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Abstract
Discussions regarding the certification of the psychiatric-mental health (PMH) clinical nurse specialist (CNS) resulted in its elimination by the American Nurses Credentialing Center (ANCC), effective 2014. The sole remaining advanced practice registered nurse (APRN) certification for providing psychiatric and mental health care will be the Family Psychiatric Nurse Practitioner (NP). Disagreement still lingers with the changes in certification, including fears that the role of the PMH-CNS, which include care for the child and adolescent patient population and psychotherapy, will no longer exist. Additional concerns include the loss of duties traditionally performed by PMH-CNS to other behavioral health disciplines. In contrast to these fears are the hopes that a single title will reduce confusion among consumers and professionals, allow for an improvement in the allocation of resources for roles with similar core functions, and better address the current needs of individuals seeking mental health care. This paper describes the implications of such a transition and how even with a change in title, the role of the CNS can and should survive.

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Discussions regarding the certification of the psychiatric-mental health (PMH) clinical nurse specialist (CNS) resulted in its elimination by the American Nurses Credentialing Center (ANCC), effective 2014. The sole remaining advanced practice registered nurse (APRN) certification for providing psychiatric and mental health care will be the Family Psychiatric Nurse Practitioner (NP). Disagreement still lingers with the changes in certification, including fears that the role of the PMH-CNS, which include care for the child and adolescent patient population and psychotherapy, will no longer exist. Additional concerns include the loss of duties traditionally performed by PMH-CNS to other behavioral health disciplines. In contrast to these fears are the hopes that a single title will reduce confusion among consumers and professionals, allow for an improvement in the allocation of resources for roles with similar core functions, and better address the current needs of individuals seeking mental health care. This paper describes the implications of such a transition and how even with a change in title, the role of the CNS can and should survive.

Implications of Change on Advanced Practice Psychiatric-Mental Health Nursing

The history of the psychiatric-mental health clinical nurse specialist is impressive. As one of the initial advanced practice roles in nursing (Harahan, Delaney, & Stuart, 2012), the PMH-CNS has evolved into an autonomous yet dynamic leadership role in the behavioral health workforce. Today, PMH-CNSs are viewed as graduate-prepared APRNs who utilize biological, social, and psychological models and "a variety of theoretical frameworks to facilitate the understanding of individuals, groups and systems; and a variety of individual and group psychotherapeutic treatment modalities to support comprehensive treatment and consultation" (Dempsy & Ribak, 2012, p. 296). Their expertise may be observed in multifarious settings including hospitals, outpatient clinics, along with an array of organizations and institutions (Jones & Minarik, 2012). Ironically, as of the year 2014 (Jones & Minarik, 2012) the PMH-CNS—one of the pioneers for advanced practice nursing—will no longer have an examination offered by the American Nurses Credentialing Center (ANCC), the impacts of which will end the credentialing for the PMH-CNS.

The aforementioned announcement by the ANCC encountered oppositional voices within the APRN-PMH community. Nevertheless, the recommendations formulated by the joint International Society of Psychiatric Mental Health Nurses/American Psychiatric Nurses Society (ISPN/APNA) Task Force of the implementation of licensure, accreditation, credentialing, and education (LACE) contributed to the transition toward a Consensus Model for Advanced Practice (Regan-Kubinski & Horton-Deutsch, 2012). In 2014 their will be a termination of the PMH-CNS credentialing, as well as the elimination of the Adult Psychiatric and Mental Health Nurse Practitioner examination, and that those choosing to practice as an advanced practice psychiatric nurse will have only one option—the Family Psychiatric Nurse Practitioner (across the lifespan) certification (Jones & Minarik, 2012). Although this decision has led to uncertainty amongst the APRN-PMH contingent, the change has the potential to improve the strength and unity of the psychiatric-mental health nursing profession.

Positive appraisal of the transition in psychiatric-mental health advanced practice nursing should not be interpreted as a promotion of the PMH-NP as a replacement for the PMH-CNS due to a lack of capability. Rather the position is that it affords the profession the opportunity to consolidate the roles into a singular title. This concept is not novel, as hybrid programs have existed for years, although these programs are without consensus as to what educational training and preparation is necessary (Jones & Minarik, 2012). The transition toward the integration of competencies will require both the collaboration and cooperation of all parties involved with LACE.

There are other practical considerations, which must be addressed to ensure the viability of the APRN-PMH practice. So long as the debate over role and titling demonstrates reluctance toward resolution,

others that provide care for those with behavioral health problems will continue to encroach upon roles that may be provided for by the body of APRN-PMHs. Moreover, professionals outside of those who traditionally provide care for patients with behavioral health problems, including APRNs in different specialties such as family nurse practitioners, will increasingly treat these patients while the professional boundaries of APRN-PMHs remain clouded (McCabe & Grover, 1999).

As previously discussed, the transition to one title for APRN-PMHs is not an issue of which has more value, but rather one rooted in pragmatic substance. Therefore, with an understanding of the roles, functions, and knowledge of the CNS, this paper will discuss which of these are and are not currently being absorbed into the PMH-NP role, their future potential to be absorbed, and to evaluate the consequences and implications for care, policy, education, and research.

Method

A literature review was conducted to discover research articles describing the current advanced practice psychiatric-mental health workforce. Four online databases were utilized during this search, including Cumulative Index of Nursing and the Allied Health (CINAHL), Medline (PubMed), PsychINFO, and MEDLINEPlus/OVID. Variability between database searches existed due to differences in features specific to each database.

A Medline search was conducted using the terms psychiatric nursing, advanced nursing practice, and workforce, and resulted in 27 articles. These returned results were narrowed to 10 articles after applying parameters that limited the results to include only articles written in the English language from 2007 to 2012. Among these results, two were eliminated because they were commentary on other articles. Another article was eliminated because it was a qualitative study on the experience of nursing students, and was irrelevant to the focus of this paper. This same search process was utilized in PsycINFO, CINHAL, and MEDLINEPlus/OVID using the search parameters as previously described. These results returned an additional 22 articles (6 from MEDLINEPlus/OVID, 9 from PsychINFO, and 7 from CINAHL). Duplicate articles that were returned from the various databases were eliminated along with articles that did not fit the scope of this paper, including articles describing the advanced practice psychiatric-mental health nursing workforce outside the United States. Five additional articles were included after a review of the reference lists of the articles initially discovered in the database search. These articles were topically relevant but were outside the initial search parameters, which ranged from the years 1995 to 2003. A total of 17 articles were used for the review and synthesis of the current advanced practice psychiatric-mental health nursing workforce. These articles discuss the implication for the changing titles, certifications, and education, as well as the impact each of these items may have on the role of the APRN-PMH. Lastly, a broad range of sources such as databases, conference proceedings, and government and national nursing association data were comprehensively evaluated to provide background for this paper.

Results

Examining the evidence

Knowing that the transition away from the titling and certification of the PMH-CNS is inevitable, much of the literature focuses on the future by drawing upon conclusions from the past and current state of the profession. The literature attempts to demonstrate what roles and knowledge bases may survive, what may be lost, and the reasons for such.

The debate over the differences of roles, responsibilities, and educational preparation between psychiatric mental health clinical nurse specialists and psychiatric mental health nurse practitioners is certainly not new. In a 1999 article by McCabe & Grover entitled Psychiatric nurse practitioner versus clinical nurse specialist: Moving from debate to action on the future of advanced psychiatric nursing, the authors concluded that incorporating the roles of both PMH-CNS and the PMH-NP was necessary. This idea of a blended approach is observed throughout the literature, although it is the implementation of such an approach that poses substantial challenges.

Some of these challenges include incorporating the competencies of the PMH-CNS and the PMH-NP that do not overlap into the educational preparation of a blended program. Of course, the larger the overlap, the less challenging it should be to combine the two roles. A job analysis performed by a task force assembled by the American Psychiatric Nursing Association found a commonality of 90% between the practices of PMH-CNSs and PMH-NPs (Rice, Moller, DePascale, & Skinner, 2007). For those that promote integrating competencies, this is an encouraging finding. Nevertheless, for those that fear losing the essential roles of the PMH-CNS, these results may suggest that there is

not a major difference in roles between PMH-CNSs and PMH-NPs. Thus, the rationale for the concern for losing the traditional roles of the PMH-CNS may be unfounded.

A real challenge for maintaining the traditional roles of the PMH-CNS, such as the usage of psychotherapy in practice, has more to do with the changing reimbursement climate than it does with the PMH-CNS being overtaken by PMH-NP competencies. After all, it was just shown that evidence exists for the similarity among competencies between the two. What does appear to be true is that the reduction in reimbursement for services means that it is less economically viable to perform these services. Theoretically, there is an amount of money a payer may reimburse that transforms a profession into charity. For example, Delaney and Handrup explained that although many APRN-PMHs find psychotherapy to be "an essential element of their work," (p. 303), the reimbursement for medication therapy and assessment is superior to that of psychotherapy (2011). This phenomenon of shifting away from certain competencies valued by PMH-CNS and other behavioral health professionals alike may also reflect the needs of the current population.

There is a current demand for licensed providers capable of providing comprehensive care across the lifespan (Delaney, 2009). Of the four existing APRN-PMH certifications—Child and Adolescent CNS, Adult CNS, Adult NP, and Family NP—only one facilitates the educational preparation to provide such care. Furthermore, the inadequate number of professionals licensed to prescribe medication increases the desirability of PMH-NPs and their educational preparation having a focus on psychopharmacology. This need becomes increasingly important due to the shortage of psychiatrists in the United States. Moreover, the evolving nature of the behavioral health care industry favors a model that emphasizes medications and psychopharmacology (Delaney, Hamera, & Drew, 2009). A need for prescribers of medications will exist, and the preparation of the PMH-NP is one solution to address this shortage. Furthermore, the need for access to behavioral health providers that prescribe (96% of counties in the United States underserved) significantly outweighs the behavioral health need of providers that do not prescribe (18% of counties in the United States underserved) (Hanrahan et al., 2012). This data must not be interpreted as a difference in importance or effectiveness of providers, but rather a difference in need. Consequentially, with a demand for those that can prescribe (Kaas et al., 2000), it is not a coincidence that graduates from APRN-PMH programs have responded to this demand by requesting more training in prescribing. Delaney, et al., used a descriptive survey of APRN-PMHs and found that there was an overall desire to have more instructional content on psychopharmacology and the practice of prescribing (2009).

Another factor implicated in the abolishment of the PMH-CNS position is a history of producing little data on patient outcomes (Hanrahan et al., 2003). It is not that the ending of certification of PMH-CNSs is a result of poor-quality, inadequate to that of PMH-NP, but rather a product of misfortune in the context of the demands of the political environment. Though outcomes data do exist, such as Baradell, J. G. (1995), the rate and consistency at which the outcomes data emerges remains insufficient. While positive outcomes and patient satisfaction appear in the literature (Baradell & Bordeaux, 2001), the scarcity of research in this area may suggest a lack of evidenced-based practices often required for reimbursement for services provided.

Discussion

State of the Science

Synthesizing the empirical findings of multiple studies each evaluating unique variables presents a challenge when appraising the state of the science. Nevertheless, the studies that do exist are rarely empirical in nature, and often synthesis articles themselves. However, when assessing the literature used for this paper, the quality of evidence is good (B) to high (A), whereas the strength of the evidence ranges from level V to level III. The data is rather consistent in that, when taken as a whole, the research designs are appropriate in the context of attempting to predict the future; this requires the utilization of measurement, empiricism, and expert-understanding of the past to formulate such future predictions (Polit & Beck, 2008).

Such research was consistently performed by expert opinions of nationally recognized panels and consensus panels with clearly evident expertise (level IV-A evidence). Furthermore, much of the literature utilized for this paper included the opinions of individual experts based on literature review, organizational experience, and personal expertise (level V-A evidence). Although the quality of the evidence remains high, the strength of the evidence could improve, but

again is limited by the nature of the question this paper attempts to address.

In regards to the non-experimental studies used in this paper, not one had a level of evidence greater than level III-B. Specifically, there could be more extensive research into the differences between the roles of the PMH-CNS and the PMH-NP, as only one study showed the limited differences in roles (Rice et al., 2007). Expert opinion also questions the validity of the results of this study, specifically citing the lack of inclusion of roles pertaining to the common practice of PMH-CNSs:

The results reflect the bias inherent in the questions. The majority of the questions were in the client domain, therefore providing limited information about the totality of PMH-CNS practice. In addition, questions about non-pharmacological functions that impact care quality, that is, organizational consultation, the system as client, research, and consulting with nursing personnel, were shallow and did not capture the depth and breadth of skills needed. A study that concludes "no difference" in practice between the psychiatric CNS and NP practice most likely reflects the failure to ask a full range of questions about the practice of CNSs. (Jones & Minarik, 2012, p. 123)

Although the knowledge surrounding the implications of the evolving nature of the APRN-PMH, through improving our understanding of the differences (or lack thereof) among how PMH-CNS and PMH-NP practice, better methods of combining the identified variable roles may be actualized.

Recommendations

There is an opportunity during this time of transition among the APRN-PMH field, for the newly-labeled family psychiatric-mental health nurse practitioner to address many of the challenges that previously were not possible. This shift in the field has significant implications for practice, policy, education and research, which will be discussed in the subsequent paragraphs.

The transition from an APRN system that had two providers that perform similar care to a unified provider that integrates the roles of both the PMH-CNS and the PMH-NP may have the largest impact on practice. Full-spectrum healthcare is limited to psychiatrists, APRN-PMHs, and psychologists in 2 states (Hanrahan et al, 2012). After expanding their certification to allow all APRN-PHMs to provide care for individuals across the lifespan, APRN-PMHs would be in a better position to provide such full-spectrum care. The ability to serve the lifespan may address the chronically underserved child and adolescent population, where all APRN-PMHs certified after 2014 will be able to provide care for this demographic, whereas only a fraction of APRN-PMHs can currently treat this population.

Through the combination of the APRN-PMH workforce into one solitary unit, the capability of producing research increases within the field. The existence of both the PMH-CNS and PMH-NP currently allows for the potential duplication of outcomes research under separate titles. The distinctive qualities between the two are outweighed by their similarities, and the overall production of research from APRN-PMH becomes confusing and diluted, not only to those in the profession but also to policymakers. In regards to this disconnect "the assumption was that the underlying problem with CNS enrollments was a gapping public knowledge deficit" (Delaney, 2009, p. 454). The author continues to assert that not only could there be a problem with understanding the role of the PMH-CNS among policymakers and the public alike, but also that this disconnect may be due to the PMH-CNS tradition of providing therapy is outweighed in manpower, and thus the influence of policy, by other professionals (e.g. psychologists), 40-to-1. By combining numbers and reducing confusion among the population, we can strengthen the impact of the research that is needed to guide policy.

It is essential that policymakers have an increased awareness of the capabilities of the APRN-PMH workforce, and therefore there is an important connection between research and policy. To this end, it is essential to produce outcomes research. This may include creating new ways to measure outcomes of those APRN-PMHs whose outcomes are difficult to measure when not working independently. Furthermore, policymakers may have limited funding to APRN-PMHs because the majority of them are CNSs, and often do not have roles in the provision of direct care (Hanrahan et al, 2010). By transitioning to one title, policymakers may be more likely to recognize the size and benefits of the workforce.

Of course, the true integration of the differing competencies of the PMH-CNS and the PMH-NP must happen at the educational level. This poses some significant challenges, as one study showed that an addition of 150 supervised clinical hours to the minimum 500 hours are needed to adequately prepare a student to have the comprehensive skillsets from the PMH-NP

and PMH-CNS domains (Rice et al, 2007). Addressing increasing educational needs poses a challenging task, as there is already a well-known shortage of faculty and clinical sites; as faculty age and retire and clinical sites become increasingly crowded, it will be difficult to facilitate these increased needs. Furthermore, this will mean that the time of preparation will be longer, and this may deter students from pursuing an APRN-PMH license.

Conclusion

Continuing the debate regarding the variation among roles serves only to diminish the profession's primary responsibility. PMH-CNSs and PMH-NPs must act with an approach that is less self-centered and more patient-centered. Though change often demands sacrifice, through working together to preserve and promote the core competencies that define not only psychiatric-mental health advanced practices nurses but also the entire nursing profession, patients will ultimately reap the benefits that nurses may offer. Although titles may be changing, it is up to the profession to ensure the services of all APRN-PMH backgrounds are maintained. And that is the message: A practice that changes in response to the needs of our patients does not mean that a practice is disappearing, yet evolving.

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