced education in allied mental health disciplines. There are four generally accepted categories of advanced practice registered nurses in the nursing profession: CRNAs, CNMs, NPs, and CNSs. In the psychiatric-mental health nursing specialty, advanced practice registered nurses are either NPs or CNSs. Some states require APRNs or APNs to have a second license whereas others issue certificates authorizing such advanced practice, and other states do not even address advanced practice as a separate category. States may recognize the practice of all four advanced practice categories or selectively recognize particular ones. This lack of uniformity has confused both nurses and the public.

Each state’s nurse practice act grants the legal authority for the full scope of nursing practice. There has been pressure for separate recognition of advanced practice both to clarify the authority for practice and to ensure third-party reimbursement for the nurse’s practice. Nurse practice acts should cover the full spectrum of nursing prac-
Psychiatric-Mental Health Advanced Practice Nurses

Critical Thinking Question

What are some specific differences in the scopes of practice of a psychiatric-mental health registered nurse and a psychiatric-mental health advanced practice registered nurse? 

Third-Party Reimbursement

Third-party reimbursement for the services of APRNs in psychiatric-mental health care has been a longstanding problem. Such services may be reimbursed through traditional indemnity insurance plans; self-insured plans constructed by employers and other groups; managed care plans and state and federal government plans such as Medicaid, Medicare, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and the Federal Employees Health Benefits Program (FEHBP). CNMs, NPs, and CNSs have been directly reimbursed by CHAMPUS since 1982, CRNAs since 1987. FEHBP has reimbursed NPs and CNMs since 1990, when the Office of Technology Assessment analyzed the fiscal implications of the initiative and found it cost-effective and revenue neutral. Often, the problem with obtaining payment for such services was that both mental health care as a covered service and the practitioner had to be included in the plan. For
many years, most plans resisted adding mental health services and nurses as providers of those services, so psychiatric-mental health APRNs in private practice often became frustrated and discouraged.

From the 1970s through the 1990s, the ANA on a federal level, the state nurses associations on a local level, and the psychiatric nursing specialty organizations advocated in the states and in Congress the inclusion of the services of psychiatric mental health APRNs in all appropriate plans where mental health services were covered. Examples of some of these federal initiatives include four demonstration projects establishing community nursing organizations providing community-based nursing and ambulatory care services under the direction of RNs (1992), CNMs directly receiving reimbursement at 65% of the physician's prevailing fee (1987), NPs in all geographic areas and CNSs in rural areas under a physician's supervision being reimbursed for certifying and recertifying residents for skilled nursing care (1991), the Rural Nursing Incentive Act providing direct reimbursement at 75–85% of the physician's fee to NPs and CNSs who serve rural areas (1990), and NPs and CNMs providing covered services in federally qualified health centers (1992).

A significant reimbursement victory involved the legislation of Medicare reimbursement for CNSs and NPs in all specialty areas, regardless of geographic setting, in the 1997 federal Balanced Budget Act. Prior to this law's passage, Medicare paid only for NPs and CNSs in rural areas and for specific, limited NPs' services in nursing homes. As of January 1, 1998, if a service is covered under Medicare Part B and can be provided within the legal scope of practice of an NP or CNS, that service is reimbursable directly to the nurse, or, if the nurse agrees, the facility, physician, or group that employs the NP or CNS can submit the claim. However, payment is not made to both a facility and a nurse. The payment amount is either 85% of the physician's payment or 80% of the actual charge, whichever is smaller. The law also contains a definition of CNS for the sole purpose of implementing the law. It states that a CNS is a registered nurse who is licensed to practice in the state in which the nursing services are performed; these nurses are required to have a master's degree and certification in a defined clinical area of nursing. For NPs and CNSs to receive reimbursement, they have to be approved by the local fiscal intermediary for the Centers for Medicare and Medicaid Services (CMS) and must be granted Medicare provider numbers for Medicare Part B services.

Over the past decade, there has been growing debate concerning whether advanced-level practitioners in psychiatric-mental health nursing should be a CNS or an NP. In an interesting article in 1995, Lego and Caverly held opposing views. Lego argued that primary care and specialization are two separate entities. The educational preparation of NPs is varied, although CNSs have always been prepared at the master's level. Traditionally, the CNS practice model has been that of an advanced-level autonomous practitioner with no requirements for collaborative practice or supervision from medicine, whereas NPs work with medical supervision or collaboration. National certification from the ANA has been the method of credentialing the CNS. Finally, Lego suggests that two tracks should exist in graduate nursing programs, one for the NP in psychiatry and one for the psychiatric-mental health CNS. Caverly argues that the APRN category represents a significant public policy contribution and could result in an unprecedented unity within the profession. In addition, she urges the profession to focus on securing reimbursement, revising regressive nurse practice acts, explaining to the public the roles of psychiatric-mental health nurses, and simplifying for the public the titles used to describe the APRN (Lego & Caverly, 1995).

### The Nursing Process and Classification Systems

The nursing process encompasses “all significant actions taken by registered nurses and forms the foundation of the nurse’s decision-making” (ANA, 2003, p. 4). When applied to psychiatric-mental health nursing, the nursing process involves the following five areas.

#### Assessment

During the assessment interview and in subsequent interactions, the psychiatric-mental health registered nurse collects both subjective and objective data, including observations made during the interview. These may include: main complaint or problem; general physical, mental, and...
emotional health status; personal and family history; support systems in the family, social group, or community; activities of daily living (ADLs); health habits and beliefs; substance use or abuse; use of prescription medications; interpersonal relationships; risk of injury to self and others; coping patterns; spiritual beliefs and values; client’s interest in changing behaviors; and any other factors that may influence the client's ability to function and respond to treatment.

**Diagnosis**

The psychiatric-mental health registered nurse uses the assessment data to identify the actual or potential problems. Depending on the nurse’s level of practice and skill, the data are organized into an acceptable framework using one or more of the common classification systems. These systems are the North American Nursing Diagnosis Association’s (NANDA) Nursing Diagnosis Classification, which includes appropriate psychiatric nursing diagnoses and the fourth edition, text revision, of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR)*; and any future editions of these classifications.

**Planning**

The psychiatric-mental health registered nurse develops an individualized plan of care, clearly identifying the interventions that should be used to meet the expected outcomes. Each diagnosis should have at least one corresponding goal. Goals should be measurable, realistic, understandable, and prioritized. A time frame should be established for both short- and long-term goals. This plan of care is developed in collaboration with the client, family, and other clinicians. It provides continuity of care, reflects current psychiatric nursing practice, and can include both short- and long-term goals.

**Intervention**

Nursing activities or actions are identified and implemented to help the client meet the planned goals. The implementation interventions may include counseling, milieu therapy, self-care activities, medications, health education, health promotion, psychotherapy, and case management.

**Evaluation**

The psychiatric-mental health registered nurse determines whether the goals and expected outcomes were met and whether the interventions were effective. If they were not, the nurse should reconsider all steps of the process and consider changes in the plan and interventions.

**Utilization of NANDA and DSM-IV-TR Classification Systems**

A *nursing diagnosis* states the actual or potential nursing problems based on the nurse’s critical appraisal and analysis of the assessment data, including responses and stressors, as they apply to individuals, families, and groups (Reighley, 1988). Formulating a correct nursing diagnosis is a critical step in the nursing process. In writing the nursing diagnosis, the psychiatric-mental health registered nurse utilizes the NANDA-I Taxonomy II, identifies the etiology, and describes the specific signs and symptoms particular to the client. Some nursing diagnoses are specific to mental health problems. The taxonomy itself uses a multiaxial structure (see Appendix II). Many resources are available to students and instructors regarding nursing diagnoses and their use in the delivery of nursing care. These should be reviewed and used when constructing nursing care plans for clients with particular psychiatric-mental health problems. It is not within the scope of this book to explore in detail all potential nursing diagnoses in psychiatric-mental health nursing practice.

A variety of practitioners provide mental health services to clients, so the most frequently used diagnostic nomenclature utilized by the multidisciplinary team is the *DSM-IV-TR*. This manual, compiled by the American Psychiatric Association (APA), has its critics. There is concern that the *DSM* is gradually converting many of life’s expected stresses and bad habits into mental disorders such as caffeine-induced anxiety disorder, inhalant abuse, telephone scatology, and Internet addiction disorder, and thus using the *DSM* to differentiate between the normal and the truly disordered has become increasingly difficult (Leo, 1997). In addition to the *DSM-IV-TR*, some APRNs in psychiatric mental health nursing may use the ninth edition, clinical modification of the *International Classification of Diseases (ICD-9-CM)* to identify and record diagnoses.
There are three levels of preventive intervention: primary, secondary, and tertiary. Currently in the United States, more emphasis is placed on secondary and tertiary prevention than on primary prevention. Continued interest by the healthcare professions, consumers, insurance plans, and government in health promotion and disease prevention should provide more support for activities that emphasize primary prevention.

Primary prevention focuses on reducing the incidence of mental disorders or the rates at which new cases develop by identifying the causes of specific mental health disorders and offering early intervention programs. These programs include health promotion and education, growth and development classes, parenting classes, stress management, biofeedback, relaxation techniques, and community or political activities.

Secondary prevention focuses on reducing the prevalence of mental disorders by decreasing the number of existing cases through screening and evaluating clients, identifying health needs and health problems, and providing crisis and emergency intervention, medication treatment, case management, and early treatment when symptoms are identified.

Tertiary prevention focuses on reducing the severity of a mental disorder and its associated disabilities through such activities as rehabilitation programs, educational programs that increase understanding of how to manage the symptoms of the disorder and medications, case management, social skills training, aftercare, vocational counseling, and job training (Klainberg, Holzemer, Leonard, & Arnold, 1998; Krupnick & Wade, 1997).

Haber and Billings identify the concept of primary mental health care as the care that is provided to those at risk of or already in need of mental health services—invoking all of the continuous and comprehensive services necessary for the promotion of optimal mental health, prevention of mental illness and health problems, and includes the management (treatment) of and/or referral for mental and general health problems. (1995, p. 155)

This care is holistic and addresses the needs and strengths of the whole person. According to the ANA, primary mental health care from a nursing viewpoint is “a mode of service delivery that is initiated at the first point of contact with the mental health care system.” It involves the “continuous and comprehensive mental health services necessary for promotion of optimal mental health, prevention of mental illness, and intervention, health maintenance, and rehabilitation” (ANA, 2007, p. 15). Increasingly, individuals with mental health conditions have been treated with interdisciplinary care. Therapists from the various disciplines of psychiatry, psychology, nursing; social work; art, dance, and music therapy; and more recently philosophical counseling are administering care interchangeably. Ideally, interdisciplinary care should focus on a team approach, with the overlapping strengths and knowledge of the various healthcare professionals matched to the needs of the client, family, group, or community and, as a result of this planned synergy, the outcomes of care are enhanced and more comprehensive (ANA, 2007).

Outcomes of Care

The ANA standards clearly state that psychiatric-mental health registered nurses must identify expected outcomes, develop plans of care to attain expected outcomes, and evaluate the client’s progress in attaining expected outcomes. This participation is an integral part of psychiatric-mental health nursing practice (ANA, 2007).

There is increasing pressure on the healthcare industry to measure the quality of outcomes of care, including psychiatric-mental health care, through quality assurance, total quality management, and continuous quality improvement. It is often difficult to isolate the particular nursing interventions that produce specific client outcomes. Indicators are qualitative measures used in evaluating and monitoring outcomes; outcomes are measurable changes.

Dramatic shifts in the nursing workforce and concerns among nursing professionals regarding quality of care and client safety resulted in the formation of the National Database of Nursing Quality Indicators (NDNQI) (formerly the Safety and Quality Initiative) in ANA’s The National Center for Nursing Quality Indicators.
Evidence-based practice (EBP) has been defined as “the integration of the best possible research to evidence with clinical expertise and with patient needs” (Malloch & Porter-O’Grady, 2006, p. 1) and “the conscientious, explicit, and judicious use of the best evidence from systematic research to make decisions about the care of individual patients” (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996, p. 71). In order for evidence-based practice to truly work and to impact upon today’s health care and mental health delivery systems, it must arise from the practice setting, include the actual practitioners involved in the delivery of care, and represent the aggregation and integration of applied clinical experiences (Breslin & Lucas, 2003; Malloch & Porter-O’Grady, 2006).

Interest in utilizing evidence-based practice in the delivery of medical, nursing, and health care has increased in the last decade, buoyed by the incredible changes in technology that are available to researchers. Health care as an industry has been slow in utilizing these technologies in the practice setting at the point of care. Also, nurses and other healthcare practitioners can be reluctant to try “something new,” and are often distracted from participating in a new approach by the ongoing problems (organizational, staffing, lack of support from peers and/or management) encountered in the practice setting. Some practitioners complain that it is “too much work” or “just not practical” to incorporate evidence-based practice into the clinical setting.

Stuart (2000) has identified levels of evidence that can be incorporated into evidence-based nursing practice (EBNP). In ascending order of the importance and reliability of these levels, they include opinions of reviewers based on their experience and knowledge, opinions promulgated by well-known experts and respected authorities, and results of research studies. Within the research studies, nonrandomized controlled studies provide the weakest evidence, small randomized controlled trials provide stronger evidence, and evidence from large randomized controlled trials and meta-analysis of studies supply the strongest evidence upon which to base practice and interventions (Stuart, 2000; Zauszniewski & Suresky, 2004). However, any evidence only becomes meaningful when it is successfully integrated into nursing practice.

A recent study of three years of published research (2000–2002) in the five most commonly read U.S. psychiatric nursing journals was inconclusive. The authors found that the main research foci were global perspectives, psychiatric nurses as subjects, family caregivers as subjects, clients across the life span, and testing of nursing interventions. Of the studies, 63% involved testing the recipients of mental health care and only 11% actually tested psychiatric nursing interventions.
Documentation and Client and Family Education

Documentation

An accurate record of the client’s care is required for legal reasons, regulatory agencies, accrediting organizations, institutional requirements, staffing requirements, and, most important, to provide an accurate and comprehensive care plan for the client. Psychiatric-mental health registered nurses are required by state laws and regulations, facility policies, and standards of practice to document all information, plans, interventions, and outcomes in an understandable and retrievable manner that can be accessed as needed by all members of the healthcare team. Health care continues to use multiple methods for documenting care, from traditional paper charts to concept mapping to electronic records.

In the process of recording client care, two types of plans are generally used in psychiatric-mental health settings—nursing plans and multidisciplinary treatment plans. The latter is a record reflecting the care delivered by members of the treatment team and are termed treatment action plans, case management plans, or interdisciplinary care plans depending on the treatment setting (Rowland & Rowland, 1997). Nursing plans of care (e.g., standardized care plans; computerized records; concept mapping; CareMaps; clinical pathways; charting by exception; clinical protocols; critical paths; flow sheets; nursing interventions list; practice guidelines; problem, intervention, and evaluation [PIE] notes) provide documentation of the delivery of nursing care by establishing a record of the nursing assessment, identified problems, nursing diagnoses, short- and long-term goals, suggested and implemented nursing interventions, expected client outcomes, and discharge planning. The increased utilization of concept mapping in clinical practice settings should result in less paperwork, enhance the nurse’s critical thinking skills and clinical reasoning, and assist in identifying priorities and determining critical relationships in the clinical data (Schuster, 2000).

Typical charting or documentation rules that generally apply in many settings include writing neatly and legibly, using proper spelling and grammar, using blue or black ink, employing military time, utilizing only institutionally approved abbreviations, and transcribing orders carefully. The nurse should also document complete information about medication administration, document punctually but never chart nursing care or observations ahead of time, clearly identify care that was given by another member of the healthcare team, and never leave blank spaces on charts or forms. Additionally, the nurse must correctly identify late or supplemental entries, correct mistaken entries properly, and avoid sounding tentative. The nurse should never tamper with or modify a record, never criticize the actions of other healthcare team members in the chart, and eliminate personal biases from the written descriptions of the client. Finally, the nurse precisely documents information reported to the physician or other team members and carefully records any client actions that might negatively influence the outcome of care (Frank-Stromberg, Christiansen, & Do, 2001; Iyer, 1991a, 1991b).

Research

Nurse researchers need to conduct ongoing research regarding the effectiveness of psychiatric nursing interventions and the various mental health treatment modalities, including conventional therapies and complementary and alternative therapies. Additionally, research is required to successfully combine psychodynamic, psychosocial, and psychobiological interventions with psychiatric-mental health nursing practice. Nurse researchers need to clearly identify and interpret for psychiatric-mental health nurses the research findings that are applicable to clinical practice and have been adequately studied. In addition, nurse researchers need to collaborate with nurse administrators so that there is an organizational culture that supports both doing and implementing nursing research, especially when such research involves nursing interventions.

(Zauszniewski & Suresky, 2004). A similar study of 12 leading mental health journals involving 1,076 studies demonstrated that less than 25% evaluated clinical interventions (Shumway & Sentell, 2004). There was little evidence for changes in clinical practice in either analysis. However, evidence-based practice is critically needed in order to provide quality care for mental health clients. Therefore, throughout this book, the reader will see examples of evidence-based practice and how it can influence psychiatric nursing interventions and client care.

More research is required to successfully combine psychodynamic, psychosocial, and psychobiological interventions with psychiatric-mental health nursing practice.

Psychiatric-mental health nurses are required to document all information, plans, interventions, and outcomes in an understandable and retrievable manner that can be accessed as needed by all members of the healthcare team.
Examples of types of specific observations, behaviors, and outcomes of care that should be included in nursing documentation are (Eggland, 1997; Finkelman, 1997; Menenberg, 1995):

- Behaviors specific to the presenting problems
- New behaviors
- Nutrition and ADLs
- Interactions with other clients, staff, and family
- Family response to and involvement in the treatment plan
- Positive responses to medications
- Side effects (tardive dyskinesia, fluid retention, dystonia, oculogyric crisis)
- Client and family educational needs and responses to teaching
- Comments on mood, affect, anxiety levels, reality testing, orientation, suicidal thoughts, or periods of aggression
- Symptom relief
- Improved ability to function
- Specific expressions of feelings
- Substance abuse
- Failure to comply with treatment plan
- Restraints and seclusion
- Aggression and potential for violence
- Life events

As the electronic health record (EHR) becomes increasingly utilized in mental healthcare settings, nurses need to have the appropriate computer skills and expertise. Regardless of the format of the documentation, the professional nurse retains responsibility for the accurate recording of the client’s nursing care. Like all nurses, psychiatric-mental health nurses are ethically and legally responsible for maintaining the confidentiality of the client’s record and information. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government established more stringent regulations regarding the security and privacy of health data and new national standards for electronic healthcare transactions. For more information on documentation, see Chapter 3.

**Education for Clients and Families**

Psychoeducation has proven to reduce relapse rates and support the recovery of persons with mental illnesses. It has been established that the components of an effective client/family psychoeducation program include education, supportive resources during crisis periods, assistance with problem-solving skills, and emotional support (Dixon et al., 2001).

Clients and their families and significant others require basic knowledge of the mental disorder, the treatment plan, medications, and any support services or advocacy groups (e.g., National Alliance on Mental Illness [NAMI]) that might be involved. Such education promotes understanding and adherence to the mental health plan. Positive treatment outcomes are directly related to the client’s and family’s willingness to be engaged in the treatment process. If the client does not understand the mental health condition, the treatment plan, any medication regimen, and expectations for changes in behavior, the result will be poor outcomes of care. Psychoeducation can benefit clients by establishing a clear understanding of the treatment plan, increasing client motivation, improving compliance with medical and behavioral recommendations, and increasing the client’s and family’s overall satisfaction with the healthcare experience (O’Donohue & Levensky, 2006).

**Case Management, Managed Care, and Mental Health Parity**

**Case Management**

Case management is a method of assigning the coordination of a client’s care, whereas managed care is a method for delivering prepaid healthcare services. Case management and managed care are not interchangeable terms. According to Bower (1992, p. 3), “The fundamental focus of case management is to integrate, coordinate, and advocate for individuals, families, and groups requiring extensive services. . . . The goal is to achieve planned care outcomes by brokering services across the health care continuum.” Case management may be a role, a technology, a process, a service, and a system. The goals of case management are to:

- Assist the client in gaining access to appropriate resources
- Assist the client in making choices
- Support the client in making personal healthcare choices
settings." (Bower, p. 4). Case management is especially effective when used with selected populations such as frail and chronically disabled clients; clients with long-term, medically complex problems; and clients who are severely compromised by an acute episode of illness or an exacerbation of a chronic condition. The goals of case management are to assist the client in gaining access to appropriate resources and to help the client make personal healthcare and other choices.

Registered nurses typically have the special knowledge and skills that are appropriate to the case management field. Nurses are able to recognize the signs and symptoms of physical illness and mental health disorders, are taught to be good communicators, and understand family dynamics and the use and abuse of psychotropic medications. The psychiatric-mental health registered nurse can provide case management to coordinate the client's comprehensive health services and ensure continuity of care. According to Cohen and Cesta,

By emphasizing care that is patient-centered, the nursing case management approach embraces techniques of business in which the patient is seen as a valuable consumer who has the right to demand the best in health care. . . . Placing the patient at the core of nursing’s power base authorizes the profession to reconfirm its commitment to society. (1997, p. 18)

Managed Care

Managed care is both a delivery system and a reimbursement system; it is a healthcare system that aims to combine cost-effectiveness with quality care.

Some managed care buzzwords are alternative delivery system, capitation, case mix, gatekeeper, panelled provider, integrated delivery system, and seamless care.

Mental Health Parity

Health insurance plans such as traditional indemnity plans, self-insured plans, government programs, or managed care plans have a history of bias against covering mental health treatment. Recently, with considerable reluctance, these various third-party reimbursement plans have begun to provide mental health coverage, often with considerable annual and lifetime restrictions on the number of visits and total expenditure both annually and for the lifetime of the plan (e.g., a typical plan may pay for just 10 or 20 visits to a mental health practitioner, while a client with diabetics can see a physician as often as necessary). Other restrictions include in-patient versus outpatient care, the type of practitioner covered (psychiatrist, psychologist, registered nurse, social worker, various counselors), the use of psychotropic medication, higher deductibles than for physical conditions, and requirements for detailed treatment plans that may compromise the confidentiality of the record and increase the potential for job discrimination. The requirement for a detailed treatment plan may be viewed by some as quite intrusive, including requests for information on the total plan of care, incidences of trauma, substance abuse, the status of marital
Behavioral Health, U.S. Behavioral Health, and Empire Choice (Melek, 1997). Although the MHPA worked to end discrimination against individuals who suffer from mental disorders and seek coverage under employer-sponsored insurance plans, the act had a sunset provision, with its supporters having to depend upon yearly extensions as more all-inclusive legislation makes its way through Congress.

In 2001, Senators Domenici and Wellstone and Representative Roukema introduced broader parity legislation that quickly was passed by both the Senate and the House of Representatives as an amendment to a Departments of Labor and Health and Human Services appropriations bill. Unfortunately, it was dropped by the Joint Conference Committee and returned to the original committees. In 2003, after the death of mental health advocate, Senator Paul Wellstone, Senators Domenici and Kennedy and Representatives Kennedy and Ramstad introduced the Senator Paul Wellstone Mental Health Equitable Treatment Act. In 2006, even with strong bipartisan support and a promise from President Bush to support mental health parity, action on this bill languished (http://www.nmha.org/go/parity and http://www.wellstone.org/network/index.aspx). In February 2007, it was once again introduced as the Mental Health Parity Act of 2007.

Critical Thinking Question How does inadequate access to mental health services impact upon the health of the individual, family, and community?

Home Care and Community Practice Settings

Offering psychiatric-mental health services to clients in their homes is a cost-effective method of providing services to this population. Psychiatric clients receiving services through home care agencies or similar outreach programs often have complex physical health problems in addition to the presenting mental disorder (often depression, anxiety, or difficulty coping with life situations). Most psychiatric home care is short-term care. Clients may be receiving multiple home healthcare services, have family caregivers on site, or have no readily available support systems. More information is needed on the specific psychiatric-mental health nursing interventions that are helpful to

and family, relationships, sexual dysfunction, sleep patterns, finances, aggressive acts toward self or others, school performance, and potential for contracting human immunodeficiency virus (HIV) (Hymowitz, 1998).

As a result of the federal Mental Health Parity Act (MHPA) of 1996, as of January 1, 1998, employer-sponsored health plans were required to provide coverage for mental health benefits, ensuring that the annual and lifetime limits for the medical and surgical benefits and the mental health benefits are equivalent. Limits could be imposed only if the plan also restricted the medical and surgical benefits for physical conditions; both limits must be the same. If a plan has different limits for different medical and surgical benefits, then an average aggregate limit is calculated for mental health benefits. The law did not require that a plan offer mental health benefits; however, if mental health benefits were offered in a plan, mental health parity became mandatory. The parity requirement did not apply to treatment for substance abuse or chemical dependence. There were two technical exemptions to this law. First, the parity requirement applied only to plans covering more than 50 employees. Second, group health plans were exempt from the parity requirement if they could demonstrate that enforcing the parity provisions would result in a cost increase of at least 1%.

For decades, health insurance plans used expense as a rationale for not providing mental health coverage. Many analysts now indicate that parity adds little to total health costs and may even save money, especially if the mental health benefit is provided through a managed care plan. Certain groups that have studied the cost of parity estimate that providing equitable insurance coverage for mental illnesses for an entire year for one employee costs as little as one cup of coffee. Equalizing the annual limit of a typical insurance policy will increase costs approximately $1 per employee under managed care, and removing limits on inpatient stays and outpatient visits will increase costs by less than $7 per enrollee per year. There are few or no cost implications of parity in a managed care setting in states that have already legislated health insurance parity (internal document, Alliance for the Mentally Ill of New York, 1998). Many employers responded to the original legislation by moving the mental health benefit into such programs as Value.
these clients and their caregivers (Horton-Deutsch, Farran, Loukissa, & Fogg, 1997). Increasing numbers of elderly clients, individuals with persistent mental disorders, clients with significant medical illnesses in addition to the mental disorder, and clients who are essentially homebound are receiving psychiatric home care.

According to Peplau (1995), psychiatric-mental health nurses are uniquely able to provide the multiple appropriate services needed by clients in a home setting, are able to integrate assessment of both physical and psychiatric needs into a treatment plan, can provide health education, can coordinate care, can supervise home health aides, and can integrate the family and significant others into a support system for the client. Peplau emphasized that the mental illness of the individual is a family problem. The family may thus fear that the mental health practitioner blames them for the family member’s illness. This fear then negatively impacts what should be a positive collaboration between the practitioner and family (Peplau).

In the 1970s, under the direction of the National Institute of Mental Health, the community support system concept evolved, encouraging the development of formal and informal supportive networks of caring and responsible people to meet the needs of the mentally ill. According to Pickens (1998), currently there is a critical need for psychiatric nurses to help establish and join in a true collaboration and partnership with clients, family, and community groups. Pickens identifies attributes, skills, and knowledge nurses need, including an awareness of one’s preconceptions, a nonjudgmental attitude, an awareness of cross-cultural variations, respect for others, and the ability to promote negotiation and consensus building. In addition, the nurse needs to respond to the feelings of family members, facilitate problem management and solving, share knowledge and expertise with all involved, include families in treatment and discharge planning, make referrals to community resources, participate in family support groups as a learner, and participate in mental health advocacy.

As psychiatric-mental health clients are more often placed in less restrictive, more normal settings, psychiatric-mental health nurses will be increasingly required to move throughout the community, offering mental health services wherever clients are, including their homes, congregate housing, partial hospitalizations, soup kitchens, homeless shelters, single-room-occupancy hotels, adult homes, and assisted living arrangements. Psychiatric-mental health nurses will have to combine multiple nursing skills to meet clients’ increasingly complex and interdependent physical and mental health needs in a variety of living arrangements.

### Cultural Issues and Mental Health

An estimated 6 to 8 million immigrants entered the United States in the last decade of the twentieth century. The United States is a diverse country with strong immigrant roots, and the nation’s diversity will continue to expand, with significant increases in African, Hispanic, and Asian populations. Psychiatric-mental health nurses will encounter clients of many different racial, ethnic, and cultural backgrounds. It is important that there be positive interactions between the culture of the healthcare practitioner, the culture of the client, and the culture of the setting (Dienemann, 1997).

Psychiatric-mental health nurses need to be both culturally sensitive and culturally competent. Cultural sensitivity refers to the psychiatric-mental health nurse’s “ability to be aware of and respect the client’s values and lifestyles even when these differ from the nurse’s own”; cultural competence refers to “a multidimensional concept involving various aspects of knowledge, attitude and skills” (Louie, 1996, p. 572). Clients from diverse backgrounds have different ideas about the causes of mental illness and their acceptance of the illness. Some cultures believe that disorders may be caused by evil spirits, events in previous lives, bad thoughts or curses from other people, racism, or divine retribution. The nurse should carefully evaluate unusual or unexpected behaviors for cultural influences and the client’s acceptance of the behavior before assuming the behaviors are intrinsic to a mental disorder. Language differences must be accommodated by using competent and sensitive translators, preferably not family members.

Clients may seek to replace conventional therapies or use them in conjunction with cultural therapies and complementary or alternative treatments. Such therapies include the treatment of herbalists, folk healers, and family healers; invocations of the good spirits; imagery; religious ceremonies; the use of magical, life-giving objects; healing touch; and communing with the spirit world for guidance and assistance. The psychiatric-mental health nurse must understand and appreciate the influence of
culture on the client, family, and community support system. The nurse should learn to incorporate these cultural therapies into the plan of care to achieve the best outcomes.

■ Professional Psychiatric Nursing Organizations

The two major professional psychiatric nursing organizations are the American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric-Mental Health Nurses (ISPN), which has three divisions—the Association of Child and Adolescent Psychiatric Nurses (ACAPN), the International Society of Psychiatric-Consultation Liaison Nurses (ISPCLN), and the Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN). Prior to the 1996 dissolution of the ANA’s Council on Psychiatric and Mental Health Nursing and the other specialty practice councils, the ANA’s council and the APNA, ACAPN, and SERPN successfully collaborated on practice, political, and legislative issues as the Coalition of Psychiatric Nursing Organizations (COPNO).

Founded in 1987, APNA provides national leadership on psychiatric-mental health nursing issues. An organizational affiliate of the ANA, APNA works closely with the ANA on legislation, practice standards, certification of psychiatric nurses as generalists and specialists, and provision of continuing nursing education in the specialty. In 1997, the ANA, APNA, and many other mental health advocacy groups signed a bill of rights for individuals seeking treatment for psychiatric and substance-abuse disorders. This bill of rights includes:

- The individual’s right to know what mental health benefits are included in an insurance plan
- The right to receive full information concerning the professional expertise of the treating practitioner
- The right to know if there are contractual arrangements between the treating practitioners and a third-party payer
- The right to receive information concerning how to submit complaints or grievances about care
- The right to guaranteed confidentiality
- The right to choose any duly licensed or certified mental health professional for care
- The right to receive mental health care

- Other rights related to discrimination, including receiving mental health services, the structure of mental health benefits plans, treatment review, and accountability

ACAPN was founded in 1971 and has focused in the mental health care of children and adolescents. In 1998, the ACAPN, ISPCLN, and SERPN agreed to form the International Society of Psychiatric Mental Health Nurses (ISPN), which now also includes the Association of Geropsychiatric-Mental Health Nurses (AGPN). Each of the four organizations is an ISPN division, maintaining its specialized focus and identity. The purposes of the new alliance were to unite and strengthen the presence and impact of specialized psychiatric-mental health nurses, to work together on major issues affecting the nursing profession, to impact health policy, and to promote equitable and quality care for individuals and families with mental health problems.

■ Summary

Many issues and trends influence the practice of psychiatric-mental health nursing. The chapter began with a look at definitions of mental health, mental disorders, and psychiatric-mental health nursing practice. The independent and dependent legal authorizations for practice in states’ nurse practice acts and the profession’s scope and standards of practice and psychiatric-mental health nursing practice were discussed. The nursing process (assessment, diagnosis, planning, intervention, and evaluation) and its application to psychiatric-mental health nursing were described. Documentation specific to psychiatric-mental health nursing was identified: client behaviors, new behaviors, interactions, responses to medications, symptom relief, substance abuse, restraints and seclusion, and life events. The need for research on psychiatric nursing interventions and the types of client outcomes related to psychiatric nursing practice (client satisfaction, return to functional status, response to educational interventions) were discussed. The unique role of managed care in the delivery of mental health services, the utilization of case management, and the need for mental health parity were reviewed. The roles and contributions of registered nurses and advanced practice registered nurses to the care of the mental health client were discussed and the missions of the various professional psychiatric nursing organizations were presented.
CHAPTER 2  Issues and Trends in Psychiatric-Mental Health Nursing

Annotated References

This book provides a historical review of managed care and numerous discussions of achieving quality in a managed care system.

This is an authoritative statement on the clinical aspects of psychiatric-mental health nursing practice, including the scope and standards of practice in keeping with the contemporary and future needs of clients. This document was a collaborative effort of the ANA, APNA, and ISPN.

This is a foundational document that articulates the essentials of nursing, its activities, and its accountabilities: the who, what, where, and how of practice. It provides 17 standards with accompanying measurement criteria.

This document establishes the basic clinical nursing standards of care and standards of professional performance.

This article is a thoughtful discussion of nursing’s traditional ethical values and principles in relation to a managed health care environment.

This is the second in a series of publications on the outcomes of nursing care. The text proposes a study to accumulate and compare national data on nursing quality in acute care settings.

This is the fourth edition with text revision of the American Psychiatric Association’s official nomenclature of psychiatric conditions and disorders. It provides a systematic listing of the official codes and categories, a description of the multiaxial system for diagnosis, and diagnostic criteria for each of the disorders. This book is used by psychiatrists, physicians, psychologists, registered nurses, social workers, therapists, and other mental health workers in all clinical settings.

This publication provides a guide for the continued development and expansion of case management practice.

This book utilizes evidence-based practice as it explores women’s health problems across the life span, highlighting key phenomena. It discusses foundational concepts essential to the care of women, and it covers health history, screening and diagnostic tests, and physical examinations.

This book examines nursing case management by explaining its historical roots and current and future challenges.

This monograph promotes culturally competent teamwork. It explores types of cultures, the cultural competence of U.S. nurses, intercultural counseling, and training for cultural sensitivity.

This article examines the evidence-based practice that supports family psychoeducation that has been shown to reduce relapse rates and facilitate recovery of persons with psychiatric disabilities.

This brief article is a commentary on how unspoken beliefs and “word compartments” create incredible pain and cause unnecessary delay in providing care.

This article provides a brief listing of specific suggestions for documenting nursing outcomes in psychiatric care.

This book provides a complete review of the care of the psychiatric client in a home care setting. Topics discussed include psychiatric rehabilitation, the family and significant others, psychoeducation, psychopharmacology, case management, and specific clinical problems.

Evaluating nurses about the principles of documentation and the importance of implementing risk-reduction practices will help guard against liability and ultimately improve patient care.

This article introduces and defines the concept of primary mental health care as a model for the delivery of community-based, comprehensive psychiatric-mental health nursing care.


This article presents an interesting description of the psychiatric client in home care.


This article describes the choices clients face when payment for mental health services requires that the therapist be permitted to share specific details of the client's life and treatment with the insurance company. The author's viewpoint is that many clients choose to pay directly for treatment and do not seek reimbursement to avoid losing confidentiality.


This article focuses on what should not be documented in a chart and how to record clients' actions that contribute to personal injury.


This article discusses the recommended mechanics of charting and documentation.


This concise textbook provides a focused and thorough introduction to community health nursing.


This excellent reference includes specific suggestions for planning the care of psychiatric clients including psychiatric diagnostic categories, nursing diagnoses, outcome criteria, and discharge planning.


In this article, a point-versus-counterpoint article, two leaders of psychiatric nursing debate different points of view regarding advanced-practice titles and roles in the specialty.


This opinion article questions the appropriateness of reducing many of an individual's most common behaviors to potential mental disorders.


This chapter identifies the changing demographics of the U.S. population and discusses cultural sensitivity, assessment, and competence in psychiatric-mental health nursing practice.


This introduction to the use of evidence-based practice in nursing and health care provides an excellent orientation to the basic principles of evidence-based practice and explores barriers and strengths within organizations seeking to implement such a process.


This article identifies the major components of the law that created mental health parity in healthcare plans across the nation.


This article discusses the multiple factors that require careful documentation of psychiatric care and the need to coordinate all aspects of the interdisciplinary care record.


This classic, early psychiatric textbook describes mental conditions and related behaviors.


This practical handbook for clinicians offers comprehensive information and strategies for understanding and promoting treatment compliance.


Four unresolved issues of importance to psychiatric-mental health nurses are explored in this article: biology versus environment, community and family nursing, primary care and advanced practice, and external versus internal regulation of nursing.


This article provides a review of the historical relationship between formal and informal caregivers and those with serious mental illness and discusses the attributes and actions needed by nurses to develop a truly collaborative relationship with clients, families, and community advocacy groups.


This classic reference guides the planning of nursing care for clients with mental health conditions through the application of a nursing diagnosis framework.
Rowland, H., & Rowland, B. (1997). *Nursing administration handbook* (4th ed.). Gaithersberg, MD: Aspen. This comprehensive overview of the field of nursing administration can be used as a hands-on tool by nurse managers. It explains leadership skills, problem solving and decision making, the overall working environment, finances and budgeting, technology and informatics, the operation of a nursing service, human resources, research, and the impact of today’s healthcare environment on the nurse manager.


Shumway, M., & Sentell, T. L. (2004). An examination of leading mental health journals for evidence to inform evidence-based practice. *Psychiatric Services, 55*(6), 649–653. This study examined whether data needed to inform evidence-based practice could be found in leading mental health journals. The results were disappointing.


SERPN focuses on graduate education in psychiatric nursing and the evolving research base for psychiatric nursing practice. Its members include nurse educators, researchers, and advanced practice registered nurses—all dedicated to addressing the mental health needs of the consumers via the education and development of the advanced practice workforce, research, and innovative practice models.


This State of the Evidence review analyzed 227 data-based studies published in the five most commonly read U.S. psychiatric nursing journals from January 2000 through December 2002.

### Additional Resources


Burgess, A. (1997). *Advanced practice psychiatric nursing*. Stamford, CT: Appleton & Lange. This is an excellent text that examines many of the issues facing advanced-practice nurses, including case management, prescriptive privilege, interdisciplinary collaboration, role merging, and ethical issues.


This article presents three options for maintaining the clinical nurse specialist role in psychiatric-mental health nursing.

### Internet Resources