CHAPTER 2

PSYCHIATRIC-MENTAL HEALTH NURSE PRACTITIONER ROLE, SCOPE OF PRACTICE, AND REGULATORY PROCESS

Starting in the 1950s with the seminal work of two psychiatric nurses, June Mellow (1968) and Hildegard Peplau (1952), psychiatric nursing has been a well-established, well-recognized subspecialty of nursing. The emergence of the psychiatric-mental health nurse practitioner (PMHNP) role reflects the growth of the advanced practice role, the acceptance of a brain-based etiology of psychiatric disorders, and an awareness of the need to provide holistic nursing care that does not artificially separate mind and body (Stuart, 2013). The PMHNP role is built on fundamental, advanced practice core knowledge that is common to all nurse practitioners (NPs). This base of knowledge is expanded to include the specific knowledge of the subspecialty of psychiatry. This chapter reviews the role of the PMHNP, the scope of practice, and the regulatory process.

Advanced practice nurses specializing in psychiatry are educationally prepared at the master's or doctoral level, possess in-depth knowledge and skills in the specialty area, and provide primary psychiatric care to individuals or families at risk of or currently experiencing a psychiatric disorder.

NURSE PRACTITIONER ADVANCED PRACTICE CORE CONTENT

All NPs upon graduation are expected to meet a set of core competencies (National Organization of Nurse Practitioner Faculties [NONPF], 2022). NONPF revised the competencies to be in alignment with *The Essentials: Core Competencies for Professional Nursing Education* (American Association of Colleges of Nursing [AACN], 2021). Specialty competencies, such as the *Psychiatric-Mental Health Nurse Practitioner Competencies* (NONPF, 2013), are then built upon these core competencies.

AACN ESSENTIALS: CORE COMPETENCIES

- Domain 1: Knowledge of Nursing Practice
  - NONPF NP Domain 1: Knowledge of Practice
- Domain 2: Person-Centered Care
  - NONPF NP Domain 2: Person-Centered Care
- Domain 3: Population Health
  - NONPF NP Domain 3: Population Health
- Domain 4: Scholarship for Nursing Discipline
  - NONPF NP Domain 4: Practice Scholarship and Translational Science
- Domain 5: Quality and Safety
  - NONPF NP Domain 5: Quality and Safety
- Domain 6: Interprofessional Partnerships
  - NONPF NP Domain 6: Interprofessional Collaboration in Practice
- Domain 7: Systems-Based Practice
  - NONPF NP Domain 7: Health Systems
- Domain 8: Informatics and Healthcare Technologies
  - NONPF NP Domain 8: Technology and Information Literacy
- Domain 9: Professionalism
  - NONPF NP Domain 9: Professional Acumen
- Domain 10: Personal, Professional, and Leadership Development
  - NONPF NP Domain 10: Personal and Professional Leadership

NURSE PRACTITIONER ADVANCED PRACTICE SPECIALIZED CONTENT

The specialty competencies are designed specifically for entry-level PMHNP. These specialty competencies are to be used with the *Nurse Practitioner Role Competencies* (NONPF, 2022). The specialty competencies address the life span PMHNP focus, including families and populations. As changes occur within the health care system, these competencies will also change.

LEADERSHIP COMPETENCIES

- Participates in community and population-focused programs that evaluate programs, promote mental health, and prevent or reduce risk of mental health problems
- Advocates for complex client and family medicolegal rights and issues
- Collaborates with interprofessional colleagues about advocacy, and policy to reduce health disparities and improve outcomes for populations

QUALITY COMPETENCIES

- Evaluates the appropriate uses of seclusion and restraints in the care process

POLICY COMPETENCIES

- Employs opportunities to influence health policy to reduce the impact of stigma on services for the prevention and treatment of mental health problems and psychiatric disorders

INDEPENDENT PRACTICE COMPETENCIES

- Develops individualized, age-appropriate treatment plans
- Includes differential diagnosis
- Assesses the impact of acute and chronic medical problems on psychiatric treatment
- Conducts individual, couples, group, and family psychotherapy
- Applies supportive psychodynamic, cognitive, behavioral, and other evidence-based psychotherapies to brief and long-term practice
- Applies recovery-oriented principles
- Demonstrates best practices of family care approaches
- Plans care to minimize the development of complications and promote function
- Treats acute and chronic psychiatric disorders and problems
- Ensures client safety through the appropriate prescription of pharmacologic and nonpharmacologic interventions

- Explains the risks, benefits, and alternatives of treatment to client and family
- Identifies the role of PMHNP in risk-mitigation strategies in areas of substance use and misuse
- Seeks consultation
- Uses self-reflection to improve care
- Provides consultation to health care providers and others to enhance quality and reduce cost
- Guides clients in evaluating the appropriate use of complementary and alternative treatment
- Uses individualized outcome measures to evaluate psychiatric care
- Manages psychiatric emergencies
- Refers clients appropriately
- Facilitates the transition of clients across levels of care
- Uses outcomes to evaluate care
- Attends to the client–NP relationship as a vehicle for change
- Maintains a therapeutic relationship over time with individuals and groups
- Therapeutically concludes the client–NP relationship
- Demonstrates an ability to address sexual and physical abuse, substance use, sexuality, and spiritual conflicts
- Applies therapeutic relationship strategies based on theory and research
- Applies principles of self-efficacy, empowerment, and others to effect change
- Identifies and maintains professional boundaries
- Teaches clients, families, and groups
- Provides psychoeducation
- Modifies the treatment approach based on client readiness
- Considers motivation and readiness to improve self-care
- Demonstrates knowledge of the appropriate use of seclusion and restraint
- Documents the appropriate use of seclusion and restraints

HISTORY OF THE NP ROLE

The NP role was introduced in 1965 by Loretta C. Ford, EdD, and Henry K. Silver, MD, at the University of Colorado (Mirr Jansen & Zwygart-Stauffacher, 2006). They identified new roles in which experienced registered nurses (RNs) with advanced education and skills were performing clinical duties traditionally reserved for physicians. Universities were slow to implement NP programs at the master's level. However, RNs embraced the new role and rushed into continuing education programs of varying length, quality, and focus to accomplish the necessary educational preparation for this new role.

In 2008, the License, Accreditation, Certification, and Education (LACE) consensus model was finalized and adopted by many nursing organizations. The consensus model identified four Advanced Practice Registered Nurse (APRN) roles: Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife (CNM), Clinical Nurse Specialist (CNS), and Certified Nurse Practitioner (CNP). As part of the LACE model, psychiatric-mental health was identified as a population focus. The APNA and International Society of Psychiatric-Mental Health Nurses (ISPN) recommendation was for PMHNPs to be prepared across the life span (American Psychiatric Nurses Association [APNA], 2011). In 2015, APRN in psychiatric-mental health nursing moved to certification examination, PMHNP–Life Span, with the American Nurses Credentialing Center (ANCC).

Proven competence brought an acceptance of the NP role in the health care system, with acceptance and recognition of the title and role by consumers and other health care professionals. NP programs are accredited by one of two organizations to achieve standardization and control over quality: the Commission on Collegiate Nursing Education (CCNE, 2023) and the Accreditation Commission for Education in Nursing (ACEN, 2023). NPs are recognized providers under many third-party insurance coverage plans (e.g., Medicare, Medicaid, Civilian Health and Medical Program of the Uniformed Services, federal programs funding school-based clinics, U.S. military, Veterans Administration).

GROWTH OF THE NP ROLE

- Facilitating factors for growth
  - Consumer demand for services
  - Acceptance of the advanced practice nursing role
  - Emergence of the PMHNP role
  - Decreasing stigmatization
  - Emphasis on integrated health care services

- Constraining factors for growth
  - Growing competition in the job market in general for NPs
  - Reimbursement struggles with Medicare and private insurance companies
  - Overlapping scope of practice with other NPs
  - Increased concerns over reimbursement fraud and abuse (e.g., issues of coding and billing for services)
  - Scope of practice and need for formal supervisory or collaborative relationships with physicians

REGULATORY AND STATUTORY DIMENSIONS OF THE NP ROLE

- State legislative statutes
  - Grant legal authority for NP practice
  - The Nurse Practice Act of every state
    - Provides title protection (who may be called an NP)
    - Defines advanced practice
    - Prevailing state laws that define scope of practice (what NPs may do)
    - Places restrictions on practice
    - Sets NP credentialing requirements (e.g., educational requirements, certification)
    - States grounds for disciplinary action
      - Practicing without valid license
      - Falsification of records
      - Medicare fraud
      - Failure to use appropriate nursing judgment
      - Failure to follow accepted nursing standards
      - Failure to complete accurate nursing documentation
    - May specifically require that an NP develop a collaborative agreement with a physician
      - Collaborative agreement: Also known as a protocol that describes what types of drugs might be prescribed and defines some form of oversight for NP practice
- Statutory law
  - Rules and regulations differ for each state

- ◊ May further define scope of practice and practice requirements
- ◊ May provide restrictions in practice that are unique to a specific state

- ♦ Licensure
  - ◊ A process by which an agency of state government grants permission to persons to engage in the practice of that profession
  - ◊ Also prohibits all others from legally doing protected practice
- ♦ Credentialing
  - ◊ A process used to protect the public by ensuring a minimum level of professional competence
- ♦ Certification
  - ◊ A credential that provides title protection
  - ◊ Determines scope of practice (i.e., who NPs can see and what NPs can treat)
  - ◊ The process by which a professional organization or association certifies that a person licensed to practice as a professional has met certain predetermined standards specified by that profession for specialty practice
  - ◊ Assures the public that a person has mastery of a specified body of knowledge
  - ◊ Ensures that the person has acquired the skills necessary to function in a particular specialty
  - ◊ ANCC, a subsidiary of the American Nurses Association (ANA), is the only certifying body for advanced practice psychiatric nursing.
- ♦ Certification offered as a PMHNP–Life Span (ANCC, 2023)
- ♦ Scope of practice
  - ◊ Defines NP roles and actions
  - ◊ Identifies competencies assumed to be held by all NPs who function in a particular role
  - ◊ Varies broadly from state to state
  - ◊ Advanced practice PMHNP standards are identified in *Psychiatric-Mental Health Nursing: Scope and Standards of Practice* (ANA, APNA, & ISPN, 2022).
- ♦ Standards of practice
  - ◊ Authoritative statements that describe the quality and type of practice that should be provided
  - ◊ Provide a way to judge the nature of care provided
  - ◊ Reflect the expectation for the care that should be provided to clients with various illnesses
  - ◊ Reflect professional agreement focused on the minimum levels of acceptable performance

- ◊ Can be used to legally describe the standard of care that must be met by a provider
- ◊ May be precise protocols that must be followed or more general guidelines that recommend actions

PROFESSIONAL ROLE RESPONSIBILITIES

- ♦ Confidentiality
  - ◊ The client's right to assume that information given to the health care provider will not be disclosed
  - ◊ Protected under federal statute through the Medical Records Confidentiality Act of 1995 (S.1360)
  - ◊ Pertains to verbal and written client information
  - ◊ Requires that the provider discuss confidentiality issues with clients, establish consent, and clarify any questions about disclosure of information
  - ◊ Requires that the provider obtain a signed medical authorization and consent form to release medical records and information when requested by the client or another health care provider
- ♦ Health Insurance Portability and Accountability Act (HIPAA)
  - ◊ The first national comprehensive privacy protection act
  - ◊ Guarantees clients four fundamental rights
    - To be educated about HIPAA privacy protection
    - To have access to their own medical records
    - To request amendment of their health information to which they object
    - To require their permission for disclosure of their personal information
- ♦ The Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 (U.S. Department of Health and Human Services [HHS], 2017)
  - ◊ Provides incentive payments for sharing specific electronic health record (EHR) data
  - ◊ Provides meaningful-use incentives
  - ◊ EHRs can improve both individual and population-based health outcomes (Friedman et al., 2013).
  - ◊ EHRs can improve quality, safety, efficiency, effectiveness, and outcomes (HHS, Office for Civil Rights, 2013).
- ♦ E-prescribing
- ♦ Computerized physician order sets

- Tracking care and avoiding duplication of services
- Telehealth
  - The use of electronic information and telecommunication technologies to support long-distance clinical health care (Health Resources and Services Administration [HRSA], 2022). It is often used for those who may otherwise not be able to access care.
  - Must follow the same standards as care delivered in person
  - Must be practiced in accordance with international, federal, and state regulatory agency standards
  - Must include provisions for emergency care of the client
  - The PMHNP must ensure that HIPAA regulations regarding confidentiality and maintenance of the health record are followed.
- Exceptions to guaranteed confidentiality
  - When appropriate persons or organizations determine that the need for information outweighs the principle of confidentiality
  - If a client reveals an intent to harm self or others
  - Information given to attorneys involved in litigation
  - Releasing records to insurance companies
  - Answering court orders, subpoenas, or summonses
  - Meeting state requirements for mandatory reporting of diseases or conditions
  - Tarasoff principle (*Tarasoff v. Regents of the University of California*, 1976): Duty to warn potential victim of imminent danger of homicidal clients
  - In cases of child or elder abuse
- Informed consent
  - The communication process between the provider and the client that results in the client's acceptance or rejection of the proposed treatment
  - An explanation of relevant information that enables the client to make an appropriate and informed decision
  - The rights of all competent adults or emancipated minors
    - Emancipated minors: Persons younger than 18 years who are married, are parents, or are self-sufficiently living away from the family domicile
  - Elements of informed consent
    - Nature and purpose of proposed treatment or procedure
    - Risks or discomforts and benefits of treatment
    - Risks and benefits of not undergoing treatment
    - Alternative procedures or treatments

- Diagnosis and prognosis
  - The provider must document in the medical record that informed consent has been obtained from the client.
  - The PMHNP is responsible for ensuring that the client is cognitively capable of giving informed consent.
    - Capacity is the ability to use information given related to the diagnosis and treatment to make decisions regarding the plan of care.
    - Capacity is not fixed and must be assessed throughout treatment
      - Disorders and conditions that may affect cognition and, therefore, capacity include:
        - Neurocognitive disorders
        - Mental health disorders
          - Schizophrenia
          - Depression
          - Substance use
        - Traumatic brain injury
        - Hospitalized adults
        - End of life
      - Elements of decision-making capacity
        - Understanding: is able to state the diagnosis, risks, benefits, options
        - Expressing a choice: is able to clearly state the decision
        - Appreciation: expresses how the information applies
        - Reasoning: is able to compare the information given and possible consequences
  - A person is described as having adequate, marginal, or inadequate decision-making capacity
- Ethics
  - Important aspect of the NP role that deals with moral duties, obligations, and responsibilities
  - What is right versus what is wrong
  - Bioethical principles provide the foundation and direction in clinical decision-making:
    - Justice: Doing what is fair; fairness in all aspects of care
    - Beneficence: Promoting well-being and doing good
    - Nonmaleficence: Doing no harm

- Fidelity: Being true and loyal
- Autonomy: Doing for self
- Veracity: Telling the truth
- Respect: Treating everyone with equal respect

◊ In 2015, ANA published the *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2015). Its nine provisions are:

1. The nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person.
2. The nurse's primary commitment is to the client, whether an individual, family, group, community, or population.
3. The nurse promotes, advocates for, and protects the rights, health, and safety of the client.
4. The nurse has the authority, accountability, and responsibility for nursing practice; makes decisions; and takes action consistent with the obligation to promote health and provide optimal care.
5. The nurse owes the same duties to self as to others, including the responsibility to promote health and safety, preserve wholeness of character and integrity, maintain competence, and continue personal and professional growth.
6. The nurse, through individual and collective effort, establishes, maintains, and improves the ethical environment of the work setting and conditions of employment that are conducive to safe, quality health care.
7. The nurse, in all roles and settings, advances the profession through research and scholarly inquiry, professional standards development, and the generation of both nursing and health policy.
8. The nurse collaborates with other health professionals and the public to protect human rights, promote health diplomacy, and reduce health disparities.
9. The profession of nursing, collectively through its professional organizations, must articulate nursing values, maintain the integrity of the profession, and integrate principles of social justice into nursing and health policy.

◊ Important ethical principles in psychiatry

- Clients must be involved in decision-making to the full extent of their capacity (shared decision-making).
- Clients have a right to treatment in the least-restrictive setting.
- Clients have a right to refuse treatment unless a legal process resulting in a mandatory court order for treatment has been obtained.

◊ Ethical dilemma

- Occurs in a situation in which there are two or more justifiable alternatives
- Occurs when the choice is made to promote good

- Which option sacrifices the fewest high-priority values (a harm-reduction approach)?

◊ Theoretical approaches to ethical decision-making

- Deontological theory: An action is judged as good or bad based on the act itself regardless of the consequences.
- Teleological theory: An action is judged as good or bad based on the consequence or outcome.
- Virtue ethics: Actions are chosen based on moral virtues (e.g., honesty, courage, compassion, wisdom, gratitude, self-respect) or the character of the person making the decision.

ETHICS OF DISCLOSURE BY PROVIDERS

- Clients have a right to know what is happening during the course of their treatment.
- Providers have an ethical responsibility to disclose medical errors, accidents, injuries, and negative results to clients.
- As a result of the disclosure, a client may have a legal right to compensation for harm suffered due to medical misadventures (Sadock et al., 2017).

RISK VERSUS BENEFITS OF DISCLOSURE OF DISABILITY REGARDING EMPLOYMENT

- The Americans with Disabilities Act (ADA) works to prevent discrimination by employers with 15 or more employees against qualified persons in hiring, firing, advancement, job training, compensation, and workplace conditions (Buppert, 2021).
- The ADA is federal legislation granting Americans who have disabilities, including mental illness, the opportunity for employment on an equal basis with the nondisabled.
- Employers are required to make reasonable accommodations for qualified applicants or employees with a disability.

Risk of Disclosure

- Employers may find ways to avoid hiring persons known to have a disability.
- Coworkers may harass or discriminate against persons with psychiatric illnesses.
- It may be unfairly assumed that persons with psychiatric illnesses may be less productive.

- May limit an employee's chance for advancement in career.
- Feedback for improvement may not be given to the employee because others may attribute the employee's behavior to the psychiatric illness.
- Labeling oneself as "disabled" may affect one's beliefs or self-image.

Benefits of Disclosure

- Ability to request reasonable accommodations
- Opportunity to have a job coach come to the worksite and communicate directly with employer
- Employee can involve an employment service provider, employee assistance program, or other third party in the development of accommodations
- Easier for employee to come to work during an exacerbation of symptoms
- May help with the recovery process
- Allows coworkers to offer personal support
- May empower another employee to disclose

LEGAL CONSIDERATIONS

- Malpractice insurance
  - Provides financial protection against claims of malpractice
  - Provides coverage for negligent professional acts
  - Provides coverage for highly technical or professional skills required by health care professionals, including NPs
  - Is recommended universally for all NPs
  - Does not protect NPs from charges of practicing outside their legal scope of practice
  - Provides NPs with their own legal representation to advocate for them even if their agency also carries malpractice liability insurance protection
  - Four elements of negligence that must be established to prove malpractice
    1. Duty: The NP had a duty to exercise reasonable care when undertaking and providing treatment to the client.
    2. Breach of duty: The NP violated the applicable standard of care in treating the client's condition.

3. Proximate cause: There is a causal relationship between the breach in the standard of care and the client's injuries.
4. Damages: The client experiences permanent and substantial damages as a result of the breach in the standard of care.

COMPETENCY

- A legal, not a medical, concept
- A determination that a client can make reasonable judgments and decisions regarding treatment and other health concerns
- A person is considered competent until a court rules the person to be incompetent.
- If a person is deemed incompetent, a court-appointed guardian will make health-related decisions for that person.

COMMITMENT

- The process of forcing a person to receive involuntarily evaluation or treatment
- The process may differ from state to state.
- Basic criteria
  - Person has a diagnosed psychiatric disorder
  - Person is harmful to self or others as a consequence of the disorder
  - Person is unaware of or unwilling to accept the nature and severity of the disorder
  - Treatment is likely to improve functioning
- Involuntary admission
  - Admission to a hospital or other treatment facility against the person's will
  - Clients maintain all civil liberties except the ability to come and go as they please.
  - Amount of time clients can be kept against their wishes varies by state.
- Voluntary admission
  - Admission to a hospital or other treatment facility that a person desires or agrees to
  - Client maintains all civil liberties
  - Client consents to potential confinement within the structure of a hospital setting

ROLES OF THE PMHNP

SCHOLARLY ACTIVITIES

- It is important for NPs to engage in the following scholarly activities:
  - Publishing
  - Lecturing or presenting
  - Precepting PMHNP students continuing education

MENTORING (APNA, 2022)

- Mentoring implies a knowledge or competence gradient, in which the teaching–learning process contributes to a sharing of advice or expertise, role development, and formal and informal support to influence the career of the protégé (Jakubik et al., 2016)
- A mutually agreed upon relationship with goals and methods for accountability
- A process in which a more experienced NP agrees to guide and support a junior colleague in the role, competencies, and skills
- Requires mutual respect and an interactive process of learning
- Most mentoring relationships are long term and end when mutually agreed to do so.

CLIENT ADVOCACY

- Means to stand up for clients' rights and empower them to become their own advocates
- Reduces the stigma of mental illness
- Helps clients receive available services
- Promotes mental health by participating in one or more of these professional organizations:
  - American Nurses Association (ANA)
  - American Psychiatric Nurses Association (APNA)
  - International Society of Psychiatric Nurses (ISPN)

HEALTH POLICY

- Advanced practice nurses have a legal and ethical responsibility to be client advocates.
  - Participation in local, state, national, and international health policy activities (Buppert, 2021)
  - Involvement: Testify at a public meeting, lobby, or work with the media to bring awareness to an issue
  - Phases of policy-making: Formulation, implementation, and evaluation (Abood, 2007)

CASE MANAGEMENT

- A system of controlled oversight and authorization of services and benefits provided to clients
- Consists of coordinating care, ensuring quality outcomes, monitoring plan of care, and doing advocacy
- Overall goal is to promote quality, cost-effective outcomes

Risk Assessment

- Continuous monitoring for high-risk situations
- Assessing persons for nonhealthy behaviors

Risk Management

- Activities or systems designed to recognize and intervene to reduce the risk of injury to clients
- Appropriate interventions implemented to reduce unhealthy behaviors in clients and high-risk situations
- Recognition and intervention to reduce subsequent claims against health care providers

ADVANCE DIRECTIVES

- Durable power of attorney for health care, also known as health care proxy
  - Legally binding in all 50 states

- ◊ Designates, in writing, an agent to act on behalf of a person should they become unable to make health care decisions
- ◊ Not limited to terminal illness; also covers other aspects of illness, such as making financial decisions during a person's illness
- ◊ Should be considered as an aspect of relapse planning for clients with chronic psychiatric disorders

- ♦ Living will: Document prepared while client is mentally competent to designate preferences for care if client becomes incompetent or terminally ill
  - ◊ Not legally binding in all states

CULTURALLY COMPETENT CARE AND SPECIAL POPULATIONS

- ♦ Treating clients from diverse cultures, viewing each client as a unique person, and noting a potential relationship between clients' cultural experiences and their symptom presentation and perceptions
- ♦ Assumes that if the NP becomes more sensitive to cultural issues influencing the client's symptoms and treatment, more comprehensive health care can be provided
- ♦ Culture: The learned beliefs and behaviors or the socially inherited characteristics that are common among all members of a group; may be a racial, social, ethnic, or religious grouping
- ♦ Culture-bound syndromes: Specific behaviors related to a person's culture and not linked to a psychiatric disorder
  - ◊ Be cognizant of inaccurately judging a client's behavior as psychopathology when it is really related to their culture.

BARRIERS TO CULTURAL AND SPIRITUAL COMPETENCES

- ♦ It is the responsibility of the provider to recognize and address barriers on an ongoing basis. Barriers have been identified as the following:
  - ◊ Lack of diverse providers and organizational leadership
  - ◊ Limited awareness of differences
  - ◊ Lack of training
  - ◊ Ethnocentrism
  - ◊ Unrecognized prejudice

CULTURAL INFLUENCES AND DETERMINANTS OF HEALTH

- Family: A group of adults and children who are usually related and whose adults participate in carrying out the essential functions of providing food, clothing, shelter, safety, and education of children
  - Concept broadened beyond the traditional husband–wife–children pattern
  - Family initially teaches the belief patterns, religion, culture, and mores of a society
- Ethnicity: Self-identified race, tribe, or nation with which a person or group identifies and that greatly influences beliefs and behavior
- Community: A group of individuals linked together due to their common characteristics or interests
- Social determinants of health:
  - Economic stability
  - Educational access and quality
  - Health care access and quality
  - Neighborhood and built environment
  - Social and community context

BEING UNHOUSED

Being unhoused is an enormous problem affecting the United States and the world. It can have devastating effects on individuals' and families' emotional and physical health. Substance use, violence, and severe mental illnesses are just a few major issues faced by persons who are unhoused. The practitioner must be aware of the challenges faced by this vulnerable population. Possessing appropriate communication skills and knowledge of available resources is invaluable.

- Unhoused person
  - Someone who does not have stable or consistent nighttime housing or who maintains permanent residence at shelters, hotels, transitional housing, or public places not appropriate for human beings to live in; someone intended to be institutionalized who is in an institution for transitory residence
  - Men, women, and children make up the unhoused population. The number of unhoused families is on the rise.
- The majority of unhoused families are headed by a single parent, usually a woman.
  - Female-headed households are at high risk for becoming unhoused if the head of household has limited education or employment skills, low-paying employment with little or no benefits, and limited access to affordable housing.

- ◊ Teen mothers are at high risk due to lack of education and incomes that older parents possess.

- Reasons for becoming unhoused
  - ◊ Mental illness
  - ◊ Substance use disorders
  - ◊ Poverty
  - ◊ Unemployment
  - ◊ Inadequate public assistance
  - ◊ Domestic violence
  - ◊ Lifestyle choice
- Mental illness and substance use disorders in the unhoused population
  - ◊ Approximately 50% of people who are unhoused have co-occurring substance use disorders and serious mental illness, including bipolar disorder, schizophrenia, and depression.
  - ◊ Severe mental illness accounts for 25% to 30% of the U.S. unhoused population (Padgett, 2020; Sadock et al., 2017).
  - ◊ Symptoms are often active and untreated.
  - ◊ Untreated serious mental illness results in symptoms such as paranoia, hallucinations, mania, anxiety, and depression, making it difficult for people to maintain employment, relationships, and activities of daily living.
  - ◊ People who are unhoused with co-occurring disorders are at a greater risk for violence, medication nonadherence, and treatment resistance.

Strategies for Reducing Rates of Unhoused Individuals

- Outreach: Introducing services to persons who are unhoused with serious mental illness in various settings; building an empathetic, consistent, and caring relationship to provide treatment
- Integrated care: Treatment combining mental health and medical care to improve overall functioning in the community; may also include access to dental care and pharmacy services
- Co-location: Providing mental health and primary care services at a single site
- Supporting services to persons in housing: Effective in moving persons who are unhoused with serious mental illness directly to independent housing with support and intensive attention
- Prevention: Beginning with discharge planning in inpatient settings, provide resources for mental health care, housing, transitioning service, and follow-up

MIGRANT AND SEASONAL FARM WORKERS

- Migrant: Persons who leave their permanent residences to take agricultural jobs in different locations
- Seasonal: Workers who travel from their permanent residences seasonally for agricultural employment
- Includes men, women, and children of all cultures
- It is estimated that more than 3 million migrant and seasonal farm workers work in the United States (National Center for Farmworker Health, 2023).
  - Hard to get an accurate census because families and workers move a great deal
- Working conditions; problems with the process of acculturation, isolation, discrimination; and impaired access to health care play a role in a high prevalence of mental illness among migrant and seasonal farm workers.
- Very high incidence of depression, anxiety, and substance use
- Physical and emotional abuse of women is harder to address because of frequent changes of location.
- Meeting the mental health needs of this vulnerable population can pose a challenge because of the ways specific cultures perceive mental illness. Displaying an empathic, understanding, and culturally sensitive attitude is imperative when promoting care to this population.

SEXUAL ORIENTATION AND GENDER IDENTITY

Possessing a thorough understanding of sexuality is of great importance when communicating with clients of different sexual orientations. The practitioner must possess an open, supportive, sensitive, and empathetic attitude toward the client. Understanding the client's viewpoint and what they are seeking will help facilitate an effective psychiatric evaluation. In addition, an awareness of the factors that the client may have faced because of their sexuality is crucial (Sadock et al., 2017).

- Gender identity: A person's identity along a continuum between normative constructs of masculinity and femininity. Note that some clients may identify with genders outside of these normative constructs (e.g., nonbinary, genderfluid)
  - Influences on gender identity may consist of biological and social factors.
  - Biological factors may include pre- and postnatal hormone levels and gene expression.

    - ◊ Social factors may include gender messages from family, mass media, and cultural attitudes.
- ♦ Gender dysphoria: The formal diagnosis to describe a marked incongruence between one's experienced and expressed gender, and the gender assigned at birth
- ♦ Sexual orientation: The direction of sexual attraction; preferred over "sexual preference" or "lifestyle," which imply choice, whereas "orientation" does not; some prefer "sexual identity" because it allows people to determine their own identities. Sexual orientation does not always relate to gender identity.
- ♦ Asexual: Does not experience sexual attraction to others
- ♦ Bisexual: Attracted to both sexes
- ♦ Pansexual: Attraction to others not limited by sex, current gender identification, or gender expression
- ♦ Heterosexual: Attracted to the opposite sex
- ♦ Homosexual: Attracted to the same sex
- ♦ Transgender: Umbrella term describing persons whose gender identity does not conform to gender norms associated with the gender they were assigned at birth; does not imply a particular sexual orientation
- ♦ Transsexualism: This is an outdated term and could be offensive to some clients. It should be avoided unless a client specifically requests to use this term. Persons who identify as the opposite gender from the one they were assigned at birth; some change their bodies hormonally and surgically to conform to their gender identity
- ♦ LGBTQIA+: Lesbian, gay, bisexual, transgender, queer or questioning, asexual, and intersex
- ♦ Many clients seek treatment from a provider of the same orientation
- ♦ Sexual behavior: The manner in which humans experience and express their sexuality; includes attracting partners, sexual interactions, and social interactions

Caring for Clients in the LGBTQIA+ Population

People with gender identity and sexual orientation outside of the perceived societal norms

- ♦ Have increased rates of mental illness
- ♦ Have increased high-risk behaviors
- ♦ Have increased attempts to end their own life

- Have increased lack of stable housing, especially youth
- Have less access to care because of provider or clinic bias

Because of the preceding, this population is often medically and psychiatrically underserved. The following are mental health statistics for the LGBTQIA+ population (National Alliance on Mental Illness [NAMI], 2023):

- LGBTQIA+ adults are more than twice as likely as heterosexual adults to experience a mental health condition.
- LGBTQIA+ people are at a higher risk than the general population for suicidal thoughts and attempts to end their own life.
- Youths who identify as lesbian, gay, or bisexual are almost four times as likely to attempt to end their own life compared to their heterosexual peers.
- 48% of all transgender adults report that they have considered suicide in the past 12 months, compared to 4% of the overall U.S. population.

Equity, diversity, and inclusion include the following ideals:

- Patient-perspective care values the viewpoint and preference of the individual (Carey, 2016).
- Intentionally create a welcoming environment that embraces diverse people, perspectives, and experiences.
- Clients, families, and communities are equal partners in promoting well-being.

Best practices are as follows:

- Allow people to self-identify
  - Pronouns or identified pronouns
    - Avoid using the term "preferred pronouns" as it insinuates that gender identity is a choice
    - Use requested names and pronouns
- Accept parents outside the mother–father dyad (e.g., two mothers can come into the ICU)
- Be respectful
- Ask about their lives and what is important in their care; accept the answers

The following are ways to navigate documentation and legal issues:

- Have a way to document in the EHR the requested name and gender if it does not match official documentation.

- Documented names and genders are needed only for legal items such as consents or prescriptions.
- It is acceptable to use preferred name and gender in notes if there is notation of this elsewhere in the chart.

Unique Medical Needs of Transgender Clients

There is no standard stage of physical transition. It is highly variable due to time since transition, various ages when transition starts, ability to have surgery or take hormones, and client preference. It is impossible to tell by visual exam.

Document the medications and hormones that the client is taking, plus a list of surgical procedures and an "organ list" that the client has presented. This will inform what preventive care and routine screenings are needed.

Examples include transgender men with breasts and traditionally female genitalia and sexual organs or transgender women with prostates and testicles.

The PMHNP needs to be aware of the policies and regulations impacting gender affirming care, which can vary by state.

The following are guidelines for medical or surgical transitioning (Coleman et al., 2022; World Professional Association for Transgender Health, n.d.):

- The diagnosis of gender dysphoria or gender incongruence is made by a mental health professional prior to surgical or medical treatment by an endocrinologist.
- A mental health professional needs to be involved in the diagnosis and treatment of gender dysphoria or gender incongruence in adolescents.
- The adolescent client has reached the Tanner stage 2 of puberty prior to the initiation of pubertal suppression.
- Gender affirming surgery is considered only after a minimum of 12 months of gender affirming hormone therapy.
- Mental health care is recommended due to the risk of side effects from the medications used and the stresses of transitioning.

Gender-Affirming Medical Treatment—Hormone Therapy (Unger, 2016)

Testosterone ("T"): Used as a monotherapy (US Food and Drug Administration [FDA] off-label use)

- Provided as intramuscular < subcutaneous (IM < SubQ) and topical formulations

- Risk of cardiovascular events, hyperlipidemia, and increased blood pressure when using testosterone; increased monitoring required
- Risk of increased depression and suicidal ideation
- Can interact with oral hypoglycemic agents with increased lowering of blood sugar

Leuprolide

- Hormonal suppression for male-to-female transition in combination with estrogen; off-label use
- Given as a depot shot, 1-month and 3-month formulations
- Increased risk of hyperglycemia and cardiac events when used with transgender women
- Possible psychiatric side effects include emotional lability, irritability, anger, and aggression

Estrogen

- Used to reduce the male secondary sexual characteristics
- Formulations transdermal or oral
- Concerns with prolonged use include breast cancer and decrease in bone density

Spironolactone

- A potassium-sparing diuretic; is also a mineralocorticoid receptor antagonist
- Given orally
- Commonly used in the United States as an aldosterone blocker in combination with estrogen due to higher cost and IM dosing of leuprorelin
- Potassium levels need to be monitored

FORENSICS AND CORRECTIONS

Deinstitutionalization began in the 1970s, leaving many with a mental illness or intellectual disability in need of housing in the community. One of the places that persons with a mental illness are overrepresented is in the criminal justice system (Kennedy-Hendricks et al., 2016, p. 1077). Persons in the prison system have higher rates of serious mental illnesses as compared to those in the community (Prins, 2014).

According to the Prison Policy Initiative (2023)

- 43% of the state prison population have a diagnosed mental health disorder

- 44% of those incarcerated in local jails are diagnosed with a mental health disorder
- 1 in 4 report experiencing serious psychological distress in jail
- 66% of federal and 74% of state inmates received no mental health treatment while incarcerated
- 27% of those incarcerated 3 or more times in 1 year reported a moderate or severe mental illness
- Mental health effects of being incarcerated
  - Posttraumatic stress disorder
  - Anxiety
  - Impaired decision-making
- 27% of police shootings in 2015 involved a mental health crisis

Unfortunately, lack of synchronized care among criminal justice, mental health, and public health systems results in repeat incarcerations (Baillargeon et al., 2010; Kushel et al., 2005). It is essential to remain neutral, calm, and objective and to be skilled in self-reflective techniques as well as acknowledging one's own emotional response and biases when providing care for imprisoned clients. Lyons (2009) recommends that the practitioner compartmentalize emotional responses and biases temporarily and debrief afterward.

- Forensic: The application of scientific knowledge to legal problems and legal proceedings, for example, in forensic anthropology, forensic dentistry, forensic medicine (legal medicine), forensic psychology, and forensic science
- Forensic science: The application of a broad range of sciences to answer questions of interest to the legal system; a high-technology field using electron microscopes, lasers, ultraviolet and infrared light, advanced analytical techniques, and computerized databanks to analyze and research evidence
- Forensic nursing: The practice of nursing when health and legal systems intersect; the forensic nurse provides direct services to individual clients; consultation services to nursing, medical, and legal agencies; and expert court testimony in areas dealing with trauma or investigations of questioned deaths, adequacy of services delivery, and specialized diagnoses of specific conditions as related to nursing

FORENSIC VERSUS CORRECTIONAL

- Forensic: Nurse–client relationship based on crime committed and investigational aspect of the interaction

- Correctional: Nurse–client relationship based on offender's current mental health and medical conditions
- Locations: Emergency departments, prisons (high-, medium-, and low-security units), courts, and police stations (Lyons, 2009)

Forensic Knowledge Base

- Relies on evidence-based practice as well as past clinical experience
- Incorporates both criminal justice and mental health systems
- The forensic PMHNP should possess theoretical and practical knowledge of the criminal justice and mental health systems.
  - Function of the court
  - Litigation procedures
  - Workings of the criminal justice system
  - Relevant case law and health litigation
  - Understanding of mental health, distorted thinking patterns, and impaired cognition
  - Areas of competence and skill: safety, security, management, and assessment of risk; management of aggression and violence; therapeutic relationship; offending behavior knowledge; prison culture; documentation; medical knowledge; psychopharmacology; and crisis de-escalation (Lyons, 2009)

Forensic Risk Assessment Versus Risk Assessment

- Forensic risk assessment: "Aims to asses whether a patient is a risk to themselves or others in terms of serious violence, dangerousness, absconding, and recidivism now or in the future" (Lyons, 2009, p. 53)
- Risk assessment:
  - Utilized throughout the process of interaction between the PMHNP and the client
  - May be initially performed in emergency department
  - Often implemented based on the need to keep the client safe and to protect healthcare workers
  - Should be continuous part of PMHNP's decision-making process to "predict and manage crises as they arise, control freedom of movement, and maintain safe levels of supervision and observation" (Lyons, 2009, p. 53)

CASE STUDY 1

A newly graduated PMHNP who worked as a psychiatric nurse before going to graduate school is considering a position at a community mental health center. The client population would consist of mainly adults with serious, chronic, and persistent mental illness; occasional children; clients in crisis; and emergent medical needs such as management of diabetes, hypertension, and chronic pain.

What does the PMHNP need to consider before accepting this position?

1. Is the PMHNP legally authorized to treat both children and adults?
2. What regulation, rule, or standard should be consulted to determine if the PMHNP is legally allowed to treat both children and adults?
3. What regulation, rule, or standard should be consulted to determine if the PMHNP is legally allowed to treat both physical and psychiatric disorders?
4. What is the role of professional psychiatric nursing organizations in assisting PMHNPs to determine the scope of practice that is appropriate for a new graduate?

The PMHNP decides not to take that job and instead has been working for about a year as a PMHNP in a nurse-managed primary mental health clinic. One day the PMHNP is asked to assess a client who is talking to people not present in the room, is anxious that other people want to harm them, and is expressing verbal threats against many persons at another clinical practice in town who had "malpracticed" them. The client is adamant that they do not wish any treatment and that they are not ill. To care for this client, the PMHNP must consider these questions:

5. Is the PMHNP able to treat the client if they do not consent to care?
6. What legal standards must be met to treat this client without his consent?

About 5 weeks later the previously mentioned client returns to the clinic for follow-up care. The client is clinically stable, on medication, and showing no active symptoms, and is interested in developing a relapse prevention plan and asks the PMHNP to assist them in this process. The PMHNP must consider thse additional questions:

7. Is the inclusion of a durable power of attorney an appropriate strategy in relapse planning for this client?
8. What quality indicators should be considered in planning the client's care with them?
9. What risk management and liability issues should be considered?

CASE STUDY 2

A PMHNP working in a rural mental health clinic is asked by a primary care provider to evaluate a 35-year-old client. The client insists they are not "depressed," but rather that they have been feeling understandably distressed after being fired from their job for excessive absenteeism related to "head, neck, and back pain." The client has difficulty falling and staying asleep, wakes up feeling tearful, and does not want to get out of bed. The client has become socially isolative and spends hours sitting in front of the television. For the past 6 months, the client has been taking 50 mg of amitriptyline that was prescribed by the primary care provider. After evaluating the client, the PMHNP decides that the criteria for major depression have been met and increases the dose of amitriptyline.

1. How should the PMHNP explain to the client their rationale for increasing the dose of the amitriptyline?
2. Because amitriptyline is a tricyclic antidepressant, is it reasonable for the PMHNP to continue and even adjust the dose of this medication—in other words, is this treatment within the scope of the PMHNP's practice?

ANSWERS TO CASE STUDY DISCUSSION QUESTIONS

CASE STUDY 1

1. The key word here is "legally." Professional standards and scope of practice documents suggest what is reasonable and prudent practice. Professional nursing organizations will provide information on what is seen as acceptable educational preparation for practice. However, the individual legislative regulations of each state determine what constitutes legal practice for each individual PMHNP.
2. The Nurse Practice Act and related legislation of the state in which the PMHNP practices will delineate the legal boundaries of their practice.
3. Professional standards and scope-of-practice documents suggest what is reasonable and prudent practice. The individual legislative regulations of each state determine what constitutes legal practice for each individual PMHNP.
4. Professional nursing organizations provide information through a scope and standards document about what is seen as an acceptable practice role for PMHNPs, but the PMHNP's practice is ultimately guided by the individual state's nurse practice act.
5. Any client, including a psychiatric client, has the right to refuse treatment. The PMHNP is legally and ethically bound to honor the client's rights.
6. The legal standard must be met in the state where the PMHNP practices to treat a client against their wishes. This usually entails performing the legal task of committing a client, and in most states, ensuring that the following criteria are met:
   - ◊ The person has a diagnosed psychiatric disorder.
   - ◊ The person is unaware of or unwilling to accept the nature and severity of disorder.
   - ◊ As a result of a mental disorder, a person is harmful to self or others.
   - ◊ As a result of a mental disorder, a person cannot take care of their basic needs of food, clothing, and shelter.
7. A durable power of attorney allows a person in a state of health to choose another person to act on their behalf should they become unable to make their own health care decisions. Chronic mental illness has the potential to render a person unable to make health care decisions, and a durable power of attorney document should be part of relapse planning.
8. Standardized client assessment and rating scales, evidence-based standards of care, and measures of quality, including client and family satisfaction, should be considered.
9. The PMHNP should adhere to standards and scope of practice and identify factors specific to this client that increase liability exposure.

CASE STUDY 2

1. The PMHNP must discuss the treatment plan in the context of the client's psychiatric symptoms. Without trying to convince the client that they have major depression, the PMHNP can discuss how chronic pain may have led to the distress that is currently being experienced and that the medication may address many of the distressing symptoms. The provider will also need to address the potential side effects from this tricyclic antidepressant and the usual course of treatment in terms of dosing and timeline.
2. Yes, if the PMHNP is using the medication to target the client's depressive symptoms and if it is believed that the benefit-to-risk ratio is reasonable in this instance, it is reasonable for the PMHNP to continue the medication and adjust the dose. The PMHNP must do all the relevant medical tests to prescribe this medication.

REFERENCES AND RESOURCES

Abood, S. (2007). Influencing health care in the legislative arena. *Online Journal of Issues in Nursing, 12*(1). https://doi.org/10.3912/OJIN.Vol12No01Man02

Accreditation Commission for Education in Nursing. (2023). *Accreditation manual*. www.acenursing.org/acen-accreditation-manual/

American Association of Colleges of Nursing. (2013). *CCNE: Commission on Collegiate Nursing Education*. www.aacn.nche.edu/ccne-accreditation/why-accreditation

American Association of Colleges of Nursing. (2021). *The Essentials: Core Competencies for Professional Nursing Education*. www.aacnnursing.org/Portals/42/AcademicNursing/pdf/Essentials-2021.pdf

American Nurses Association. (2000). *Medicare and "incidental to" payment: Coverage of nursing services in hospital outpatient clinics and emergency departments*. www.acenursing.org/accreditation-manual/

American Nurses Association. (2015). *Code of ethics for nurses with interpretive statements* (2nd ed.).

American Nurses Association, American Psychiatric Nurses Association & International Society of Psychiatric-Mental Health Nurses. (2022). *Psychiatric-mental health nursing: Scope and standards of practice* (3rd ed.).

American Nurses Credentialing Center. (2023). *Psychiatric-mental health nurse practitioner (across the lifespan) certification (PMHNP-BC)*. www.nursingworld.org/our-certifications/psychiatric-mental-health-nurse-practitioner/

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., Text rev.).

American Psychiatric Nurses Association. (2011). *APNA Board of Directors endorses APNA/ISPN Joint Task Force recommendation on the implementation of the 'Consensus model for APRN regulation: Licensure, accreditation, certification & education.'* ww1.prweb.com/prfiles/2011/03/07/8187513/LACE.pdf

American Psychiatric Nurses Association. (2022). *APNA Guidance regarding precepting and mentorship*. www.apna.org/resources/apna-guidance-regarding-precepting-and-mentorship/

Baillargeon, J., Penn, J. V., Knight, K., Harzke, A. J., Baillargeon, G., & Becker, E. A. (2010). Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders. *Administrative Policy in Mental Health, 37*(4), 367–74. https://doi.org/10.1007/s10488-009-0252-9.

Brownson, R. C., & Petitti, D. (2006). *Applied epidemiology: Theory to practice* (2nd ed.). Oxford University Press.

Buppert, C. (2021). *Nurse practitioner's business practice and legal guide* (7th ed.). Jones & Bartlett Learning.

Burgess, A. W. (1998). *Advanced practice psychiatric nursing*. Appleton & Lange.

Carey, T. A. (2016). Beyond patient-centered care: Enhancing the patient experience in mental health services through patient-perspective care. *Patient Experience Journal*, *3*(2), 46–49. https://doi.org/10.35680/2372-0247.1139

Coleman, E., Radix, A. E., Bouman, W. P., Brown, G. R., de Vries, A. L. C., Deutsch, M. B., Ettner, R., . . . Arcelus, J. (2022). Standards of care for the health of transgender and gender diverse people, Version 8. *International Journal of Transgender Health*, *23*(sup1), S1–S259. https://doi.org/10.1080/26895269.2022.2100644

Commission on Collegiate Nursing Education. (2023). *CCNE accreditation*. https://www.aacnnursing.org/ccne-accreditation

Cotroneo, M., Kurlowicz, L. H., Outlaw, F. H., Burgess, A. W., & Evans, L. K. (2001). Psychiatric-mental health nursing at the interface: Revisioning education for the specialty. *Issues in Mental Health Nursing*, *22*, 549–569.

Delaney, K., Chisholm, M., Clement, J., & Merwin, E. (1999). Trends in psychiatric mental health education. *Archives of Psychiatric Nursing*, *13*(2), 67–73.

Donabedian, A. (1988). The quality of care. How can it be assessed? *JAMA*, *260*(12), 1743–1748.

Edmunds, M. W., Horan, N. M., & Mayhew, M. S. (2000). *Adult nurse practitioner review manual*. American Nurses Association.

Farnam, C., Zipple, A. M., Tyrell, W., & Chittiinanda, P. (1999). Health status risk factors of people with severe and persistent mental illness. *Journal of Psychosocial Nursing*, *37*, 16–19.

Fineout-Overholt, E., Melnyk, B. M., & Schultz, A. (2005). Transforming health care from the inside out: Advancing evidence-based practice in the 21st century. *Journal of Professional Nursing*, *21*(6), 335–344.

Friedman, D. J., Parrish, G., & Ross, D. A. (2013). Electronic health records and US public health: Current realities and future promise. *American Journal of Public Health*, *103*(9), 1560–1567.

Friedman, M. (2002). *Family nursing*: *Research*, *theory*, *and practice* (5th ed.). Appleton & Lange.

Ford, L. C. (1992). Advancing nursing practice: Future of the nurse practitioner. In L. H. Aiken & C. M. Fagin (Eds.), *Charting nursing's future: Agenda for the 1990s*. J. B. Lippincott.

Harris, E., & Barraclough, B. (1999). Excess mortality of mental disorder. *British Journal of Psychiatry*, *173*, 476–481.

Health Resources and Service Administration. (2022). *What is telehealth*. www.hrsa.gov/telehealth/what-is-telehealth

Institute for the Future. (2000). *Health and health care 2010: The forecast, the challenge*. Jossey-Bass.

Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. https://pubmed.ncbi.nlm.nih.gov/24983041/

Institute of Medicine, Board on the Health of Special Populations. (2011). *The health of lesbian, gay, bisexual, and transgender people: Building a foundation for better understanding*. National Academies Press.

Jakubik, L. D., Eliades, A. B., & Weese, M. M. (2016). Part 1: An overview of mentoring practices and mentoring benefits. *Pediatric Nursing, 42*(1), 37.

Johnson, M., Maas, M., & Moorhead, S. (Eds.). (2003). *Nursing outcomes classification* (3rd ed.). Mosby.

Karlawish, J. (2021). *Assessment of decision-making capacity in adults*. UpToDate. https://www.uptodate.com/contents/assessment-of-decision-making-capacity-in-adults

Kennedy-Hendricks, A., Huskamp, H.A., Rutkow, L. & Berry, C. L. (2016). Improving access to care and reducing involvement in the criminal justice system for people with mental illness. *Health Affairs, 35*(6), 1076–1083.

King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay and bisexual people. *BMC Psychiatry,8*(70). https://bmcpsychiatry.biomedcentral.com/articles/10.1186/1471-244X-8-70

Kruks, G. (2010). Gay and lesbian homeless/street youth: Special issues and concerns. *Journal of Adolescent Health, 12*(7), 515–518.

Kushel, M. B., Hahn, J. A., Evans, J. L., Bangsberg, D. R., & Moss, A. R. (2005). Revolving doors: imprisonment among the homeless and marginally housed population. *American Journal of Public Health, 95*(10), 1747–1752.

Lyons, T. (2009). Role of the forensic psychiatric nurse. *Journal of Forensic Nursing, 5*, 53–57.

Macnee, C., & McCabe, S. (2000). Micro stressors: The impact of hassles and uplifts. In V. H. Rice (Ed.), *Handbook of stress and coping: Implications for nursing research, theory, and practice*. Sage.

Matlow, A. G., Wright, J. G., & Zimmerman, B. (2006). How can the principles of complexity science be applied to improve the coordination of care for complex pediatric patients? *Quality and Safety in Health Care, 15*, 85–88.

McBride, A., & Austin, J. (1996). *Psychiatric-mental health nursing: Integrating the behavioral and biological sciences*. W. B. Saunders.

McCabe, S. (2000). Bringing psychiatric nursing into the twenty-first century. *Archives of Psychiatric Nursing, 14*(3), 109–116.

McCabe, S. (2002). The nature of psychiatric nursing: The intersection of paradigm, evolution, and history. *Archives of Psychiatric Nursing, 16*(2), 51–60.

McCabe, S., & Macnee, C. L. (2002). Weaving a new safety net of mental health care in rural America: A model of integrated practice. *Issues in Mental Health Nursing*, *23*, 263–278.

McCloskey, J. C., & Bulechek, G. M. (Eds.). (2000). *Nursing interventions classification* (3rd ed.). Mosby.

Medical Record Confidentiality Act of 1995, S. 1360, 104th Cong. (1995). https://www.gpo.gov/fdsys/pkg/BILLS-104s1360is/content-detail.html

Mellow, J. (1968). Nursing therapy. *American Journal of Nursing*, *68*, 2365–2369.

Melnyk, B. M., Fineout-Overholt, E., Stillwell, S. B., & Williamson, K. (2010). The seven steps of evidence-based practice. *American Journal of Nursing*, *110*(1), 51–53.

Mirr Jansen, M., & Zwygart-Stauffacher, M. (2006). *Advanced practice nursing: Core concepts for professional role development*. (3rd ed.). Springer Publishing.

Nagle, M., & Krainovich-Miller, B. (2001). Shaping the advanced practice psychiatric nursing role: A futuristic model. *Issues in Mental Health Nursing*, *22*, 461–482.

National Alliance on Mental Illness. (2023). *LGBTQ+*. https://www.nami.org/Your-Journey/Identity-and-Cultural-Dimensions/LGBTQ.

National Center for Farmworker Health. (2023). *Migrant and seasonal farmworker demographics*. https://www.ncfh.org/naws-fact-sheet.html

National Organization of Nurse Practitioner Faculties. (2013). *Psychiatric-mental health nurse practitioner competencies*. National Panel for Nurse Practitioner Faculties.

National Organization of Nurse Practitioner Faculties. (2022). *Nurse practitioner role competencies*. National Panel for Nurse Practitioner Faculties. https://www.nonpf.org/page/NP_Role_Core_Competencies

Nettina, S. M., & Knudtson, M. (2001). *The family nurse practitioner review manual*. American Nurses Credentialing Center.

New York City Health and Hospitals. (2011). *To treat me you have to know who I am*. [Video]. YouTube. https://www.youtube.com/watch?v=NUhvJgxgAac

North American Nursing Diagnosis Association. (2000). *Nursing diagnosis: Definitions and classifications 1999–2000*.

Northouse, P. G. (2007). *Leadership theory and practice* (4th ed.). Sage Publications.

Padgett, D. (2020). Homelessness, housing instability and mental health: Making the connection. *BJPsych Bulletin*, *44*(5), 197–201. https://doi.org/10.1192/bjb.2020.49

Peplau, H. (1952). *Interpersonal relations in nursing*. GP Putnam's Sons.

Perese, E. F. (2012). *Psychiatric advanced practice nursing: A biopsychosocial foundation for practice*. F. A. Davis.

Prins, S. J. (2014). The prevalence of mental illness in U.S. state prisons: A systematic review. *Psychiatric Services*, *65*(7), 862–872.

Prison Policy Initiative. (2023). *Mental health*. www.prisonpolicy.org/research/mental_health

Reinhardt, A. C., & Ray, L. N. (2003). Differentiating quality improvement from research. *Applied Nursing Research*, *16*(1), 2–8.

Richardson, K. A., Cilliers, P., & Lissack, M. (2001). Complexity science: A "gray" science for the "stuff in between." *Emergence, Complexity and Organization*, *3*(2), 6–18.

Richardson, W. S., Wilson, M. C., Nishikawa, J., & Hayward, R. S. (1995). The well-built clinical question: A key to evidence-based decisions. *ACP Journal Club*, *123*(3), A12–A13.

Sadock, B., Sadock, V., & Ruiz, P. (2017). *Kaplan and Sadock's comprehensive textbook of psychiatry* (10th ed.). Wolters Kluwer.

Shea, C. A., Pelletier, L., Poster, E. C., Stuart, G. W., & Verhey, M. P. (1999). *Advanced practice nursing in psychiatric and mental health care*. Mosby.

Sherwood, G. D., & Horton-Deutsch, S. (2012). *Reflective practice transforming education and improving outcomes*. Sigma Theta Tau International.

Stuart, G. W. (2013). *Principles and practice of psychiatric nursing* (10th ed.). Mosby.

Substance Abuse and Mental Health Services Administration. (2023, June 13). *Lesbian, gay, and bisexual behavioral health: Results from the 2021 and 2022 national surveys on drug use and health*. U.S. Department of Health and Human Services. https://www.samhsa.gov/newsroom/press-announcements/20230613/samhsa-releases-new-data-lesbian-gay-bisexual-behavioral-health

Tarasoff v. Regents at the University of California, 17 Cal. 3d 425, 551 P. 2d 334, 131 Cal. Rptr. 14 (Cal. 1976). www.ojp.gov/ncjrs/virtual-library/abstracts/tarasoff-vs-regents-university-california-et-al-mental-health Retrieved August 1, 2023

Unger C. A. (2016). Hormone therapy for transgender patients. *Translational andrology and urology*, *5*(6), 877–884. https://doi.org/10.21037/tau.2016.09.04

U.S. Department of Health and Human Services. (2005). *Healthy People 2010*. Office of Disease Prevention and Health Promotion. https://wayback.archive-it.org/5774/20220415230712/https://www.healthypeople.gov/2010/

U.S. Department of Health and Human Services. *Mental health: A report of the Surgeon General*. Substance Abuse and Mental Health Service Administration, National Institute of Mental Health. https://www.loc.gov/item/2002495357/

U.S. Department of Health and Human Services. (2017). *HITECH Act Enforcement Interim Final Rule*.

U.S. Department of Health and Human Services. (2019). *Healthy People 2020: Lesbian, Gay, Bisexual and Transgender Health*. https://www.healthypeople.gov/2020/topics-objectives/topic/lesbian-gay-bisexual-and-transgender-health.

U.S. Department of Health and Human Services, Office for Civil Rights. (2013). Modifications to the HIPAA privacy, security, enforcement, and breach notification rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; other modifications to the HIPAA rules. *Federal Register*, *78*(17). https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

U.S. Institute of Medicine Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. National Academies Press. https://doi.org/10.17226/13128

U.S. Department of Health, Education, and Welfare. (1979). *The Belmont report*. https://www.hhs.gov/ohrp/regulations-and-policy/belmont-report/index.html

Ward, B.W., Dahlhamer, J. M., Galinsky, A. M., Joesti, S. S. (2014). *Sexual orientation and health among U.S. adults: National Health Interview Survey*, *2013*. National Center for Health Statistics. https://www.cdc.gov/nchs/data/nhsr/nhsr077.pdf

World Health Organization. (2023). International Statistical Classification of Diseases and Related Health Problems (ICD). https://www.who.int/standards/classifications/classification-of-diseases

World Professional Association for Transgender Health. (n.d.). *Standards of care version 8*. https://wpath.org/publications/soc8/