SECTION I

The Practice of Psychiatric-Mental Health Nursing

CHAPTER CONTENTS

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CHAPTER 1

MENTAL HEALTH TRENDS AND THE HISTORICAL ROLE OF THE PSYCHIATRIC-MENTAL HEALTH NURSE

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EXPECTED LEARNING OUTCOMES

After completing this chapter, the student will be able to:

1. Identify key events that helped to shape the current view of psychiatric-mental health care
2. Describe the early role of the psychiatric nurse
3. Identify the changes in the field of mental health that correlate with the evolution of psychiatric-mental health nursing
4. Define interpersonal relationships as being the foundation for clinical practice
5. Delineate between the roles and functions of basic and advanced practice in psychiatric-mental health nursing

KEY TERMS

Deinstitutionalization
Interpersonal models
Milieu management
Process groups
Psychoeducational groups
Psychopharmacology
Somatic
Therapeutic communication

Professional nursing originated from the work of a visionary leader, Florence Nightingale, who identified a need to organize the profession into a respectable discipline with its own body of knowledge and practice skill sets. As professional nursing evolved, so too did the practice of psychiatric-mental health nursing. This evolution paralleled the development in the field of mental health care. Subsequently, mental health care and psychiatric-mental health nursing practice have progressed from a poorly understood and poorly organized area of concern to a highly specialized area of health care.

This chapter provides an overview of the key historical events associated with the evolution of mental health care and their influence on psychiatric-mental health nursing. It also describes the current status of psychiatric-mental health nursing, focusing on the scope of practice for the two levels of psychiatric-mental health nursing practice: basic and advanced. This chapter emphasizes the interpersonal models of practice as the standard of care across the full range of settings and client groups. Relationships, interactions, and environment are important components of these models. This focus was selected to enhance this crucial element of nursing practice, the nurse–patient relationship, and, in particular, to establish interpersonal relations as the cornerstone of psychiatric-mental health nursing practice to assist patients in meeting their needs.

HISTORICAL OVERVIEW OF MENTAL HEALTH AND MENTAL ILLNESS CARE

History reveals that mental illness has been around since the beginning of time. However, it was not until the late 18th century when the view of mental illness became that of a disease requiring treatment and humane care. Overall, the views of mental health and mental illness closely reflect the sociocultural climate of the time.

The Earliest Years

Mental illness is a complex experience, with different values and meanings worldwide. Although some cultures considered mental illness in a negative light, attributing it to possession by spirits or demons, other cultures considered mental illness somewhat differently, even as an exceptional state; one that would prepare that person to become a healer as, for example, in shamanism. However classified or viewed, the complexity of mental illness has prompted treatment, from ridding the person of spirits or demons to enabling the person to explore the possibility that he or she is a potential healer. For the former, magical therapies such as charms, spells, sacrifices, and exorcisms were used. For the latter, various initiation rituals were used.

In the West, however, the prevailing view of mental illness involved possession. A person who exhibited an odd or different kind of behavior without identifiable physical injury or illness was seen as possessed, specifically by an evil spirit or demon, and the patient's behavior was the result of this state of possession. In response, treatments such as magical therapies were commonplace. Physical treatments such as bleeding, blistering, and surgically cutting into the skull to release the spirit also were done. If the patient was not disruptive, he or she could remain in the community. However, if the patient's behavior was violent or severe, the patient often was ostracized and driven from the community.

During the Middle Ages and the Renaissance period, the view of mental illness as demonic possession continued. Witch hunts and exorcisms were common. In addition, the strong religious influences at that time led to the belief that mental illness was a punishment for wrongdoings. Persons with mental illness were inhumanely treated, being placed in dungeons or jails and beaten.

The 18th and 19th Centuries

The early to middle 18th century laid the groundwork for future developments in the latter half of this century and the next, especially in the United States. Society was beginning to recognize the need for humane treatment, which led to a gradual reshaping of the view of mental illness. Treatment, rather than punishment, exorcisms, and magical therapies, was becoming the focus. During this time, public and private asylums, buildings specially constructed to house persons with mental illness, were developed. Individuals with mental illness were removed from their homes and placed in these institutions.

This need for treatment prompted the development of institutions where care could be provided. For example, in 1751, Benjamin Franklin established Pennsylvania Hospital in Philadelphia. This was the first institution in the United States to provide treatment and care for individuals with mental illness. As the late 18th century approached, medicine began to view psychiatry as a separate branch. At that time, mental illness embraced only such medical interventions as bloodletting, immobilization, and specialized devices such as the tranquilizer chair both in the United States and abroad. These practices continued until the very late 18th and early 19th centuries. Through the work of

Dr. Benjamin Rush in the United States, the focus of treatment began to shift to supportive, sympathetic care in an environment that was quiet, clean, and pleasant. Although humane, this care was primarily custodial in nature. Moreover, individual states were required to undertake financial responsibility for the care of people with mental illnesses, the first example of government-supported mental health care.

A key player in the evolution of mental health and mental illness care during the 19th century was Dorothea Dix. A retired schoolteacher, Dix was asked to teach a Sunday school class for young women who were incarcerated. During her classes, she witnessed the deplorable conditions at the facility. In addition, she observed the inhumane treatment of the women with mental illness. As a result, she began a crusade to improve the conditions. She worked tirelessly for care reform, advocating for the needs of the mentally ill through the establishment of state hospitals throughout the United States. Unfortunately, these state institutions became overcrowded, providing only minimal custodial care. Although she was a nurse, her impact on the evolution of mental health and mental illness may be overlooked because her work was primarily humanitarian.

Dorothea Dix was instrumental in advocating for the mentally ill. She is credited with the development of state mental hospitals in the United States.

The 20th Century

The 20th century ushered in a new era of ideas regarding mental health and illness. Scientific thought was coming to the forefront. In the beginning of the 1900s, two schools of thought about mental illness were prevalent in the United States and Europe. One school viewed mental illness as a result of environmental and social deprivation that could be treated by measures such as kindness, lack of restraints, and mental hygiene. The other viewed mental illness as a result of a biological cause treatable with physical measures such as bloodletting and devices. This gap in thinking—deprivation on one end of the spectrum and biological causes on the other end—led to the development of several different theories attempting to explain the cause of mental illness.

One such theory was the psychoanalytic theory developed by Sigmund Freud. His theory focused on a person's unconscious motivations for behaviors, which then influenced a person's personality development. Freud, a neuropathologist, examined a person's feelings and emotions about his or her past childhood and adolescent experiences as a means for explaining the person's behavior. According to Freud, an individual develops through a series of five stages: oral, anal, phallic/oedipal, latency, and genital. He considered the first three of these five stages (oral, anal, and phallic) to be the most important. If the person experiences a disruption in any of these stages, experiences difficulty in moving from one stage to the next, remains in one stage, or goes back to a previous stage, then that individual will develop a mental illness. Freud's views became the mainstay of mental health and mental illness care for several decades.

The development of **PSYCHOPHARMACOLOGY**, the use of drugs to treat mental illness and its symptoms, also changed treatment for mental illness. The intent was control of symptoms through the use of drugs to allow individuals to be discharged from institutions and return to the community where they could function and live productive lives. Subsequently, the numbers of persons requiring hospitalization dramatically decreased. Moreover, psychopharmacology provided a lead into the future for deinstitutionalization and for addressing the underlying biological basis for mental illness.

Research into the proposed causes or factors associated with mental illness exploded during the 1990s, which was dubbed "the decade of the brain." Interest in neurotransmitters and their role in influencing mental illnesses was explored. New medications were developed based on proposed theories of how medications may regulate neurotransmitter reuptake. Along with the burgeoning pharmaceutical industry and the embracing of the biological model of illness by physicians, this era led to a major shift away from more humane, less-invasive forms of therapy, such as counseling, as the main psychiatric treatment to one involving medical-somatic options as first-line intervention (Whitaker, 2011).

Governmental Involvement and Legislation

Governmental involvement in mental health care took on an expanded role during the 20th century. In the United States at the time of World War II, individuals were rejected for military service due to psychological problems. Additionally, those returning from combat were often diagnosed with emotional or psychological problems secondary to the effects of the war. The view that anyone could develop a mental illness was beginning to take root. As a result, the National Mental Health Act was passed in 1946. This act provided governmental funding for programs related to research, mental health professional

training, and expansion of facilities including state mental health facilities, clinics, and treatment centers. It also called for the establishment of a National Advisory Mental Health Council and a National Institute of Mental Health (NIMH), which was formally established in 1949. NIMH focused its activities on research and training in mental health and illness.

In 1955, the Mental Health Study Act was passed, which called for a thorough analysis of mental health issues in the nation. This resulted in a Joint Commission on Mental Illness and Health, which prepared a major report titled *Action for Mental Health*. The report established a need for expanded research and training for personnel, an increase in the number of full-time clinics as well as supplemental services, and enhanced access to emergency care and treatment. In addition, the report recommended that consumers should be involved in planning and implementing the delivery systems and that funding would be shared by all levels of government.

The impact of psychopharmacology coupled with the social and political climate of the 1960s led to the passage of the Mental Retardation Facilities and Community Mental Health Centers Act. This act was designed to expand the resources available for community-based mental health services. It called for the construction of mental health facilities throughout communities to meet the needs of all those experiencing mental health problems. The result was to ease the transition from institutionalized care to that of the community. The ultimate goal was to provide comprehensive humane treatment rather than custodial care. This legislation was part of President John F. Kennedy's New Frontier program and led to the **DEINSTITUTIONALIZATION** (the movement of patients in mental health institutions back into the community) of many who had been in state-run and other mental health facilities that had provided long-term mental health care and treatment.

At this time, the NIMH expanded its service role and assumed responsibility for monitoring the community mental health centers programs (National Institutes of Health [NIH], 2010). Unfortunately, the number of community mental health centers grew slowly and often were understaffed. Care was fragmented and inadequate. Thus, the demands resulting from deinstitutionalization became overwhelming.

In the late 1960s, care of the mentally ill began to shift to community clinics.

The overwhelming demands faced by the community mental health centers continued. In addition, society was changing. Population shifts, a growing aging population, changes in family structures, and increased numbers of women in the workforce further complicated the system. In 1980, the Mental Health Systems Act was passed in response to the report findings of the President's Commission on Mental Health. This act was designed to establish research and training priorities and address the rights of patients and community mental health centers. However, the election of a new president led to dramatic changes in focus. In 1981, the Omnibus Budget Reconciliation Act (OBRA) was passed, which provided a set amount of funding for each state. Each state would then determine how to use these funds. Unfortunately, mental health care was not a priority for the majority of states and, subsequently, mental health care suffered. Individuals with chronic mental illness often were placed in nursing homes or other types of facilities. In an attempt to address the issues associated with OBRA, Congress passed the Omnibus Budget Reconciliation Act of 1987, which was to provide a means for ensuring that the chronically mentally ill would receive appropriate placement for care. However, the political climate of concern for an ever-widening federal budget deficit led to a significant decrease in funding for mental health care.

In 1992, NIMH joined the NIH as one of the institutes that continues today to fund research on mental health and illness. NIMH also serves as a national leadership organization for mental health issues (NIH, 2010).

As a result of the changes in society and the political climate of the times, mental health care suffered once again. In response, Surgeon General David Satcher issued *The Surgeon General's Report on Mental Health* in 1999. This was the first national report that focused on mental health. The report included recommendations for broad courses of action to improve the quality of mental health in the nation as follows: continuing the research on mental health and illness to build the science base; overcoming the stigma of mental illness; improving public awareness of effective treatment; ensuring the supply of mental health services and providers; ensuring delivery of state-of-the-art treatments; tailoring treatment to age, gender, race, and culture; facilitating entry into treatment; and reducing financial barriers to treatment (Satcher, 1999). Subsequently, mental health care was brought to the forefront.

Current Perspectives

Following publication of *The Surgeon General's Report on Mental Health* in 1999, another key report focusing on

children's mental health was published. *The Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda* called for:

- *Improved recognition/assessment of children's mental health needs and promotion of public awareness of children's mental health issues*
- *Continued development, dissemination, and implementation of scientifically proven prevention and treatment services*
- *Reduction and/or elimination of disparities in access to mental health services and increased access and coordination of quality mental health services (U.S. Public Health Service, 2000)*

This report further emphasized the need for improved mental health care.

Continued problems in the mental health system prompted the launch of the President's New Freedom Commission on Mental Health in 2001. Its goal was to promote increased access to educational and employment opportunities for people with mental health problems. This commission was specifically targeted with reducing the stigma associated with mental illness, lifting the financial and access barriers to treatment, and addressing the system fragmentation. The report, *Achieving the Promise: Transforming Mental Health Care in America*, was issued in 2003 with several recommendations for service delivery. It identified the need for changing the current system to one that is more consumer and family driven and that underscored the need for mental illnesses to receive the same attention as other medical illnesses. Many of these changes are in the process of being implemented on the national and state levels (President's New Freedom Commission on Mental Health, 2003).

Mental health, which first appeared as a major priority area in the *Healthy People 2000* objectives, continued to be a priority for *Healthy People 2020* (U.S. Department of Health and Human Services, 2016). In December 2010, the *Healthy People 2020* objectives were released. As in 2010, mental health and mental disorders were a priority concern. The *Healthy People 2020* objectives for mental health and mental disorders are highlighted in **Box 1-1**.

BOX 1-1: *HEALTHY PEOPLE 2020* OBJECTIVES

MENTAL HEALTH AND MENTAL DISORDERS

1. Reduce the suicide rate.
2. Reduce the rate of suicide attempts by adolescents.
3. Reduce the proportion of adolescents who engage in disordered eating behaviors in an attempt to control their weight.
4. Reduce the proportion of persons who experience major depressive episode.
   - 4.1. Adolescents aged 12–17 years.
   - 4.2. Adults aged 18 years and older.
5. Increase the proportion of primary care facilities that provide mental health treatment onsite or by paid referral.
6. Increase the proportion of children with mental health problems who receive treatment.
7. Increase the proportion of juvenile residential facilities that screen admissions for mental health problems.
8. Increase the proportion of persons with serious mental illness who are employed.
9. Increase the proportion of adults with mental health disorders who receive treatment.
   - 9.1. Adults aged 18 years and older with serious mental illness.
   - 9.2. Adults aged 18 years and older with major depressive episode.
10. Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.
11. Increase depression screening by primary care providers.
    - 11.1. Increase the proportion of primary care physician office visits that screen adults aged 19 years and older for depression.
    - 11.2. Increase the proportion of primary care physician office visits that screen youth aged 12–18 years for depression.
12. Increase the proportion of homeless adults with mental health problems who receive mental health services.

From the U.S. Department of Health and Human Services (2010).

EVOLUTION OF PSYCHIATRIC-MENTAL HEALTH NURSING

The evolution of the nursing profession and the evolution of mental health care have striking similarities. **Figure 1-1** depicts a timeline of events, highlighting significant events in the evolution of mental health care in conjunction with significant events in the evolution of psychiatric-mental health nursing. As seen in the timeline, as mental health care evolved, so too did psychiatric-mental health nursing.

Nurses have always been available to care for the mentally ill. At first, this care occurred in sanitariums, where the focus of care was custodial. From the 1890s to after World War II, nurses did things *to* and *for* patients, rather than *with* patients. Mental illness was poorly understood and the role of the nurse was focused on making the environment comfortable, safe, and amenable to healing. Although there was a body of knowledge regarding practices that were unique to nursing, this was a new and developing field. Thus, many of the nursing activities were focused on the carrying out of medical regimes.

Early Emergence of the Profession

The early beginnings of psychiatric-mental health nursing can be traced back to Florence Nightingale, who first identified the need to view the patient holistically. Her focus was not mental illness; she was an advocate for patient self-care, believing that when a patient developed independence, he or she would be better able to face illness with lessened anxiety.

Specialization for psychiatric-mental health nursing arose along the same time that humane treatment for mental illness was coming to the forefront. Linda Richards, the first nurse trained in the United States, opened a training school for psychiatric-mental health nurses (PMHNs) in 1882. Although the training primarily consisted of meeting the patient's physical needs, Richards strongly emphasized

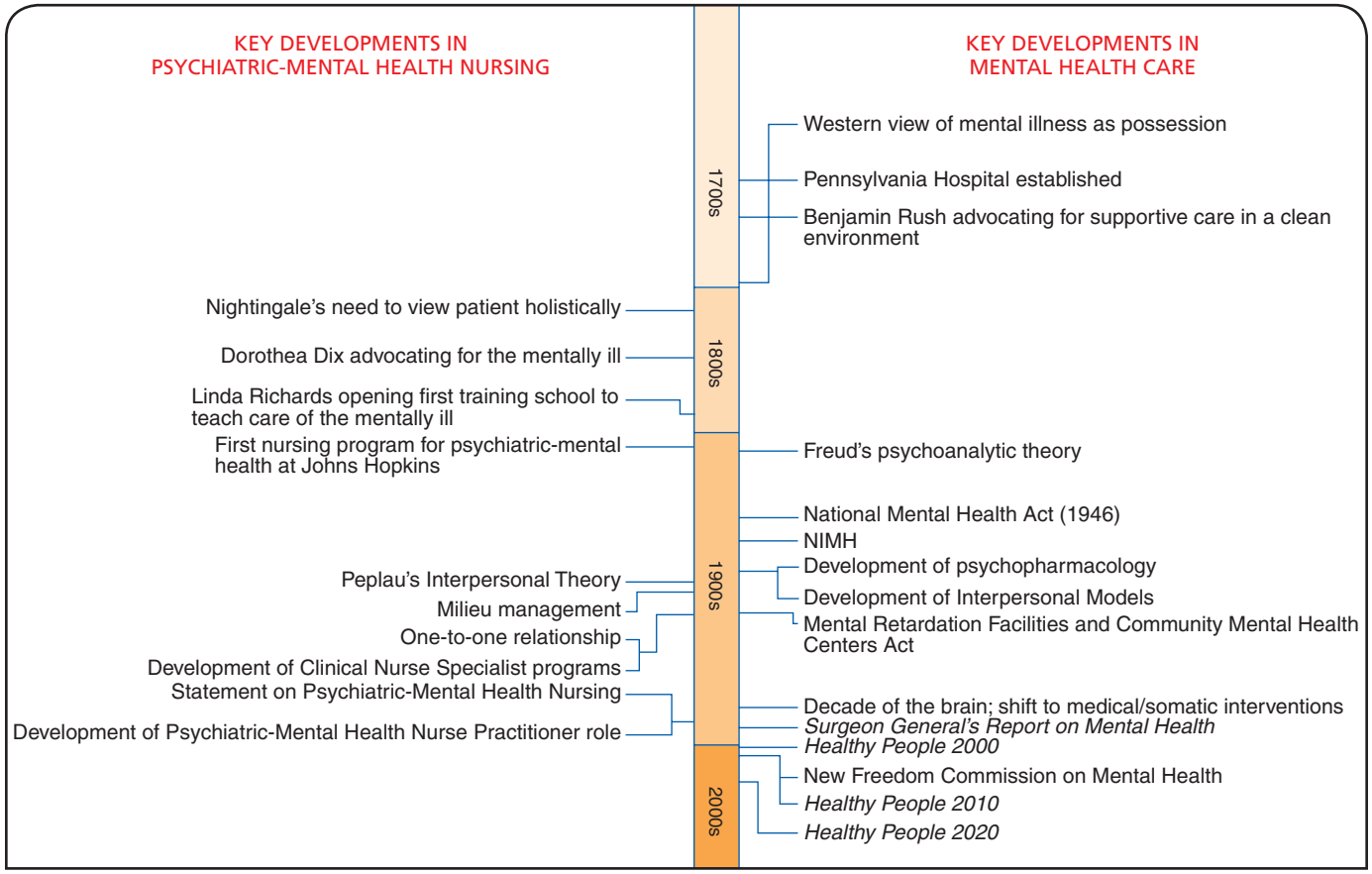

Figure 1-1 *Evolution of mental health care and psychiatric-mental health nursing.* Events listed at the right identify key developments associated with mental health care. Events listed at the left identify key developments associated with psychiatric-mental health nursing. Note how significant events in mental health care parallel those in psychiatric-mental health nursing.

the need to assess a patient's physical and emotional needs. Thus, she is credited as being the first American psychiatric nurse.

Approximately 40 years later, the first nursing program for psychiatric-mental health nursing was established by Effie Taylor at Johns Hopkins Phipps Clinic. Taylor, like Nightingale, emphasized the need to view the patient as an integrated whole. She also believed that general nursing and mental health nursing were interdependent. This was the first time that a course for psychiatric-mental health nursing was included in a curriculum.

Continued Evolution

During the first half of the 20th century, the mental health field continued to evolve through the discovery of new therapies and theories. With the introduction of these new therapies, PMHNs were required to adapt the principles of medical-surgical nursing care to the care of psychiatric patients. In 1920, the first textbook of psychiatric-mental health nursing was written by Harriet Bailey. This book primarily focused on procedure-related care by nurses.

Continued involvement with the use of therapies resulted in a struggle for PMHNs to define their role. However, the social climate of the time promoted a view of women as subservient to men. This view also carried over into the realm of nursing.

Near the middle of the 20th century, **INTERPERSONAL MODELS** (those that focus on the interaction of the person with others) by leaders such as Harry Stack Sullivan and others began to emerge. Sullivan believed that personality was an observable reflection of an individual's interaction with other individuals. Thus, a person's personality, be it healthy or ill, was a direct result of the relationship between that person and others. Sullivan also identified two key needs: the need for satisfactions (biological needs) and the need for security (state of well-being and belonging). Any block to satisfactions or security results in anxiety (Sullivan, 1953).

Again, the emergence of interpersonal models paralleled a shift in nursing practice as interpersonal models of nursing practice were being developed. Interpersonal systems became prominent in mental health around 1945 and then in nursing practice in 1952. Both the field of mental health and the field of nursing flourished during this time period with an abundance of theorists contributing to their respective disciplines.

Nursing as a profession began to again refine itself with the emergence of theorists such as Hildegard Peplau (1952), who defined nursing as "*a significant, therapeutic, interpersonal process. It functions cooperatively with other human processes that make health possible for individuals and communities. Nursing is an educative instrument, a maturing force that aims to promote forward movement of personality in the direction of creative, constructive, productive, personal, and community living*" (p. 16). Nurse educators thus began to emphasize the importance of interpersonal relations and integrated relevant content in the curricula. Peplau further clarified the PMHN's role as that of counselor, differentiating PMHNs working as general staff nurses from those who were expert practitioners with advanced degrees. According to Peplau, "psychiatric nursing emphasizes the role of counselor or psychotherapist. . . . From my viewpoint, a psychiatric nurse is a specialist and at this time specialist status can be achieved by two routes—experience and education" (Peplau, 1962, p. 51). (For a more in-depth discussion of Peplau, see Chapter 2.)

As a result, nurses were being educated in modes of **THERAPEUTIC COMMUNICATION** (patient-focused interactive process involving verbal and nonverbal behaviors), which were seen as integral parts of the patient's recovery. It was not uncommon for nurses to carry a case load of patients and to spend significant portions of their shift having one-to-one, planned, structured conversations. These conversations were then recorded in the nursing record and their content was processed by the psychiatrist and other health professionals in their evaluation of progress in treatment. (For a more in-depth discussion of therapeutic communication, see Chapter 3.)

MILIEU MANAGEMENT, which developed after 1950, was adopted by psychiatric care facilities. Milieu management refers to the provision and assurance of a therapeutic environment that promotes a healing experience for the patient. This treatment approach is reflected in everything from the physical attributes of the mental health unit such as wall color and choice and arrangement of furniture, to source and levels of lighting. Nurses became the managers of the milieu, responsible for recognizing that they themselves were part of the milieu and thus had to conduct themselves in a manner conducive to supporting a therapeutic environment. This required an ever-conscious focus on dress, body language, tone, and style of verbal interaction, as well as vigilant awareness of surroundings and environment. For example, it would not be unusual for a nurse who was mindful of milieu management therapy to sense that the unit was tense and volatile and to respond by slowly and subtly adjusting the level of light or noise to produce a more relaxed environment. As much thought was spent on how to manage the unit as on how to manage any individual patient.

Nurses also conducted therapy groups. Sometimes these were with a psychiatrist or other psychiatric staff member. Nurses led **PSYCHOEDUCATIONAL GROUPS** (groups designed at imparting specific information about a select topic such as medication) and co-facilitated **PROCESS GROUPS** (more traditional form of psychotherapy where deep feelings, reactions, and thoughts are explored and processed in a structured way). Regardless of the treatment modality, the energy expended by the nurse in the delivery of psychiatric care revolved around the development and maintenance of a therapeutic relationship and the promotion of a therapeutic environment.

From 1954 onward, the discovery and use of antipsychotic medications such as chlorpromazine (Thorazine) impacted the care for the severely mentally ill. It signaled a change of course for both nursing and mental health care. Medication administration and monitoring were now added to the nurse–patient experience. Because of the usage of newer longer acting medications (such as haloperidol [Haldol] and fluphenazine [Prolixin]), the 1960s were a time of care transition from hospital setting to community setting. However, the one-to-one nurse–patient relationship still remained important in nursing (Doona, 1979).

During the 1960s, the Division of Psychiatric and Mental Health Nursing Practice of the American Nurses Association (ANA) published the Statement on Psychiatric Nursing Practice. This was the first document to address the PMHN's holistic view of the patient. It emphasized involvement in a wide range of activities addressing health promotion and health restoration. Since its initial publication, the document has been updated three times, expanding and clarifying the roles and functions of the PMHN to reflect the status of the current society.

By the 1990s, the biological movement had so firmly been embraced by medicine that along with their alliance with the pharmaceutical industry, a major shift in both mental health care and nursing practice occurred, and medical **SOMATIC** (referring to the body) interventions became the primary focus of treatment (Whitaker, 2011).

Inpatient stays became shorter and funding for mental health treatment began to diminish both at the in-patient and community levels. The role of the psychiatrist changed from the provider of therapy and medication to that of diagnostic and pharmacological expert as schools of medicine no longer offered psychotherapy as part of physician training. Therapy was also now seen as the domain of the PhD-prepared psychologist and other independent providers such as social workers and to a lesser extent advanced practice psychiatric nurses. With less time, less money, and less integrated service lines, the generalist psychiatric nurse's role shifted to more of case manager of care. Duties were now more focused on admission and discharge proceedings, medication administration and monitoring, community linkage, and crisis management. Less time was spent on one-to-one therapeutic nurse–patient relationship modes of treatment. These changes are still evident today.

CONTEMPORARY PSYCHIATRIC-MENTAL HEALTH NURSING PRACTICE

Psychiatric-mental health nursing is "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. 14). A major component of this specialized practice is the therapeutic use of self in conjunction with theoretical and research-based foundations from the various scientific disciplines. Psychiatric-mental health nursing occurs across a continuum of care encompassing a wide variety of settings (**Box 1-2**).

Scope and Standards of Practice

Initially developed in 1973, and with the second edition published in 2014, the Scope and Standards of

BOX 1-2: SETTINGS FOR PSYCHIATRIC-MENTAL HEALTH NURSING PRACTICE

- Crisis intervention services
- Emergency psychiatric services
- Acute inpatient care
- Intermediate and long-term care
- Partial hospitalization programs
- Intensive outpatient treatment programs
- Residential services
- Community-based care: home, work sites, clinics, health maintenance organizations, shelters, schools, and colleges
- Assertive community treatment (ACT) programs
- Primary care
- Integrative programs
- Telehealth
- Self-employment
- Disaster response

Practice delineate the specific responsibilities for psychiatric-mental health nursing. The standards are divided into two areas: Standards of Practice and Standards of Professional Performance. The Standards of Practice address six major areas: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. The Standards of Professional Performance address nine areas: quality of practice, education, professional practice evaluation, collegiality, collaboration, ethics, research, resource utilization, and leadership. Each area includes specific criteria for use in measuring achievement of the standard.

Phenomena of Concern

The psychiatric-mental health practice division of the ANA has developed a list of 13 specific areas or "phenomena of concern." The phenomena provide the focus of patient care for PMHNs. These areas reflect the holistic view of the patient including the needs of the patient, family, group, and community. Therefore, when providing care to patients, PMHNs focus on the following:

- *Health promotion (optimal mental and physical health and well-being) and prevention of mental illness*
- *Impaired ability to function*
- *Alterations in thought, perception, and communication*
- *Potentially dangerous behaviors and mental states*
- *Emotional stress*
- *Management of symptoms, side effects, or toxicities related to treatment*
- *Treatment barriers*
- *Changes in self-concept, body image, and life process; issues related to development and end of life*
- *Physical symptoms associated with changes in psychological status*
- *Psychological symptoms associated with changes in physiological status*
- *Effects of interpersonal, organizational, sociocultural, spiritual, or environmental aspects*
- *Issues related to recovery*
- *Societal factors (ANA, 2007)*

Levels of Psychiatric-Mental Health Nursing Practice

Two levels of psychiatric-mental health nursing currently are recognized: basic and advanced. The levels are distinguished by the educational preparation, complexity of practice, and specific nursing functions (ANA, 2007). The American Nurses Credentialing Center (ANCC) certifies both basic and advanced practice psychiatric nurses through an examination and credential review process.

Basic-level PMHNs are registered nurses who have graduated from an accredited nursing education program and are licensed to practice in their state. In addition, basic-level PMHNs possess specialized knowledge and skills to care for patients with mental health issues and psychiatric problems. They apply the nursing process through the use of the therapeutic nurse–patient relationship, therapeutic interventions, and professional attributes such as self-awareness, empathy, and the therapeutic use of self (ANA, 2007). The ANCC recognizes the baccalaureate degree in nursing as the preferred level of educational preparation.

Advanced practice PMHNs are educated at the master's or doctorate level of education in the specialty and have achieved certification in this specialty by the ANCC. Advanced practice focuses on the "application of competences, knowledge, and experience to individuals, families, or groups with complex psychiatric-mental health problems" (ANA, 2007, p. 19). Mental health promotion, collaboration, and referral are key components of the advanced practice PMHN.

When graduate programs in psychiatric-mental health nursing were first introduced, the focus was on preparing educators to teach in basic nursing programs. Faculty members were also prepared to integrate psychiatric-mental health concepts throughout the undergraduate nursing curricula. Components such as communication skills, process recordings, and understanding of the emotional dimensions of physical illness were integrated into all nursing courses. The first psychiatric advanced practice role was the psychiatric clinical nurse specialist implemented by Hildegard Peplau. During the mid-1960s, more clinical nurse specialist (CNS) programs were introduced, emphasizing the preparation of specialists both for psychiatric-mental health nursing direct care roles and for teaching, consultation, and liaison with other nurses in clinical practice. The core focus of CNS practice today emphasizes three spheres of influence: organizational and systems; nursing practice; and client (patient). The CNS seeks to improve patient outcomes by influencing nursing practice via research and mentorship, influencing organizational systems via consultation or through direct care to individuals or communities (Fulton, Lyon, & Goudreau, 2010). Most psychiatric CNSs have training in individual psychotherapy, group psychotherapy, organizational consultation and liaison work, and research. More recently, some psychiatric CNSs have opted to add prescriptive authority to their set of services.

TABLE 1-1: FUNCTIONS OF PMHNs

BASIC LEVEL	ADVANCED PRACTICE LEVEL (CNS/NP)
Establishment of the therapeutic nurse–patient relationship	*In addition to basic level functions:*
Use of the nursing process	Collaboration
Participation as a key member of the interprofessional team	Referral
Health promotion and health maintenance activities	Primary psychiatric-mental health care delivery
Intake screening, evaluation, and triage	Comprehensive psychiatric and mental health evaluation (assessment and medical diagnosis)
Case management	Prescription of psychopharmacological agents (if allowed by state)
Milieu management	Integrative therapy interventions
Administration of psychobiological treatments and monitoring and evaluation of response and effects	Psychotherapy
Crisis intervention and stabilization	Complex case management (individual or population based)
Psychiatric rehabilitation	Consultation/liaison
	Clinical supervision
	Program development and management

CNS, clinical nurse specialist; NP, nurse practitioner; PMHN, psychiatric-mental health nurse.

In the early 1960s the nurse practitioner (NP) role was introduced in rural areas of the United States. By the late 1990s, the psychiatric-mental health NP role was introduced. Traditionally, this role has been seen as a provider of common physician services such as direct patient care for complex diagnosis and management of medical illnesses with medication prescription. More recently, the development is the blending of the CNS and NP roles for preparation of advanced practice nurses (APNs) in psychiatric-mental health nursing. The challenge to educators, however, is how to combine the two roles while preserving the uniqueness of each (Jones, 2010). The American Psychiatric Nurses Association (APNA) and the International Society of Psychiatric Nurses (ISPN), two professional psychiatric-mental health nursing organizations, have reviewed the standards for credentialing for future psychiatric-mental health nursing practice at both basic and advanced levels. According to ANCC, the current plan is to eliminate the title and role of the psychiatric CNS in favor of a psychiatric family NP model. This clinician would no longer be a specialist in any one area of psychiatric-mental health nursing, but would see clients from childhood through elderly age groups (Jones & Minarik, 2012).

Psychiatric nursing is practiced at two educational levels: generalist practice (ADN, Diploma, BSN) and advanced practice (MSN, DNP, PhD). Advanced practice nurses are clinical nurse specialists (CNSs) and nurse practitioners (NPs).

Roles and Functions of the PMHNs

Both basic and advanced practice PMHNs are guided by the Scope and Standards of Practice developed by the ANA. However, specific standards and criteria used for measurement are expanded for the advanced practice PMHN. **Table 1-1** highlights the key functions for each level of practice.

SUMMARY POINTS

- Early views of mental illness in the West focused on demonic possession with treatment consisting of charms, spells, witch hunts, and exorcisms. As the late 18th century approached, medical interventions such as bloodletting, immobilization, and specialized devices were used to treat mental illness. These practices were eventually stopped as the focus changed to supportive, sympathetic care in a quiet, clean environment.
- Dorothea Dix was instrumental in the care of the mentally ill in the United States, advocating for their needs through the establishment of state hospitals.
- During the 20th century, Freud's psychoanalytic theory and the development of psychopharmacology played key roles in the treatment of mental illness. The passage of the National Mental Health Act in 1946 provided funding for research, mental health professional training, and facility expansion programs, and established the National Advisory Mental Health Council and a National Institute of Mental Health (NIMH). Mental health was beginning to gain focus as an important area of health.
- In the 1960s, deinstitutionalization occurred. However, community mental health centers were not equipped to deal with the large numbers of persons who were deinstitutionalized. Care became fragmented and inadequate.
- In 1999, the surgeon general issued the first national report that focused on mental health that called for improving the quality of mental health in the nation. In 2001, the President's New Freedom Commission on Mental Health was created and led to recommendations for changing the current system to one that is more consumer and family driven and emphasizing the need for mental illnesses to receive the same focus of attention as medical illness.
- Although not a psychiatric-mental health nurse (PMHN), Florence Nightingale first identified the need to view the patient holistically, advocating for self-care. Linda Richards, credited as being the first American psychiatric nurse, emphasized the need to assess a patient's physical and emotional needs. Forty years later, the first psychiatric-mental health nursing program was established.
- With the evolution of the mental health field, PMHNs were required to adapt the principles of medical-surgical nursing care to those of psychiatric patients. The emergence of interpersonal models in the fields of psychiatry and nursing led to a refinement in the nurse's role. Hildegard Peplau and Joyce Travelbee emphasized the importance of interpersonal relations and the need to integrate this relevant content into the curricula.
- Publication of the American Nurses Association's (ANA) Statement on Psychiatric Nursing Practice was the first document to address the PMHN's holistic view of the patient and emphasized involvement in a wide range of activities addressing health promotion and health restoration.
- The "decade of the brain" shifted the focus of care to medical somatic interventions.
- Two levels of psychiatric-mental health nursing are recognized: basic and advanced. Basic-level PHMNs apply the nursing process through the use of the therapeutic nurse–patient relationship, therapeutic interventions, and professional attributes such as self-awareness, empathy, and the therapeutic use of self. Advanced practice PMHNs have a master's or doctoral degree and have received certification by the American Nurses Credentialing Center (ANCC). Mental health promotion, collaboration, and referral are key components of advanced practice.

NCLEX-PREP*

1. A nursing instructor is preparing a class discussion about the development of mental health care over time. Which of the following would the instructor include as occurring first?
   a. Development of psychoanalytic theory
   b. Establishment of the National Institute of Mental Health
   c. Use of medical treatments such as bloodletting and immobilization
   d. Emphasis on supportive, sympathetic care in a clean, quiet environment

2. A group of nursing students are reviewing information related to the development of psychiatric-mental nursing. The students demonstrate understanding of the information when they identify which person was emphasizing the use of the interpersonal process?
   a. Florence Nightingale
   b. Linda Richards
   c. Dorothea Dix
   d. Hildegard Peplau

3. A psychiatric-mental health nurse (PMHN) is preparing a presentation for a group of student nurses about psychiatric-mental health nursing. Which statement would the nurse include in the presentation about this specialty?
   a. A PMHN needs to obtain a graduate-level degree for practice.
   b. Advanced practice PMHNs can engage in psychotherapy.
   c. Basic-level PMHNs mainly focus on the patient's ability to function.
   d. PMHNs primarily work in acute inpatient settings.

4. When describing the results of integrating interpersonal models in psychiatric-mental health nursing, which of the following would be least appropriate to include?
   a. Therapeutic communication
   b. Milieu management
   c. Psychopharmacology
   d. Process groups

5. Deinstitutionalization occurred as a result of which of the following?
   a. Mental Retardation Facilities and Community Mental Health Centers Act
   b. National Mental Health Act
   c. Omnibus Budget Reconciliation Act (OBRA)
   d. The Surgeon General's Report on Mental Health

**Answers to these questions appear in the Answers to NCLEX Prep Questions section at the back of this book.*

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