The Plight of the Psychiatric Clinical Nurse Specialist

The Dismantling of the Advanced Practice Nursing Archetype

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If there were an endangered species list for nursing practice, the psychiatric-mental health clinical nurse specialist (PMHCNS) would surely now be at the very top. Changes in the delivery of mental healthcare over the past 2 decades have clouded the value of the traditional PMHCNS role and pushed this specialist to the brink of extinction. The latest assault was the announcement by the American Nurses Credentialing Center (ANCC) in November 2011 that it was retiring the Adult and Child/Adolescent Psychiatric Clinical Nurse Specialist examinations as well as the Adult Psychiatric and Mental Health Nurse Practitioner examination by 2014. Currently certified PMHCNSs can renew their credentials using clinical practice hours and professional development activities. American Nurses Credentialing Center is making these changes to the certification examinations as part of the implementation of the new Consensus Model for APRN (advanced practice registered nurse) Regulation: License, Accreditation, Certification & Education, also known as the LACE or the APRN Consensus Model (www.nursecredentialing.org). After that date, any nurse wanting to pursue practice in advanced psychiatric nursing will have only 1 option—the Family Psychiatric Nurse Practitioner (across the life span) certification. With this announcement, we fear that the remaining PMHCNS programs will transition to nurse practitioner (NP) programs, leaving those of us who proudly hold the CNS credential to join the ranks of the endangered species. This would be particularly troublesome for child and adolescent psychiatric CNSs whose patient population lacks an adequate number of providers. Many CNSs are now asking how this could happen to the first and historically one of the most influential nursing specialty groups, is it inevitable, and what can we do about it?

HISTORY

The psychiatric clinical nurse specialist was one of the first formal advanced practice roles actualized. As envisioned by Hildegard Peplau and then developed at Rutgers University in the mid-1950s, PMHCNSs began by delivering highly specialized direct care services in state psychiatric hospitals, based on the central concept of the relationship with the patient. Psychiatric-mental health CNSs were educated at the graduate level to function as primary therapist for individual clients, provider of group therapies, and mentor and educator for nursing staff. Psychiatric-mental health CNSs eventually became responsible for program development in hospitals and clinics, providing organizational consultation for the organization/system and engaging in research, in addition to offering direct client care for the mentally ill and their families and educating nursing staff.

From the initial conceptualization of the PMHCNS, the CNS role continued to grow. Eventually, the CNS was defined as a nurse with graduate preparation (earned master’s or doctorate) who is a clinical expert in the diagnosis and treatment of illness and the delivery of evidence-based nursing interventions within a specialty practice area. In contrast to some other CNS specialties, CNSs in psychiatric mental health nursing have a dominant focus on direct care, often with prescriptive authority and including diagnosing mental disorders and initiating psychotherapeutic treatment.
role of the NP was developed to fill the gap in physician services in rural populations, thus was initially a physician substitute or extender in the community. Nurse practitioner educational programs continued to grow but were predominately postbachelor certificate programs with limited graduate degree options until the 1980s.

The 1990s ushered in the “decade of the brain” in mental health, which “was remarkable for the pace and magnitude of change in healthcare and information technologies, neuroscience, health economics, and health policy.” New understanding of the biological bases of mental illness, in a social and economic context emphasizing primary care, led to a huge shift toward medication management and the integration of care of physical and psychological conditions. As a result, the role of the NP as physician substitute or extender was elevated even further. What followed in the late 1990s was the introduction of a psychiatric mental health NP, and schools of nursing responded by developing diverse advanced practice psychiatric NP tracks in APRN programs (see Bjorklund for a discussion of programs). The previous curricular focus of the PMHCNS, which included psychotherapy, other relationship-based therapies, and organizational consultation, began to shrink as the whole specialty began moving, pushed by the economic climate, toward an NP model focused on medication management and care of physical and psychological conditions, a trend that mirrored the overall de-emphasis on psychotherapy in psychiatrist education and practice (for more details, see Bjorklund and Delaney and Handrup). The 2 psychiatric tracks, CNS and NP, were merged in some institutions and labeled as “blended programs.”

**CHALLENGES FOR THE PMHCNS**

With the high-profile public and professional perception of advanced practice nurse as a nurse who prescribes, the inclusion of the traditional nonprescribing CNS in the definition of advanced practice has been questioned. The role of prescribers in mental health, historically the psychiatrist, has also changed as schools of medicine focused on psychopharmacology and prescribing with less intensive education for psychiatry students in modalities of psychotherapy. The disciplines of psychology and social work are now the predominant identified providers of psychotherapy. Furthermore, over the last several decades, social work has successfully commandeered the mental health administrative hierarchy, and most community mental health centers, inpatient units, and other settings now have social workers in key influential/program development positions that previously were held by PMHCNSs. The cumulative effect of less value being placed on relationship-based therapies and nurse education and support, other disciplines taking over the role of program development, leadership and organizational consultation, and advanced practice nursing being defined by prescriptive authority has resulted in a devalued PMHCNS workforce that is left in very awkward circumstances and potentially jobless. Currently, nearly half (4357 or 49.8%) of advanced practice psychiatric nurses work as CNSs. This proportion will likely shrink with the education and certification changes prompted by the APRN Consensus Model. Further complicating the issue for PMHCNSs is the aforementioned trend of advanced psychiatric nursing educational programs toward a blended CNS/NP role with an overemphasis on the NP role, based on curricular requirements of the National Organization of Nurse Practitioner Faculties (NONPF), at the expense of the unique elements of the CNS role, leaving graduates uncertain of which certification examination they are adequately prepared for.

In 2005, ANCC and the American Psychiatric Nurses Association (APNA) convened a logical job analysis task force of which one of the authors (J.S.J.) was a participant. The group was charged with reviewing a bank of questions pertaining to the practice of psychiatric CNSs and NPs and determining areas of overlap and difference. This participant was struck by the lack of content questions relative to the complete CNS practice framework, which identifies 3 domains (spheres of influence) of CNS practice competencies and corresponding outcomes. The overwhelming majority of questions focused on the patient-client domain, and the preponderance of those questions focused on medication management and physical illness. There were very few, if any, questions reflecting advanced practice role functions pertaining to the organization/systems or nursing personnel domains. These concerns about missing content were raised during the final task force debriefings but were met with disinterest and subsequently dismissed.

Another key area of contention in the task force was how “therapy” was defined and understood. There are several recognized forms of psychotherapy, and should a provider claim to be able to offer these therapies, then said provider must be educated and supervised at the graduate level in order to practice. Examples of such therapies include psychodynamic and insight-oriented modalities, cognitive-behavioral therapy, Gestalt therapy, group psychotherapy, family therapy, and marital therapy. These high-level forms of therapy require rigorous training and years of clinical supervision to master. The foundation provided in graduate education is just the beginning. Inversely, there are lower levels of therapy such as supportive therapy and psychoeducation, which are learned at the undergraduate level and sometimes reinforced as starting points in graduate school. Any practicing psychiatric generalist nurse should be able to perform the supportive and psychoeducation type of therapies. For the 2005 logical job analysis task force, a
point of disagreement was the necessary skill set of an advanced practice psychiatric nurse to perform the higher levels of therapy. Although experienced PMHCNs were quick to identify the level of skill for each therapy, psychiatric NPs present tended to classify smoking cessation groups as formal psychotherapy when it would more accurately be categorized as psychopharmacology, a lower level of intervention requiring a less skilled provider.

Published in 2007, the results of the task force’s logical job analysis purported a 90% commonality between practice sets of the psychiatric CNS and the psychiatric NP. To the general reading public, this is probably interpreted as evidence for a fusion of the roles. However, 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 PMHCNs practice. In addition, questions about nonpharmacological 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.

The number of PMHCNs with certification has been declining steadily since 2005. Graduate programs from master’s psychiatric programs are opting to take the psychiatric NP certification examination. In 2009, APNA convened a task force, in which the first author (J.S.J.) was a participant, to evaluate “blended” programs and determine how well the programs were meeting the dual practice competencies for both the CNS and the NP certification examinations. This was difficult work because of a number of factors, specifically the contrast in the lack of national curricular standards for preparing PMHCNs compared with well-documented psychiatric NP curricular standards (developed by NONPF). In the end, it was agreed that graduates from blended programs should have a minimum of 150 hours of supervised clinical experience beyond the minimum 500 clinical hours required for preparation in 1 role. The extra 150 hours was intended to ensure that CNS content regarding the domains of organization/system and nursing/nursing practice was included. With the elimination of the CNS certification and role, how will these supervised hours, associated with elements integral to the uniqueness of the role, be carried forward?

Lack of consensus about psychotherapies provided by advanced practice psychiatric nurses and the corresponding required training and skills has spurred debate over what exactly is being taught in psychiatric NP programs as “psychotherapy” and by whom. The skills associated with these therapies may be introduced in “blended” programs. The overall emphasis in education has shifted to medication/medical management services resulting in marginalizing labor- and skill-intensive psychotherapies. This drift-away from psychotherapy not only in medicine but now in nursing is alarming; many, if not most, psychiatric disorders are most effectively treated with a combination of psychopharmacology and psychotherapy. Delaney and Handrup urge the use of psychiatric mental health CNSs to supervise psychotherapy experience in psychiatric mental health NP programs or else, with only psychiatric mental health NP faculty with little psychotherapy experience, risk losing the psychotherapy role. There is much ambiguity and inconsistency across the spectrum of psychotherapy education in psychiatric APRN programs.

Further distress is now felt in graduate educational programs preparing advanced practice psychiatric nurses. Many faculty members are prepared and credentialed as psychiatric mental health CNSs. Although the organizations involved, International Society of Psychiatric Mental Health Nurses (ISPN/APNA) National Task Force, have indicated that during the transition to a psychiatric mental health NP model as envisioned by 2015, faculty who are fully credentialed as CNSs would be honored, the pressure for these faculty to change their credentials is already beginning. Out of anticipation of needing alignment with NONPF curricular requirements, faculty who have practiced as seasoned psychiatric CNSs for decades are now looking for new language in their contracts, indicating that renewal of appointments is contingent on their becoming credentialed as a family psychiatric NP within a certain time frame.

**WHY THE SHIFT TO NP?**

For PMHCNs, we suggest that this shift to the NP role results from not only powerful forces in the mental health field but also our own doing. Many PMHCNs were comfortably focused on aspects of quality improvement for nursing staff, development of programs, and patient and system consultation, activities that could be considered behind the scenes and invisible. Others were focused on their psychotherapy and prescribing practices. Few published outcomes research. Few PMHCNs focused on the psychiatric nursing specialty debate in the 1990s between competing visions of what psychiatric nursing should be and how to define the future of psychiatric nursing. Did being invisible and not reclaiming turf prove fatal? We are so adept at navigating within the 3 spheres of influence, utilizing varied skills, generating great results, and making systems, administrators, and other providers look good, all the while failing to adequately and accurately document said results as outcomes of our practice and clearly identify these as unique aspects of our role. Nurse practitioner practice is more
focused on direct patient care with outcomes that are more easily quantified and compared with physician practice. As psychiatric-mental health NPs (PMHNPs) became more visible, PMHCNSs, with much of their practice being supportive and system focused, became more invisible by comparison, and mental health administrators began farming out traditional CNS responsibilities to other mental health providers when the decade of the brain shifted services and budgets to a focus on medication management and physical conditions. Growing efforts nationally to reach uniformity in advanced practice nursing education, certification, and regulation led to a question of what do we do with the CNSs? Although the November 2011 letter PMHCNSs received from ANCC describes the reason for the discontinuation of the PMHCNS certification as a move to align advanced practice psychiatric nursing with the national effort at achieving uniformity, other interpretations are likely. Documented as far back as 2005 was a steady decline (>40%) in applicants for the PMHCNS certification examination. The 2010 data indicate only 116 adult PMHCNS candidates sat for the examination compared with 511 Adult PMHNP and 381 Family PMHNP candidates. This continued decline in applicants no doubt financially stimulated ANCC’s decision about no longer offering the credential. We would also suggest that unreliable findings of the aforementioned study purporting 90% overlap of the roles of the psychiatric CNS and NP, pressure from the National Council of State Boards of Nursing to streamline regulation, waning support and changes in the vision of the psychiatric APRN role from the psychiatric nursing community, and lingering role confusion are what actually led ANCC to retire the PMHCNS certification.

IMPLICATIONS

If the psychiatric CNS role disappears after 2014, the advanced practice psychiatric nursing community will need to address what this means for the specialty and the people it serves. We hope the following questions will provoke dialogue and debate among our readers. We welcome letters to the editor.

1. How will the educational programs prepare PMHNPs for relationship-based care, psychotherapy, and knowledge of complex healthcare systems in addition to diagnosing and prescribing psychotropic medications? Can consumers expect to obtain formal psychotherapy from PMHNPs if desired, or will they have to go to another mental health provider?
2. How will educational programs utilize the rich experience, skill, and knowledge of PMHCNSs in the preparation of the future advanced practice psychiatric nurses?
   a. Will PMHNPs be educated for the consultation/liaison role and provide services, such as identification and treatment of people with undiagnosed psychiatric disorder or coping problems, and preventive care, to both individuals and organizations?
   b. Will PMHNPs be educated/willing to participate in research or quality assurance initiatives in healthcare systems to improve outcomes?
   c. Will PMHNPs fulfill the mentoring role, including activities such as encouraging psychiatric nurses to obtain education at graduate levels and certification and pairing potential leaders with mentors?
   d. Will PMHNPs be educated to serve a system in the capacity of developing programs to meet an organizational need based on the understanding of organizational theory and change theory?
3. In some states, psychologists have prescriptive authority. If this trend continues (as many predict), what does this mean for those PMHCNSs or PMHNPs whose practice is solely based on medication management and who are more expensive than psychologists?
4. How is the PMHNP role different from that of the emerging psychiatric physician’s assistant?

THE WAY FORWARD

So what to do now with a specialty eligible for the protected list?

First, scientifically rigorous studies are needed to validate the differences between the psychiatric CNS and NP practice. The results then should be framed within the 3 established spheres of CNS influence to illustrate the differences in practice between psychiatric CNSs and psychiatric NPs. Psychiatric CNS competencies and curriculum guidelines should then emerge to guide educational programs in the same way NONPF guidelines guide psychiatric NP curricula.

Second, actively reclaim turf that has been given up to other disciplines. Psychiatric CNSs need to reemerge as leaders, policy makers, and directors of mental health centers and units. Not until psychiatric CNSs can be viewed again more broadly beyond clinical practices that overlap with psychiatric NPs will their actual value be appreciated.

Third, the LACE model itself recognizes the unique scope of practice of the CNS as distinct and separate from other APRNs. If the retirement of the psychiatric CNS examinations come to pass, how does the profession reconcile this disaffirmation? Does this not invite scrutiny of the commonalities between other CNS specialties and NP practice? Vigorous efforts to preserve the ANCC Psychiatric CNS examinations should begin based on these arguments. The ISPN, APNA, and ANCC should be contacted regarding the above via letter or e-mail. Membership in ISPN and APNA is important. If members disagree with the
position that their organizations are taking on such key issues, then they need to communicate!

■ Fourth, key elements of the CNS role need to be preserved. The blueprint for the advanced practice psychiatric nurse education contains elements that clearly have roots in CNS education. The legacy needs to be rightfully credited as CNS scope of practice and not assumed to have passed into the public domain.

PARTING THOUGHTS
The PMH CNS as envisioned and implemented by Peplau remains a crucial, viable, and relevant component in today’s consumer-driven, recovery-oriented, and evidence-based mental healthcare. Individual consumers are able to obtain high-quality individual, family, and/or group therapy services. Psychiatric-mental health CNSs with prescriptive authority are able to offer pharmacological interventions, thus providing the consumer with the full scope of expert care. Organizations benefit from expert system consultation, and nurses receive unparalleled mentoring, education, and support for evidence-based practice. The mental health landscape is changing rapidly and becoming more challenging in terms of cost-effectiveness and efficiency of services, especially in community mental healthcare. Staffs are being asked to do more with less, and the more multiskilled one is the more invaluable. The future APRN providers and coordinators of mental healthcare will need to be adept in complex case management and systems navigation, in addition to serving as providers of psychopharmacological and psychotherapeutic interventions. Once clearly articulated, evidence and rationale exist for both the CNS and NP roles. The strength of the traditional psychiatric PMH CNS role is well suited for current and future challenges, particularly as applied to the struggling community mental health area. A provider who can serve in many capacities, such as within the myriad of traditional psychiatric CNS roles of program director, psychotherapist, case manager, medication prescriber/manager, research coordinator, grant writer, and clinical supervisor, would be an ideal match for these needs. The time has come to rescue this indispensable specialty role from the brink of extinction.

References