Scope of Practice of Psychiatric-Mental Health Nursing

INTRODUCTION

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

Definition of Psychiatric-Mental Health Nursing

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

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

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

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

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

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

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

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

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

Goals or outcomes for the recipient of PMH nursing care are established early in treatment, with the individual directing this process as much as possible. Through a process of shared decision-making, the individual works with the nurse and other members of the health care team to develop a treatment plan based on assessment data, identified resources, and the individual's strengths and priorities. The PMH nurse then selects and implements evidence-based or best-practice interventions to assist with the optimal achievement of the individual's recovery goals and periodically evaluates both the attainment of the goals and the effectiveness of the interventions. The use of standardized classification systems enhances communication and permits the data to be used for research. However, in keeping with person-centered, recovery-oriented practice, the goal/outcome development must be individualized as much as possible, ideally with individuals designing their treatment goals with assistance from the PMH nurse (McLoughlin & Geller, 2010).

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

Phenomena of Concern for Psychiatric-Mental Health Nurses

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

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

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

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

Recipients of Psychiatric-Mental Health Nursing Care

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

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

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

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

Establishing the Scope and Standards of PMH Nursing Practice

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

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

HISTORY AND EVOLUTION OF PSYCHIATRIC-MENTAL HEALTH NURSING

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

Training for psychiatric nurses was originally provided by physicians. Effie Jane Taylor insisted that nurses train other nurses, and she developed the first nurse-taught course for psychiatric nursing within a general nursing education program at Johns Hopkins Hospital in the early 1900s (Stewart, 1939). This course served as a prototype for other nursing education programs. Taylor's colleague, Harriet Bailey, published the first psychiatric nursing textbook, *Nursing Mental Disease,* in 1920.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Developments in the broader context of the nursing profession have a corresponding effect within PMH nursing. One of the key messages of the Institute of Medicine's (IOM) report, *The Future of Nursing: Leading Change to Advance Health,* is that "nurses should be full partners, with physicians and other health care professionals, in redesigning health care in the United States" (IOM, 2010, p. 3). The report also calls for nurses to take a leadership role in moving quality health care forward through policy. Similarly, the AACN (n.d.) recognizes the importance of policy work with its inclusion in the essential elements of all levels of nursing education. In addition, the National League for Nursing (2019) and ANA (n.d.) support nurses' involvement in policy work as part of their profession. This work can be done at the local, state, and national levels. PMH nurses have served as mental health policy and program development leaders in both national and international arenas (Robert Wood Johnson Foundation, 2020).

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

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

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

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

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

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

LEVELS OF PMH NURSING PRACTICE

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

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

Psychiatric-Mental Health Registered Nurse

The science of nursing is based on a critical thinking framework, known as the *nursing process*, composed of assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. These steps serve as the foundation for clinical decision-making and are used to provide an evidence base for practice (ANA, 2015b).

The nursing process is meant to promote and foster health and safety; assess areas of individual strength and dysfunction; assist persons to achieve their own personal recovery goals by gaining, regaining, or improving coping abilities, living skills, and managing symptoms; maximize strengths; and prevent further disability. Data collection at the point of contact involves observational and investigative activities, which are guided by the nurse's knowledge of human behavior and the principles of the psychiatric interviewing process.

A PMH-RN is a registered nurse who demonstrates competence—including specialized knowledge, skills, and abilities—obtained through education and experience in caring for persons with mental health issues, mental health problems, psychiatric disorders, and co-occurring psychiatric and substance use disorders. Based on the work of Peplau (1952) and others, the practice of PMH-RNs is accomplished through interpersonal relationships, therapeutic use of self, and professional attributes. These attributes include but are not limited to self-awareness, empathy, and

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

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

Psychiatric-Mental Health Registered Nurse with Advanced Degrees

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

Psychiatric-Mental Health Advanced Practice Registered Nurse

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

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

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

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

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

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

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

a variety of clinical settings: provision of psychotherapy, provision of psychopharmacological interventions, and provision of clinical supervision. Psychotherapy interventions include all generally accepted and evidence-based methods of brief or long-term therapy, specifically including individual therapy, group therapy, marital or couple therapy, and family therapy. These interventions use a range of therapy models including but not limited to psychodynamic, cognitive, behavioral, and supportive interpersonal therapies to promote insight, produce behavioral change, maintain function, and promote recovery.

Psychotherapy denotes a formally structured relationship between the therapist (PMH-APRN) and the patient/client for the explicit purpose of effecting negotiated outcomes. The psychotherapeutic contract with the patient/client is usually verbal but may be written. The contract includes well-accepted elements such as the purpose of the therapy, treatment goals, time, place, fees, confidentiality and privacy provisions, and emergency after-hours contact information.

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

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

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

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

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

Examination of regulation—focusing on licensure, accreditation, certification, and education (LACE)—was completed in 2008 by the APRN Consensus Work Group and the NCSBN APRN Advisory Committee (NCSBN Joint Dialogue Group Report, 2008). Broadly, this model identifies four APRN roles for which to be certified: Clinical Nurse Specialist (CNS), Certified Nurse Practitioner (CNP), Certified Registered Nurse Anesthetist (CRNA), and Certified Nurse Midwife (CNM). Each of these roles involves specialized graduate educational preparation that may be applied to a specific population. Within each role, nurses must demonstrate specific competencies as determined by their specialty area of practice. All APRNs are educationally prepared to provide a scope of services to a population across the continuum of care as defined by nationally recognized role and population-focused competencies; however,

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

The scope of advanced practice in PMH nursing is continually expanding, consonant with the growth in needs for service, practice settings, and the evolution of various scientific and nursing knowledge bases. PMH-APRN practice focuses on the application of competencies, knowledge, and experience to individuals, families, or groups with complex psychiatric-mental health problems. Promoting mental health in society is a significant role for the PMH-APRN, as is collaboration with and referral to other health professionals, based on either the client's need or the PMH-APRN's practice focus. PMH-APRNs are accountable for functioning within the parameters of their education and training as well as the scope of practice as defined by their state practice acts. PMH-APRNs are responsible for making referrals for health problems that are outside their scope of practice.

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

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

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

CONTEMPORARY FACTORS INFLUENCING PMH NURSING PRACTICE

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

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

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

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

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

Prevalence and Treatment of Mental Disorders

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

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

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

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

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

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

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

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

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

Besides children and older adults, other vulnerable populations include:

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

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

TABLE 1 Treatment for Mental Health Conditions

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

Source: SAMHSA (2020b).

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

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

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

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

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

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

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

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

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

Disparities in Mental Health Treatment

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

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

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

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

MEETING AND ANTICIPATING POPULATION HEALTH NEEDS: REINVENTING MENTAL HEALTH TREATMENT

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

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

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

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

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

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

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