INVITED COMMENTARY

Psych NP-NC:
A Benchmark Graduate Nurse Practitioner Program for Meeting the Mental Health Needs in North Carolina

Victoria Soltis-Jarrett

UNC–Chapel Hill's Psych NP-NC program prepares clinically and culturally proficient nurse practitioners to provide psychiatric and mental health care in North Carolina areas that are medically underserved and have a greater number of health disparities. This article reviews the program and the role of its graduates and makes policy recommendations for improving mental health care in the state.

Setting the Stage for a Perfect Storm

There is an ongoing crisis in the mental health care system in North Carolina. It is a perfect storm, with multiple elements that are producing a culture of precarious, inadequate, and unsafe care. First, there is a disparate distribution and critical shortage of child, adult, and geriatric psychiatrists, both of which continue to prevail across the state, due, in part, to the state's rapid population growth, as well as to the declining number of specialty physicians [1-3]. Second, nearly two-thirds of North Carolina counties have also experienced a decline in accessible, affordable, and quality outpatient psychiatric services during the past decade, with many agencies opening up and then subsequently closing down across the state [2]. As a result, the number of admissions to the state psychiatric hospitals has increased, contrary to the goals and objectives of mental health reform outlined in 2001 by the North Carolina Department of Health and Human Services [4]. The overflow of patients who are not able to access or receive psychiatric treatment is then funneled into the emergency departments of North Carolina community hospitals, which are reporting burgeoning numbers of individuals with severe and persistent psychiatric illnesses. Such patients frequently wait an average of 63.1 hours, or 2.6 days, in the emergency department, because there are no available inpatient beds [5]. Third, providers and agencies who are approved by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and the Department of Medicaid Assistance to provide services are being inundated with individuals and families seeking mental health services, only to find that funding is limited or denied because of lack of state mental health funding. Providing safe, affordable, accessible, and high-quality mental health care is possible and needs to be a priority in North Carolina for its future.

This brief commentary will present the essential role of psychiatric–mental health nurse practitioners (PMHNPs) as part of the health care team, whether it is based in the community or in the hospital and/or is integrated into primary care or specialty practices. It will argue that PMHNPs are ideally poised—through their ability to implement professional psychiatric–mental health assessment and management, particularly in rural and remote areas—to help alleviate some of the disparities in the mental health workforce that exist across North Carolina. Three sections will focus briefly on (1) the history and role of PMHNPs; (2) the PMHNP graduate program at the University of North Carolina (UNC)–Chapel Hill, as well as its necessity to North Carolina; and (3) recommendations to assist state policymakers to ensure that this crisis can recede and be managed more effectively by use of PMHNPs, now and in the future.

The Advanced Practice Registered Nurse (APRN) and the Birth of the PMHNP: An Evolving Role Over the Course of 50 Years

The APRN in psychiatric–mental health was initiated in the 1950s, with a focus on the the unique interpersonal relationship that nurses developed with patients who were institutionalized in the psychiatric "asylums" [6]. The clinical nurse specialist (CNS) in psychiatric–mental health was the first APRN role at the graduate level in the discipline of nursing, and it has continued to evolve during the past 50 years. The role of a CNS builds on the generalist role of a nurse (which requires preparation with a bachelor of science degree in nursing and licensure as a registered nurse) with graduate, specialized education and training in psychiatric nursing, leading to the master of science in nursing (MSN).

In 1963, President John F. Kennedy introduced the Community Mental Health Act [7], an historic measure to provide community-based mental health care as an alterna-

Electronically published September 23, 2011.

Address correspondence to Dr. Victoria Soltis-Jarrett, School of Nursing, University of North Carolina–Chapel Hill, CB 7460, Carrington Hall, Chapel Hill, NC 27599 (vsoltis@email.unc.edu).

N C Med J. 2011;72(4):293-295. ©2011 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved.
0029-2559/2011/72409

tive to institutionalizing patients in the large state psychiatric hospitals that were overflowing with patients, many of whom were stable and able to return to their home communities [7]. The CNSs were at the core and foundation of this movement, which facilitated their role as equal members of a multidisciplinary team. Throughout the 1960s and 1970s, the CNSs (and their associated multidisciplinary teams) discovered that they were unable to meet the needs of the increasing numbers of individuals who presented to the community mental health centers (CMHCs). The problem was not that the patients were being discharged from the state hospitals, but that the CMHCs were being inundated by individuals who had never before had access to mental health care and were now seeking it.

Unfortunately, during the past 20 years the United States has seen the fall of the Community Mental Health Act, owing to a lack of funding and the onset of managed care. Primary care providers (PCPs) have been the mainstay and portal of entry into the health care system in most areas across the United States, and for the most part, they have been able to manage their patients who presented with symptoms of depression and anxiety. If treatment was unsuccessful, PCPs were more readily able to refer patients with challenging conditions to psychiatrists and/or CMHCs, for specialty assessment and treatment—until now. As the number of psychiatrists declined, the population grew, and the CMHCs slowly disappeared, PCPs (including NPs and physician's assistants *without* psychiatric education or training) began to struggle with managing the huge influx of individuals with severe and persistent psychiatric illnesses and developmental disabilities, as well as substance abuse and dependence.

It was at this time that the CNSs in psychiatric–mental health nursing began to diversify, and in some states they were given prescriptive authority, particularly in rural and remote areas where there were no psychiatrists. Their unique education and training provided a safe and accessible option for mental health assessment and treatment—one that combined a foundation of general nursing with graduate-level specialty skills from psychiatry, including the ability to prescribe psychotropic medications.

Nationally, there was also an outcry, from the discipline of nursing and from professional organizations representing advanced practice psychiatric nurses, for the development of a new role [8]. In 2000, the American Nurses Credentialing Center offered the first board certification examinations for PMHNPs, as a way to meet the mental health needs of the nation, as well as to advance the role of the PMHNP. Programs specializing in educating PMHNPs were growing in numbers, and by 2009, there were approximately 150 graduate schools of nursing in the United States. As the Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education is adopted and implemented nationally, board certification as a PMHNP will eventually be required, in all 50 states, to practice as a PMHNP [9].

Psych NP-NC: An Innovative Program That Offers a Solution

The UNC–Chapel Hill School of Nursing has established and maintained a graduate PMHNP program since 2004. This innovative program, now coined "Psych NP-NC," was launched to provide, implement, and sustain a competency-based program of graduate study (MSN or post-MSN certificate) that rigorously prepares NP students to become culturally sensitive and clinically proficient. At the completion of the program, graduates are eligible to sit for board certification as a PMHNP. Specific recruitment strategies were initiated in 2004, and in 2006 they were strengthened to target counties across North Carolina that have a declining number of psychiatrists and to identify and encourage nurses of minority and disadvantaged backgrounds to apply and complete the program at the UNC–Chapel Hill School of Nursing (to increase diversity among professional mental health care providers and multidisciplinary teams across the state). The spirit of the role of a CNS was maintained, with the future of advanced practice psychiatric nursing embraced. The overarching goal of the Psych NP-NC program remains to recruit and educate nurses at UNC–Chapel Hill so that they will return to their home community or county to provide essential psychiatric and mental health assessment and treatment, including prescription of psychotropic medications.

Psych NP-NC students must successfully complete rigorous graduate courses in advanced pathophysiology, advanced pharmacology, advanced physical assessment and diagnostic reasoning, and psychopharmacology. They are also educated about concepts addressing health across the life span and about translating theory into practice, through clinical courses that focus on clinical competencies, such as psychiatric interviewing, psychiatric diagnosis, neurobiology, psychopharmacology, and individual, group, and family psychotherapies. Throughout the program, PMHNP students are assessed to determine their level of clinical competency and cultural sensitivity and learn to use models of peer supervision and continuing education, to enhance their lifelong professional skills as a PMHNP.

To this end, the Psych NP-NC program has been successful in targeting a total of 67 counties and graduating 74 new PMHNPs during 2004-2011. Much of its success is attributable to a hybrid distance-educational program that minimizes travel and encourages students to remain in their home communities: students attend monthly on-campus classes and regular teleconference classes (and clinical supervision) from home or work. Three Advanced Nursing Education Traineeships totaling >$2 million from the Division of Nursing, Health Resources and Service Administration, US Department of Health and Human Services, have been instrumental in providing the fiscal support to make these sweeping curricular changes, as well as to recruit nurses into the program. Psych NP-NC has also partnered with (and

received funding from) North Carolina AHEC to explore, develop, and target the specific workforce shortages by linking with the Divisions of Nursing Education in nearly all of the North Carolina AHEC regions [10, 11]. The importance and success of this program for North Carolina has also been demonstrated by the North Carolina legislature's appropriation of scholarship funds for students who are enrolled and willing to commit to work in state-approved mental health agencies in the underserved targeted areas after graduation.

Recommendations for the Future of Mental Health Care in North Carolina

Four overarching recommendations were presented in a recent report produced by the Institute of Medicine of the National Academies (IOM), with support from the Robert Wood Johnson Foundation [12]. North Carolina is in an ideal position to meet these recommendations and to work toward resolving the mental health workforce crisis that exists across the state, by acknowledging the role and practice of PMHNPs, as well as by removing the barriers that limit PMHNPs from practicing to the full extent of their education and training. The Psych NP-NC program has consistently achieved excellence through graduate-level nursing education and training, and its graduates are well suited to become full partners, with physicians and other members of the multidisciplinary team, so that mental health care can be redesigned, accessible, and affordable. To this end, the Psych NP-NC program can be replicated and sustained as a benchmark for other states. The following are recommendations that will foster the ongoing success of this innovative program, as well as that of the role and practice of PMHNPs, now and in the future.

First, barriers related to scope of practice must be removed by redesigning the outdated regulation of NP practice in North Carolina that requires NPs to be supervised and "tied" to physicians in order to practice; doing so will conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules [9].

Second, third-party payers that participate in fee-for-service payment arrangements should be required to provide direct reimbursement to PMHNPs who are practicing within their scope of practice under state law.

Third, reimbursement codes should be developed for nontraditional settings (eg, primary care, pediatrics, women's health, and geriatrics programs) that can promote access to mental health care in mainstream health care, moving toward an integrative model of care.

Conclusion

The number of board-certified PMHNPs is anticipated to grow as part of a sustainable competency-based curriculum (ie, the Psych NP-NC program) at the UNC–Chapel Hill School of Nursing. PMHNPs are uniquely poised to be part of the swift change that is needed in North Carolina during the next decade to address the mental health disparities and workforce shortages. PMHNPs can provide safe, affordable, accessible, and high-quality mental health care in North Carolina now and in the future. NCMJ

Victoria Soltis-Jarrett, PhD, PMHCNS/NP-BC clinical professor and coordinator, MSN Psychiatric–Mental Health Program, School of Nursing, University of North Carolina–Chapel Hill, Chapel Hill, North Carolina.

Acknowledgments

Financial support. Division of Nursing, Health Resources and Services Administration, Department of Health and Human Services (to the Psych NP-NC program); North Carolina Area Health Education Centers (to the Psych NP-NC program).

Potential conflicts of interest. V.S. has no relevant conflicts of interest.

References

1. Ellis A, Konrad T, Thomas K, Morrissey J. County-level estimates of mental health professional supply in the United States. Psychiatr Serv. 2009;60:1315-1322.
2. Fraher E, Swartz M, Gaul K. The Supply and Distribution of Psychiatrists in North Carolina: Pressing Issues in the Context of Mental Health Reform. Prepared on behalf of the North Carolina Area Health Education Centers Program; the Department of Psychiatry and Behavioral Sciences, Duke University School of Medicine; and the Cecil G. Sheps Center for Health Services Research, University of North Carolina–Chapel Hill. http://www.shepscenter.unc.edu/hp/publications/Psychiatrist_Brief.pdf. Accessed August 8, 2011.
3. Thomas K, Ellis A, Konrad T, Holzer C, Morrissey J. County-level estimates of mental health professional shortage in the United States. Psychiatr Serv. 2009;60:1323-1328.
4. North Carolina Department of Health and Human Services (DHHS). State Plan 2001: Blueprint for Change. Raleigh, NC: DHHS; 2001. http://www.ncdhhs.gov/mhddsas/stateplans/sp2001/sp01-main11-30.pdf. Accessed August 8, 2011.
5. Akland G, Akland A. State Psychiatric Hospital Admission Delays in North Carolina. http://www.nami-wake.org/files/NAMI_Wake_State_Psych_Hospital_Delays_Report.pdf. Published August 6, 2010.
6. Peplau HE. Interpersonal Relations in Nursing. New York, NY: G. P. Putnam & Sons; 1952.
7. Manderscheid R, Henderson M. Mental Health, United States, 2000. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services; 2001.
8. Delaney KR. The psychiatric nurse practitioner 1993-2003: a decade that unsettled a specialty. Arch Psychiatr Nurs. 2005;9(3):107-115.
9. National Council of State Boards of Nursing. Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education. Prepared by the APRN Consensus Work Group and NCSBN APRN Advisory Committee. http://www.aacn.nche.edu/Education/pdf/APRNReport.pdf. Published July 7, 2008.
10. Mazzocco G, Soltis-Jarrett V, Hayes P. Meeting the need for graduate nursing education in a rural area: a collaborative model [poster]. Presented at: National AHEC Organization Conference; June 2006; Omaha, NE.
11. Soltis-Jarrett V, Hayes P. Providing rural mental health services: an alternative educational approach [poster]. Presented at: National AHEC Organization Conference; June 2008; Denver, CO.
12. Institute of Medicine of the National Academies. The Future of Nursing: Leading Change, Advancing Health. Washington, DC: The National Academies Press; 2011.