CHAPTER 2

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

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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).

What physically affects the body often has a mental component, and many mental disorders may manifest physically. It is important, always, to see the individual from a holistic perspective.

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).

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.

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/or impaired functioning. Etiology may include genetic, physical, chemical, biologic, psychological, or sociocultural factors" (ANA, 2007, p. 67). Mental illnesses have been traditionally categorized as neuroses or psychoses. A **neurosis** is a mental disorder usually characterized by anxiety and other uncomfortable and distressing symptoms for the individual while reality testing remains intact. A **psychosis** is a mental disorder in which the individual experiences gross impairment of reality testing, severe personality disintegration, and impairment in meeting the ordinary demands of everyday life.

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

Concerned about the continued practice in health care of differentiating between mental and physical disorders, the American Psychiatric Association (APA) offers the following definition of a mental disorder:

> a clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning) or with a significantly increased risk of suffering, death, pain, disability or an important loss of freedom. . . . It must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. (2000, p. xxxi)

The APA stresses that the classification of mental disorders should not be seen as a classification of people, but of the disorders that people manifest. Individuals should never be referred to as "the manic-depressive," "the alcoholic," or "the schizophrenic," but as "the client or individual with schizophrenia, manic-depressive episodes, or alcohol dependence." It is equally incorrect to view individuals as "the cardiac" or "the gallbladder." Such labeling reduces the person to a condition or disease and ignores his or her individuality and humanity.

In this era of managed care, the term **behavioral health** is increasingly being used instead of psychiatric or mental health care. Behavioral health is intended to encompass treatment for mental health disorders and substance abuse as well as issues addressed by employee assistance programs (EAPs). Some mental health practitioners are concerned that it may not be in the client's best interest nor facilitate obtaining appropriate mental health services to use such an imprecise term to describe the specialty. A client in commenting on the term "behavioral health" said that "To me, it implies if I would just change my behaviors, I wouldn't have a mental illness," and a nurse stated "Call it what it is. We have cardiac care units, not happy heart units" (Donohue, 2006).

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

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.

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

Advanced practice registered nurse (APRN) is an umbrella classification used to describe the four nurse specialist categories:
- Certified registered nurse anesthetist (CRNA)
- Certified nurse midwife (CNM)
- Nurse practitioner (NP)
- Clinical nurse specialist (CNS)

The phenomena of concern specific to psychiatric-mental health nursing include actual or potential health problems related to mental disorders and conditions.

Standards are authoritative statements reflecting the values and priorities of the profession. They provide direction and a framework for practice while addressing client outcomes and the nurse's accountability.

The *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* includes standards of practice and standards of professional performance. Standards of practice address the care that the mental health client receives and are based on the nursing process. Standards of professional performance address the nurse's behavior in the professional role of a psychiatric-mental health nurse.

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-

tice. In reality, a hodgepodge of different authorizations (second licensure, certification, guidelines) exists. There are amendments to the basic nurse practice acts, separate language for specific categories of APRNs (CRNAs, CNMs, NPs, CNSs), and, in some cases, separate practice acts, most notably for CNMs, whose practice is conceptualized as separate from nursing. Almost all the states have laws, regulations, or guidelines for advanced practice.

In the past, the movement for separate recognition of the different categories of APRNs was driven by the fears and beliefs that advanced nursing practice without separate authorization was illegal, the desire for prescriptive privileges, and the need for nurses in private practice to qualify for direct third-party reimbursement from traditional indemnity insurance plans, federal and state reimbursement plans, and managed care plans. Even the titles of APRN and APN were created to uniformly recognize and refer to these nurses because in some states and insurance programs the various specialty titles were unclear and often were used to refer to more than one category of practitioner, especially NP and CNS.

Nurses have a long history of collaborating with physicians in assessing, planning, implementing, and evaluating care. The difficulty is that too often organized medicine attempts to legislate control by physicians over the nurse specialist's practice by requiring direct supervision. This can limit the nurse's independent practice. In fact, the federal Drug Enforcement Agency (DEA) does not issue separate DEA numbers for prescribing controlled substances unless the APRN has independent (unencumbered) authorization to practice.

APRNs in psychiatric-mental health nursing may become certified specialists through the ANCC. There are specific requirements for educational preparation for a master's degree, including a minimum number of client contact hours, a number of hours of supervision from a certified specialist in psychiatric-mental health nursing, and the successful completion of a certifying examination.

Psychiatric-mental health registered nurses work in many different settings, including hospital in-patient units, ambulatory settings, clinics, long-term care institutions, residential settings, nursing homes, home care agencies, volunteer agencies or programs usually associated with specific charities or church groups, shelters, respite care, day care programs, schools, workplaces and EAPs, correctional facilities, and for the APRN individual private or group practices with other nurse specialists or other mental health practitioners.

Depending upon the individual nurse's level of practice, education, and special training, psychiatric-mental health registered nurses can utilize counseling; group therapy; family therapy; marital and couples therapy; milieu therapy; art, music, dance, and other expressive therapies; and alternative and complementary therapies such as imagery, therapeutic touch, and journaling. Psychiatric-mental health APRNs practice psychotherapy and psychoanalysis; may prescribe psychotropic medications and supervise medication regimens; act as consultants, educators, and clinical liaisons; and provide direct clinical supervision for psychiatric nurses and other APRNs. The areas of subspecialization in psychiatric-mental health nursing include adult, child, and adolescent; geriatric; addictions; chronically mentally ill; consultation-liaison; forensic; marital and family; home care; and case management.

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 Medicare, Medicaid, 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 is a systematic and interactive problem-solving approach that includes individualized client assessment, planning, implementation, intervention, and evaluation.

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.

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. In the United States, more emphasis is placed on secondary and tertiary prevention.

Primary mental health care is holistic and addresses the needs and strengths of the whole person.

Interventions, Outcomes, and Research

Primary, Secondary, and Tertiary Prevention

There are three levels of preventive intervention: **primary, secondary, and tertiary prevention**. 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, 1993; Worley, 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 . . . involving all of the continuous and comprehensive services necessary for the promotion of optimal mental health, prevention of mental illness and health maintenance, 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 (http://nursingworld.org/quality/database.

htm). The initiative is a national program tracking the quality of nursing care. The study addresses three categories of indicators:

- *Structure of care indicators:* Focus on the organization and delivery of nursing care (supply of nursing staff, skill mix, educational levels)
- *Process of care indicators:* Focus on the nature and amount of care provided (assessment, intervention, RN work satisfaction)
- *Outcome indicators:* Focus on the effects of interactions between nursing staff and clients (occurrence of pressure ulcers, falls, IV infiltrations)

There are three categories of indicators: structure, process, and outcome.

Although directed toward acute care, many of the indicators apply to all nursing specialties, including psychiatric nursing, and all clinical settings. Some of the indicators currently being studied include nosocomial infection rates, client injury rate, client satisfaction with nursing care, client satisfaction with pain management, client satisfaction with educational information, client satisfaction with care, maintenance of skin integrity, nurse-staff interactions, staff mix (RN, LPN, nursing assistants), total nursing care hours provided per client day, pediatric pain assessment, and psychiatric, physical, and sexual assaults. The federal government established the Agency for Healthcare Research and Quality (AHRQ) (formerly the Agency for Health Care Policy and Research) to study the effectiveness of health care and produce guidelines to support "best practices" (http://www.ahrq.gov). Some examples of this agency's early work include the management of depression in primary care, acute pain management, the recognition of early Alzheimer's disease and related dementia, and the management of cancer pain; more recently it has established Evidence-Based Practice Centers (EPCs) to produce evidence reports on clinical conditions (http://www.ahrq.gov/clinic/epc/).

Implications for Evidence-Based Practice

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

(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 psychobiologic interventions with psychiatric-mental health nursing practice.

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.

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.

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, Christensen, & Do, 2001; Iyer, 1991a, 1991b).

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.

Critical Thinking Question When reviewing a client's healthcare record, you discover what appear to be major discrepancies in the observations and information recorded by medicine, nursing, and social work. What would be appropriate actions for you to take in this situation?

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 an individual'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. Case management is unique in that "it is episode-focused, viewing health issues and responding to the care needs of clients along the illness and/or care continuum often across multiple

Case management is a method of assigning the coordination of a client's care; it 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 group and 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.

Managed care is both a delivery system and a reimbursement system; this dual role has created implementation problems. It is probably impossible to concentrate on managing a client's care and addressing health needs while focusing on controlling costs and payments. Ultimately, concerns arise about the type of care being delivered, who is receiving it, under what circumstances, and by which provider. The ANA has questioned whether managed care, with its focus on cost containment and financing arrangements, puts at risk the traditional values of nursing such as patient advocacy, holistic care, and addressing the individual's specific health needs (ANA, 1998).

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

Mental health parity means that the annual and lifetime limits in health plans for mental health benefits are equal to the plan's medical and surgical benefits.

Managed care has been described as "a health care system that combines cost-effectiveness with quality care" (Klainberg et al., 1998, p. 392). Some examples of managed care entities are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and point of service (POS) plans. Some terms that nurses encounter in managed care include alternate delivery system (services outside of the hospital), capitation (a method of providing a set payment per month per covered member to a provider), case mix (the frequency and intensity of the health needs of a population), gatekeeper (a practitioner who controls access to health care), paneled provider (practitioners who can provide care in a payment system), integrated delivery system (networks of providers joined for purposes of mutual benefit), and seamless care (coordinated care as the client moves along the health services continuum). To be identified as a managed care plan, a plan must comprise certain components: restricted service networks, control of payment for services, benefits designed to maximize services, aggressive care and case management, an active quality improvement program, and data gathering and dissemination of information on the health of the population being served by the plan (Al-Assaf, 1998).

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

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 dependency. 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 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

In psychiatric home care, many individuals have persistent mental disorders, are elderly, have significant medical conditions, and are homebound.

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

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.

Community-based psychiatric-mental health nurses must combine multiple nursing skills to meet the increasingly complex and interdependent physical and mental health needs of clients living in a variety of alternative living arrangements.

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.

Psychiatric-mental health nurses need to be both culturally sensitive and culturally competent.

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 on meeting the professional needs of nurses specializing 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.

The major professional psychiatric nursing organizations are the American Psychiatric Nurses Association, the Association of Child and Adolescent Psychiatric Nurses, the International Society of Psychiatric-Consultation Liaison Nurses, and the Society for Education and Research in Psychiatric-Mental Health Nursing.

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Stuart, G. W. (2000). Evidence-based psychiatric nursing practice. In G. W. Stuart & M. T. Laraia (Eds.), *Principles and practices of psychiatric nursing* (7th ed., pp. 76–85). St. Louis: Mosby.
An excellent psychiatric-mental health nursing textbook from one of the specialty's most competent and compelling educators.

Worley, N. (1997). *Mental health nursing in the community.* St. Louis: C. V. Mosby.
This book presents psychiatric-mental health nursing concepts with a focus on practicing in the community.

Zauszniewski, J. A., & Suresky, J. (2004). Evidence for psychiatric nursing practice: An analysis of three years of published research. *Online Journal of Issues in Nursing, 9*(1). Retrieved September 6, 2006, from http://nursingworld.org/ojin/hirsh/topic4/tpc4_1.htm
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

Alperin, R. (1997). *The impact of managed care on the practice of women in psychotherapy: Innovation, implementation and controversy.* New York: Bruner/Mazel.
This textbook considers treatment approaches, the controversies in managed care, and technological advances.

American Nurses Association. (2003). *Nursing's social policy statement* (2nd ed.). Washington, DC: ANA.
This document describes nursing care and its knowledge base, the scope of practice, and methods by which the profession is regulated.

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.

Cohen, E. (1996). *Nurse case management in the 21st century.* St. Louis: C. V. Mosby.
This book provides practical techniques and outcomes for integrating case management across the continuum of care.

Lego, S. (1996). Long live the CNS and the NP in psychiatric nursing: Do not blend the roles. *Online Journal of Issues in Nursing.* Retrieved April 23, 2007, from http://www.nursingworld.org/ojin/tpc1/tpc1_1.htm
This article presents three options for maintaining the clinical nurse specialist role in psychiatric-mental health nursing.

Internet Resources

http://nursing.jbpub.com/book/psychiatric

Visit http://nursing.jbpub.com/book/psychiatric for interactive exercises, NCLEX review questions, WebLinks, and more.