Acknowledgements

The ARNNL wishes to acknowledge the registered nurses who participated in the consultative process leading to the development of this document.

Anna-Marie Kean, RN, BN, CPMHN(c), Author and Member of the Advisory Group on Community-Based Psychiatric Mental Health Nursing.

These include:

- Advisory Group on Community-Based Psychiatric Mental Health Nursing:

- Psychiatric/Mental Health Nurses Special Interest Group of Newfoundland and Labrador (PSIGNAL).

- Individual nurses and key stakeholder group representatives for their feedback on the consultation document.

ARNNL Resource Persons: Pegi Earle RN, MScN, Executive Director
Pamela Faulkner Baker RN, MN, Project Leader
Table of Contents

Introduction .................................................................................................................. 1
Background .................................................................................................................. 1
Community Based Psychiatric Mental Health Nursing ............................................. 3
Therapeutic Relationships ......................................................................................... 4
Scope of Practice ....................................................................................................... 5
Community Based Psychiatric Mental Health Nursing Roles ............................... 6
  Community Psychiatric Mental Health Nurse as Direct Care Provider ............... 6
  Community Psychiatric Mental Health Nurse as Counselor ......................... 7
  Community Psychiatric Mental Health Nurse as Addictions Counselor ...... 7
  Community Psychiatric Mental Health Nurse as Crisis Worker ................. 8
  Community Psychiatric Mental Health Nurse as Advocate ............................ 8
  Community Psychiatric Mental Health Nurse as Case Manager .................... 9
  Community Psychiatric Mental Health Nurse as Educator ............................ 9
  Community Psychiatric Mental Health Nurse as Consultant ...................... 10
  Community Psychiatric Mental Health Nurse as Researcher/Evaluator ....... 10
  Community Psychiatric Mental Health Nurse as Community Developer .... 11
  Community Psychiatric Mental Health Nurse as a Member of a Profession ................................................................. 11
Preparation for Practice ......................................................................................... 12
Key Issues Affecting RNs in Community Psychiatric Mental Health Nursing ............ 13
Perceptual Issue ....................................................................................................... 13
Professional Identity .............................................................................................. 13
Advancing the Role of the Psychiatric-Mental Health Nurse in the Community

Human Resource Issues ........................................................................................................... 13

Human Resource Planning ..................................................................................................... 13
  Lack of Clarity and Blurring of Roles .................................................................................. 14

Impact of Collective Agreements ......................................................................................... 15

Organizational Issues ........................................................................................................... 15
  Workload and Infrastructure ............................................................................................... 15
  Changes in Program Philosophy and Types of Work .......................................................... 16
  Preparation for Workforce Redeployment ......................................................................... 16

Education Issues .................................................................................................................. 16

  Introduction ....................................................................................................................... 16

  Competencies for Entry to Practice as Community-Based Psychiatric Mental Health Nurse .................................................. 17

  Continuing Education ....................................................................................................... 18
  Credentialing ...................................................................................................................... 18

Future Vision .......................................................................................................................... 19

Strategic Directions and Recommendations ........................................................................ 20

Conclusion ............................................................................................................................ 21

References ............................................................................................................................. 23

Appendix A: Framework for Therapeutic Relations ................................................................. 29

Appendix B: Competencies for Nurses in Community-Based Psychiatric Mental Health Nursing ................................................................................................................. 31
Introduction

ARNNL believes the public should have access to a range of mental health services that focus on promotion of mental health, recognize the role of economic and social factors in mental health and are comprehensive, accessible, community-based, and non-stigmatizing (ARNNL ENDS, 2008).

As trusted health care professionals, nurses have a responsibility to the public to continue to expand their knowledge and understanding of the concepts of mental health and mental illness while delivering competent, safe, ethical, psychosocial, physical, and spiritual care to people with mental illnesses, their caregivers, their families and communities (Canadian Federation of Mental Health Nurses [CFMHN], 2006). Psychiatric/Mental Health (P/MH) nurses have historically been at the core of provincial mental health services where they have proven strengths and abilities in providing high quality care. With the shift in focus of mental health services from the institution to the community over the past several decades, the P/MH nurse’s role in community-based settings has not been well developed. P/MH nurses in all regions of the province report there is lack of clarity about their role and scope of practice and moreover, that few nurses are working in community based roles. ARNNL believes P/MH nurses are underutilized in our province and when working within an interdisciplinary collaborative health team they have the potential to play a greater role in the care of mental health consumers.

Background

ARNNL has long advocated for the development of community based mental health services and support for an expanded role for mental health nurses in the community (ARNNL, 1994, 2001a, 2001b 2004). P/MH nursing practice spans the full continuum of care providing comprehensive mental health services necessary for the promotion of mental health and the prevention, treatment, management, and rehabilitation of mental disorders of individuals/families/communities across the lifespan (CFMHN, 2006). ARNNL believes P/MH nurses working in interprofessional collaborative partnerships have a valuable contribution to offer clients and are essential to realizing the Provincial Policy Framework: Working Together for Mental Health (DHCS, 2005).

The social and economic burden of mental illness is increasingly visible in our communities with one in five
Canadians likely to experience a mental illness in their lifetime; the other 80% of Canadians will have friends or family members who are affected (Health Canada, 2002; Mood Disorders Society of Canada, 2006). Mental health problems are the most costly health issues in Canada with an estimated $14.4 billion in lost productivity (Stephens & Joubert, 2001). Significant to PMH nursing practice is the recent research on the neurophysiology of the brain that has contributed to an increased understanding of the fundamental processes underlying thought, emotion and behavior (Satcher, 2002). While the findings of recent research have shown that many physical and psychosocial interventions have been successful in treating most mental illness and mental health problems, more research is needed on strategies of health promotion and the prevention of mental illness. Barker (1999a) declares that a limitation of technology and the hard science of medical inquiry is that it tells us nothing about health and the human experience of distress (mental or physical). Stigma, embarrassment and shame are very real obstacles to seeking treatment and having a chance for recovery (Kirby & Keon, 2006). Equally disturbing are the multiple forms of discrimination that persist in our communities in areas such as housing, employment, disability benefits, and educational opportunities. The harsh reality is that as a result of stigma, there are many people (crossing all boundaries in society including: age span, occupation, and culture) who are not seeking treatment and who are suffering further psychological disability and related mental health problems in many other aspects of their lives (Health Canada, 2006a).

In response to the population needs related to mental health problems and illnesses, the Government of NL has raised the priority of mental health reform with the enactment of new legislation, “Mental Health Care and Treatment Act”, and the adoption of the Provincial Policy Framework: Working Together for Mental Health. This framework encompasses broad health reform including the provincial wellness plan and long-term care initiatives. These important developments have implications for the nursing profession. The shift in focus of mental health and addiction services provision to a client-centered and a community-oriented comprehensive system of primary mental health and specialized services will increase access to mental health and addiction services, promote individual/family/community capacity and decrease the burden of mental illness in our province. Nurses are needed to provide specialized services in mental health promotion, prevention, maintenance and rehabilitation services to address needs of clients and their families in their communities (where they live, work, play, go to school).

When ARNNL’s landmark position paper on “The Role of Psychiatric Mental Health Nurses in the Community” was published in 1994 there were approximately 20 P/MH nurses providing a variety of community-
focused services in a small number of communities across the province. In 2002, a provincial Review of the Community Mental Health System compared trends in best practice in mental health service delivery across Canada and found,

“There is an inconsistent pattern of the types of professionals present by region. In the H&CS Boards, there is a predominance of social workers. While social workers bring one perspective and knowledge base there is a need for the knowledge and skills of nurses, psychologists, physicians, psychiatrists and occupational therapists” (The Institute for the Advancement of Public Policy, Inc., 2002, p. 46).

In 2006, approximately 34 P/MH nurses reported providing community-focused services in the province (ARNNL, 2007). Thus, there is clearly a need to ensure that community mental health interprofessional teams are balanced to respond to the complexity of community mental health issues. Nurses, along with other professionals, need to articulate and clarify their unique education, roles and functions and to highlight the valuable contribution they can bring to clients/consumers of mental health services in NL.

ARNNL supports the provincial government’s aim to provide quality mental health care by providing first line services including case management, counseling, crisis response, early intervention, assertive community treatment teams and supportive housing (DHCS, 2005). As changes are achieved in the organization of service delivery and P/MH nurses are given the opportunity to work in positions that identify full scope of practice, P/MH nurses will help to provide for timely access to a high quality, effective, client-centered, and safe health care service that is both sustainable and affordable now and into the future.

Community Based P/MH Nursing

The hyphenated name, ‘psychiatric’ and ‘mental health’ nursing refers to the nursing care of people moving interactively across a health-illness continuum who in their lifetime may stop at key points encountering ‘health-mental health’, ‘mental illness’, and ‘mental health problems’ for varying lengths of time (Chambers, 2006). Carper (1999) explains psychiatric-mental health nursing is a specialized area of nursing practice, education and research which draws on unique knowledge from nursing and related health and social sciences to inform practice and to establish its disciplinary boundaries (as cited in Whitehorne, 2006). Barker (1999a) contends that the concept of ‘health’ is a social construct that is influenced by language and culture. Mental illnesses are mental disorders defined by alterations in thinking, mood or behavior, while mental health problems consist of mental distress that does not meet the criteria for a mental illness (Health Canada, 2006b). The focus of P/MH nursing is not on the origins of the diagnostic categories of diseases but on people’s relationships with their illness or with

---

1 Data based on 2006-07 licensure year.
The proper focus of P/MH nursing will always be on the person’s unique lived-experience of illness and health.

...the P/MH nurse can “enter into partnerships with people, and through the use of the human sciences, and the art of caring, develop helping relationships”...

their health and the unique lived human responses to distress such as grief, anxiety, loneliness, and other psychosocial behavioral issues (Barker, 1999b; see also Barker, Reynolds & Stevenson, 1997). Barker (1999b) acknowledging the contribution of Peplau reminds us that the proper focus of P/MH nursing will always be on the person’s unique lived-experience of illness and health.

Population-focused health interventions and primary care are two interfacing areas of practice that have particular significance for community-based P/MH nursing. Population-focused health-mental health consists of a shift away from pathology and medicine to health, lifestyle and health promotion embedded within a humanistic philosophy, grounded in hope and the principles of recovery (Chambers, 2006). The goal of P/MH nursing is on achieving and maintaining optimal health-mental health, well being, and quality of life as defined by those receiving care. Community based P/MH nurses partner with other sectors outside of health to change attitudes of stigmatization to acceptance and support, and to facilitate social integration of all marginalized populations (the aged, the abused, the poor, and the mentally disabled).

Therapeutic Relationship

Fundamental and central to nursing practice and the primary intervention of P/MH nursing is therapeutic relationship or therapeutic alliance. In this therapeutic alliance the P/MH nurse can “enter into partnerships with people, and through the use of the human sciences, and the art of caring, develop helping relationships” (RNAO, 2006a; see appendix A). Put another way, “the art provides data about the person to illuminate the scientific understanding of the problem” (Peplau, 1988, p.14). Therapeutic relationship is a goal-directed relationship that is aimed at advancing the best interest and outcome of the individual/family/community along the full continuum of care. The therapeutic relationship is central to the many psychological therapies utilized in that relationship. A summary of up-to-date research evidence in psychological therapies reports that the therapeutic alliance is the single best predictor of benefit in psychological therapy, and not the particular therapy used (Department of Health, London, 2001). Acknowledging the work of Rogers and colleagues, Barker (1999) cites ‘people want more personal contact and understanding and less specialized treatments and techniques’.

Practice Example: A mother reporting on her daughter’s well being following a day surgery procedure stated that it wasn’t the success of the operation, or the amount of post-op discomfort that her daughter reported, but what was most significant on that day was that she was cared for by a compassionate and competent nurse- and that made all the difference.
**Scope of Practice**

Scope of practice, usually defined by specialty nursing organizations, refers to a specific body of knowledge which is operationalized as the range of roles, functions, responsibilities, and activities which registered nurses are educated and authorized to perform (ARNNL, 2006). The scope of practice of P/MH nursing spans the full continuum of mental health and mental illness providing comprehensive mental health services necessary for the promotion of mental health and the prevention, management and rehabilitation of mental disorders across the lifespan (Canadian Federation of Mental Health Nurses (CFMHN), 2006). The scope of P/MH nursing practice is guided by core standards of practice generic to all nurses as well as those unique to the P/MH specialty. These standards focus on the phenomenon of concern for community-based P/MH nursing which is the individual/family/community’s response to the experience of health and illness.

The Canadian Federation of Mental Health Nurses (CFMHN, 2006) developed seven standards of practice to provide direction in promoting competent, safe and ethical care in P/MH nursing practice, education, research and administration.

The seven standards of P/MH nursing practice are:

1. Provides competent professional care through the development of a therapeutic relationship;
2. Performs/refines client assessments through the diagnostic and monitoring function;
3. Administers and monitors therapeutic interventions;
4. Effectively manages rapidly changing situations;
5. Intervenes through the teaching-coaching function;
6. Monitors and ensures the quality of health care practices; and,
7. Practices within an organizational and work-role structure.

Each of the standards includes a set of interrelated and interdependent competencies that articulate to others what is the desired and achievable level of performance in the specialty area (see Appendix B).

---

**Practice Example:** A community-based P/MH nurse providing crisis intervention to an abused woman who reports that her 14-year-old son was charged for using crack cocaine. The nurse has a 14-year-old son of her own and is aware of her own feelings of sadness for the mother. The nurse comes to terms with her own feelings, and takes care to not lose objectivity and over-identify with the mother’s grief. The nurse searches for traits of resiliency, such as the mother’s tenacity, commends the mother for this strength, and assists her to mobilize this strength to deal with her son’s addiction.
Community-Based P/MH Nursing Roles

Community-based P/MH nursing is multi-faceted depending on the needs of the client and the skills of the nurse. The extent to which individual nurses working in community-based P/MH nursing positions fulfill the various roles will depend on their experience and educational preparation.

Nurses in specific roles (practitioner, mental health and addictions counselor, crisis worker, case manager, advocate, consultant) are also primary care providers. Inherent in these roles are competencies specific to providing population-focused health-mental health promotive and preventive care, community development, group work, and family systems nursing, as well as the treatment, management and rehabilitation of mental illness (Controneo, Outlaw, King & Brince, 1999, p. 31).

The World Health Organization has identified four components of the nurse’s role in primary health care: direct provider, teacher/educator, manager and researcher/evaluator (Canadian Public Health Association, 1990). Included in these four components are other specific roles, which include: counselor (mental health and addictions), crisis worker, advocate, consultant, community developer, case manager, and member of a profession. In presenting an outline of these roles it is not possible to describe every activity pertaining to the community-based P/MH nurse, therefore general activities will be described.

Community P/MH Nurse as Direct Care Provider

P/MH nurses at both basic and advanced levels provide direct care to the individual, group, family or community. Incorporating the nursing framework of health promotion and prevention with knowledge of relational practice and new advances in neurophysiology and psychopharmacology the community-based P/MH nurse has the ability to provide a biopsychosocial, integrated approach to care—especially with people who have higher levels of need in terms of severity, acuity or complexity.

Burgess (1999) outlines the following competencies of the P/MH direct care provider:

- considers the needs and strengths of the whole person, the family and the community to assess mental health needs, formulate diagnoses, and plan, implement and evaluate nursing care;
- collaborates with people and interprofessional partners to provide people with information to make informed decisions about their health;
- uses population-focused interventions that provide health prevention and early intervention initiatives;
- identifies and responds to people/group(s) most vulnerable to mental health problems;
- motivates and enables individuals and communities to take responsibility for their health and to make healthier choices;
- provides ongoing information and education to clients, other providers, other organizations, and the...
public about current and emerging mental health issues;
• promotes community acceptance of people with mental health problems;
• fosters and supports creativity and innovation in nursing practice;
• provides culturally-sensitive care;
• provides outreach and links people to services; and,
• provides liaison function with the hospital and the emergency department to support people when they return home.

Community P/MH Nurse as Counselor

Using the therapeutic relationship, the P/MH nurse performs the role of counselor to:
• help people focus on a goal(s) or outcome(s);
• help people develop strategies that support self-care and enable individuals and their families to take responsibility for and participate in decisions about their health;
• provide a range of services including: education, research and knowledge sharing; evidence-informed practices; system navigation; and communication;
• provide an opportunity for people to work towards living in a more satisfying and resourceful way;
• use a range of counseling skills based on counseling models such as interpersonal psychotherapy, cognitive-behavioural therapy and solution-focused therapy to improve an individual’s functioning and quality of life; and,
• help people to be supported, to gain insight, and to bring about change in thoughts, feelings and behaviour.

Community P/MH Nurse as Addictions Counselor

The role of the nurse in responding to problems related to psychoactive substance use is crucial. Nurses are underutilized in the addiction counselor role in this province. P/MH nurses as addiction counselors:
• provide intake coordination, assessment, treatment (including counseling, group therapies) and follow-up care for children, youth, adults, seniors and their families with addictions, mental illness and mental health problems using common assessment tools;

Practice Example: A person struggling with symptoms of depression and arthritis. Having knowledge of the interface of these two conditions, P/MH nurses can provide for integrated holistic care. In an interpersonal relationship built on partnership, the nurse interweaves psychosocial interventions (such as cognitive-behavioral therapy (CBT), narrative therapeutic methods, etc…) with the nursing process: holistic (bio-psycho-spiritual) assessment, naming the human responses to the problem/s, intervention/monitoring (including the pharmacological) and evaluation. Key skills provided relate to knowledge and understanding of the disorders, supervision/monitoring of medication, and application of psychosocial skills. With ongoing evaluation of outcomes, nurses can make appropriate referrals depending on the identified needs of the person and address issues of stigma associated with having mental illness.
• provide health promotion, prevention and early detection of problematic substance use;
• use core competencies and knowledge in addictions and a full range of withdrawal management services including detoxification services using best practice treatment protocols, outreach, prescribing, counseling, and harm reduction (Nkowane & Saxena, 2004); and,
• provide addiction counseling using motivational interviewing techniques to help clients effect change to live out their lives that fulfill their underlying hopes, beliefs and values.

Community P/MH Nurse as Crisis Worker

A shift in philosophy to a community-based mental health service delivery has significantly influenced the growth of crisis intervention services. As front-line workers, community P/MH nurses are in a unique position to provide a range of crisis services on multiple levels (individual, family, and community) to meet the needs of people of all ages experiencing a psychiatric and mental health crisis. The P/MH nurse as crisis worker:
• provides a comprehensive holistic biopsychosocial assessment including assessment of risk to life, mental status assessment (in cases of psychiatric history or current psychiatric disorder), physical assessment and identification of the client’s strengths, coping mechanisms and current support systems (Hoff, 2001);
• provides mobile outreach response in psychiatric and mental health crisis to provide rapid assessment and intensive home treatment services, reducing the likelihood of hospitalization;
• teaches and educates colleagues, families, family practitioners, police, community leaders and the general public, regarding crisis prevention and intervention (RNAO, 2006b); and,
• provides crisis intervention, referrals and linkages, and short-term follow up (RNAO, 2006b).

Community P/MH Nurse as Advocate

P/MH nurses working in the community are advocates for social justice issues and the needs of marginalized populations. These nurses challenge the many formal and informal power structures that contribute to people’s mental distress or are a barrier to their recovery. Together with intersectoral partners, e.g. justice, education and community organizations, other health care providers, and people/family/community, the community-based P/MH nurse:
• protects the rights of clients;
• acts on behalf of clients who are in need of particular skills on which their lives depend;
• ensures that an optimal level of mental health and addictions care is available and accessible to all people;
• helps people understand the impact of social determinants on health;
• supports people, families and communities in the utilization of political strategies to address inequities in the system;
• influences healthy public policy by
taking political action;
• influences key policy decisions by seeking leadership roles;
• networks with law enforcers to facilitate medical services for individuals who are at imminent risk of danger;
• takes responsibility to resolve the conflict that might exist between the needs of the organization and those of the clientele; and,
• educates the public and other health care professionals to eliminate stigma and to dispel myths of mental illness.

Community P/MH Nurse as Case Manager

Clinical case management is an identified best practice of mental health reform. The competencies of the P/MH nurse fit well with the role of case manager in:
• supporting people to function at optimal levels of health and to become self-sufficient;
• co-ordinating, negotiating and managing the care of complex patients;
• facilitating collaborative practice;
• teaching people and their families;
• providing therapeutic interventions to the client and family;
• providing supportive counseling, problem solving, medication monitoring and relapse prevention;
• teaching psychosocial rehabilitation;
• linking clients to other services in the community; and,
• participating on assertive community treatment teams.

Community P/MH Nurse as Educator

Knowledge is power. P/MH nurses facilitate empowerment of the population in the role of educator. In this role the P/MH nurse:
• provides education on a variety of mental health issues in a range of formats for individual, families, and populations;
• uses principles of child and adult learning appropriate to the target group;
• acts as a preceptor and mentor to students and novice practitioners in community mental health settings; and,
• provides continuing education with nurses and other health care providers on mental health and addictions.

Practice Example: When visiting with an individual recovering from bipolar illness, a community mental health nurse case manager noticed that this individual was slightly confused with a noticeable fine hand tremor. This nurse immediately suspected lithium toxicity. She advised this person to stop taking their medication and facilitated emergency medical intervention.
Community P/MH Nurse as Consultant

Consultation is a vital process to the viability of primary health care (DHCS, 2005). The P/MH nurse working in the community can be a resource who:

- shares specialized knowledge and expertise which comprise best practices and facilitates their application in practice settings;
- provides consultation and education to clients, nurses, other health care professionals, health care organizations and policy makers;
- maintains a clearinghouse for best practices; and,
- develops, implements and evaluates best practices and model programs of care.

Community P/MH Nurse as Researcher/Evaluator

To ensure that mental health and addictions programs are of the highest quality the P/MH nurse as researcher/evaluator:

- identifies and uses evidence-based research in decision-making and shares this research with clients to support them to make well-informed choices;
- participates in research projects at all levels to yield qualitative and or quantitative evidence pertaining to nursing practice, administration, education and research; and,
- develops a program of research into outcomes associated with improved integration of mental health and primary health.
**Community P/MH Nurse as Community Developer**

More than clinical health care services are required to meet a person’s mental health needs. To distribute resources fairly, population focused interventions are needed (DHCS, 2005). P/MH nurses can facilitate communities taking responsibility for improving mental health and prevention of mental illness by the following:

- designing and implementing mental health prevention and early intervention initiatives that build social networks, promote and support community capacity building;
- using many strategies to help strengthen individuals, families and communities; and,
- facilitating self-help and mutual-aid to strengthen the capacity of people to be self-reliant.

**Community P/MH Nurse as a Member of a Profession**

P/MH nurses are regulated members of the nursing profession who have the responsibility to:

- protect the rights of the individual and the family in matters relating to confidentiality and privacy;
- advocate for public awareness and understanding of mental health and illness;
- maintain standards of nursing practice and professional behaviour related to nurses’ ethical, moral and legal obligations in the community;
- seek opportunities for continuing education and participate in educational opportunities that promote an integrated and multidisciplinary approach to P/MH nursing practice;

---

**Practice Example:** A family caring for an aging parent who has been diagnosed with Alzheimer’s Disease has difficulty with coping and providing support to their adolescent who has recently been a victim of bullying at her school. A community-based P/MH nurse assesses the family to understand the meaning of the distress for them. The nurse helps the family to identify problems (inside and outside their control) associated with the experience of victimization as well as identified strengths; e.g. resiliency in family’s help seeking behaviour and the adolescent keeping social ties with friends. The nurse explores the meaning of the experience of victimization (distress). She conducts biopsychosocial assessment of symptoms of anxiety of the adolescent; provides cognitive behavioural interventions and strategies for the adolescent to manage anxiety; offers guidance to the family unit in mobilizing resiliency to manage the current feelings of victimization; monitors the coping and increase or decrease in anxiety; and, provides psychoeducation and supportive counseling to successfully manage or prevent further anxiety. Other nursing care may consist of: consulting with school guidance counsellor; providing information to the family on specific strategies to manage behavioral changes associated with the parent’s illness and advocating on behalf of the family to obtain supportive services for aging parent (day programs, respite). Further nursing action may identify these issues as an historical intergenerational community problem. The PMHN partners with the school, the public health nurse and local community organizations to take ownership of the problem and to find unique solutions.
• advocate for certification for advanced practice nursing roles in the community;
• use the results of research to promote quality nursing care, e.g., impact of community treatment orders on care;
• mentor students, colleagues and promote community based P/MH nursing as a career; and,
• clarify and advance community based P/MH nurses’ scope of practice.

P/MH nurses are in an “advantageous” position to address “reintegration of physical and psychosocial care of persons with mental illness” (McBride 1993 as cited in Burgess, 1997, p. 11). Integration of specialized mental health and addiction services into primary health care is a direction for reform outlined in the Provincial Policy Framework: Working Together for Mental Health (2005). People with serious and enduring mental illnesses have higher rates of co-existing addictions and/or co-morbid medical conditions requiring a holistic, integrated plan of health care delivery. In a health care system that has an increased need for this approach, P/MH nurses have skill sets that are complementary to the mental health team. Providing an integrated framework of care based on a health-mental health linkage is essential because it relates to the total mental health experience of people. The body and mind are viewed as a helix-intertwined and functioning as a system (Younge & Boschma, 2006, p.112). Thus, coexisting psychiatric and medical diagnoses, such as depression and arthritis, have reciprocal influences and contribute to a host of physical and psychosocial problems including emotional distress, impaired functioning, pain, and loss of freedom. (See practice example page 7).

Preparation for Practice

Younge and Boschma (2006) contend that within the nursing discipline there are a number of different routes of preparation at varying education levels “resulting in a wide ranging and varied professional tapestry” (p. 108). There are nurses who are diploma prepared and entered practice before the year 2000 who completed a post-basic undergraduate diploma program in P/MH nursing. The current educational requirement (since 2000) for RNs is a Baccalaureate in Nursing (BN) preparation.

Continuing education and advanced practice education are critical to obtaining and maintaining the knowledge and skills needed to continuously improve the quality of community-based P/MH nursing. P/MH nurses work in collaborative practice environments and share knowledge with other health disciplines, with community-based service organizations, and with a well-informed population. This specialized knowledge can be acquired through a variety of educational experiences including:
• Formal study and course-work beyond the post-basic level, (e.g. post undergraduate diploma, Clinical Nurse Specialist and Nurse Practitioner preparation, Doctoral programs);
• CNA certification in Psychiatric-Mental Health Nursing;
• Lifelong learning;
• Workshops, conferences and seminars;
• Staff development programs; and,
• Experiential learning.

Key Issues Affecting RNs in Community P/MH Nursing

Perceptual Issue

Professional Identity

The historical origins of the profession have contributed to the misperceptions of roles and scopes of practice. The hyphenated name of the discipline ‘psychiatric’ and ‘mental health’ evolved throughout history as the roles evolved to accommodate changes in practice. Today, some view the role of the P/MH nurse as providing ‘psychiatric’ care only, in which the orientation of practice is the medical paradigm, providing care for people with mental illnesses. This perception can delimit P/MH nursing practice expectations as it is exclusive of the valued competencies and roles of the nursing practice paradigm of the full extent of mental health and mental illness, including roles such as counseling and community development. As health care shifts to primary health care models of practice, more effective models of collaborative practice will be the norm. For nurses, this means that both medical and nursing paradigms of care, in collaboration, will improve the delivery of primary mental health care (Jardali, 2003).

Human Resource Issues

Human Resource Planning

The shift in services from institutionally-based to community-based under mental health reform, can pose complex problems for human resource planning and development that can create barriers to P/MH nurses working in community-based mental health services. A significant issue for human resource planners to resolve is: Who will do the work? There is a direct link between human resource planning/development and the quality/efficiency of program implementation (Health Canada, 2003). The Pan-Canadian Health Human Resource Strategy, formed to address challenges across the country with respect to human resource planning, outlines that Canada's ability to provide access to "high quality, effective, patient-centred and safe" health services depends on the right mix of health care providers with the right skills in the right place at the right time (Health Canada, 2006c, Background Section, ¶ 1). Galvin and McCarthy (1994) criticized community mental health teams for the random allocation of clients as opposed to the choosing of the most skilled team member. They argue that it is the client need that determines the most appropriate provider. Organizational policies and a lack of needs based human resource planning delimit P/MH nursing’s opportunity to work to full scope of practice; thereby, creating a barrier to the utilization of P/MH nurses as primary health care providers in community mental health care.

...both medical and nursing paradigms of care, in collaboration, will improve the delivery of primary mental health care (Jardali, 2003).
Besner and colleagues (2005) found that there was substantial role confusion within nursing and between nursing and other professional groups. They point out that in determining the most appropriate health care provider in human resource planning, it is important that decisions be based on an accurate understanding of the term ‘scope of practice’ which includes differentiating nursing roles (based on education, knowledge and skill base) and role enactment (actual practice as delimited by legislation, employer policies, experience, context of practice). Besner and colleagues (2005) conclude that the clarification of roles and the redesign of work to match the most appropriate type of provider required to meet the current and emerging needs of the population might reduce workload pressures that interfere with professionals working to their full scope of practice.

An example to illustrate the delimiting of nursing scope of practice is the role enactment of specialist addiction nurses in community mental health and addiction programs. In this province while P/MH nurses have cared for clients with addictions in institutions they are under-utilized in the community in the care of people with addictions. In a climate of increasing demand for specialists in addictions care and a trend to identify key occupational competencies, human resource planning must support a framework in which career progression of the P/MH nurse is supported in the specialty area of addictions (Clancy, Adenekan Oyefeso & Hamid Ghodse, 2007).

Lack of Clarity and Blurring of Roles

In the field of mental health, many interprofessional team members share common roles. Lack of clarity of roles causes misunderstanding among team members about the potential contribution of all team members. Team members, including P/MH nurses, report that the resultant impact is tension in the workplace, less than ideal interprofessional relationships, underutilization of team members in roles appropriate to their full scope of practice, and potentially the establishment of staff mix models that do not optimize quality of care or patient safety. In addition, Galvin and McCarthy (1994) note that the consequence of ‘role blurring’ (where all team members are expected to do generic work) fails to facilitate specialist professional skills. When roles are blurred, there are turf wars as each discipline tries to gain territory and/or they do not have a full understanding of the roles, responsibilities and skills of their interdiscipli

The goal is to work as a team where service is integrated.
of decision-making becomes the person and family in partnership and collaboration with health professionals. Roles overlap and tasks are assigned based on individual competence rather than on professional title. The responsiveness of today’s health care system can be strengthened through effective collaboration among health professionals (CNA, 2005b).

**Impact of Collective Agreements**

Another organizational barrier to nurses and other professionals working to full scope of practice is the posting of positions that nurses are educated and authorized to perform, with bargaining agents other than the NLNU. As a result, it is highly unlikely that a nurse will be awarded the position if a professional within the ‘posting’ bargaining unit has built seniority in that bargaining unit (for example, currently the mental health and addiction counselor and regional health educator positions are posted in the NAPE bargaining unit).

This process limits the selection of the most qualified professional for the job to serve the population. Villeneuve and MacDonald (2006) add, “Education, job design and responsibilities must change if we are to break down divisions within nursing and barriers between it and other professions” (p. 4).

**Organizational Issues**

**Workload and Infrastructure**

Community P/MH nurses report that time constrictions and heavy workloads impact on the ability to develop effective therapeutic relationships and constrains their ability to meet the needs of service users and their families. Effective therapeutic relationships have been identified as reliable predictors of patient outcomes (McGuire, McCabe & Priebe, 2001). Furthermore, clients have a right to a therapeutic relationship and organizations have a responsibility to enable the client and the nurse to develop and maintain a relationship (RNAO, 2006a).

**Practice Example:** In the Luther (2003) report of the Reid and Power Inquiry, it was pointed out that one of the greatest supports for Norman Reid was the community nurse who visited and provided support, advocacy and friendship. People heard shocking stories of Norman’s existence which consisted of isolation, discrimination and alienation from society. Community based P/MH nurse case managers are bridging the gap of connection of people to their communities. Individuals deserve the right to feel a sense of belonging and an opportunity to contribute as valuable members of society. Case managers help people define the relationship they have with their illness and to see themselves as individuals with underlying values, beliefs, hopes, dreams, and desires and who are not defined by their illnesses.
Appropriate workloads make time available to provide structured, evidence-based psychosocial care that provides early intervention and prevention of hospitalizations. Early evidence from the provincial case management demonstration project has shown that P/MH nursing case managers are achieving success in preventing relapse and thereby, improving overall mental health and well being.

Lack of necessary equipment to perform the role is a factor that limits nurses in carrying out their full scope of practice. For example, cell phones and access to information technology and medical infrastructure are essential to effective role performance as well as helping to ensure the safety of nurses.

Changes in Program Philosophy and Types of Work

Program philosophies and the way in which services are organized impact on the ability of the P/MH nurse to provide service delivery options and are subject to wide interpretation. For example, nurses report that new roles of case management have been organized to include both the roles of case co-coordinator and therapeutic agent as well as prevention and health maintenance services. Often these roles have competing demands. These nurses have less time to engage in therapeutic relationships with clients, thereby restricting the quality of the therapeutic intervention. Added to this are the challenges presented by geographical dispersion of the client population. A range of models of case management is needed to suit the varying levels of complex needs of clients.

Preparation for Workforce Re-deployment

Fundamental to the process of mental health reform is the deployment of nurses to meet the mental health needs of people in the community. This requires educating and reskilling nurses for community based mental health roles. Continuing education is critical to obtaining the knowledge and skills to continuously improve quality of care (Public Health Agency of Canada, 2003). Without plans to transfer nursing resources to the community, P/MH nurses are prohibited from optimizing their full potential. Thus mental health service options in the community are limited.

Education Issues

Introduction

The International Council of Nurses purports that “since mental health problems are common in all health settings and since physical problems often accompany a mental illness all nurses must have knowledge and skills to respond to people’s mental health needs (ICN, 1996).” P/MH Nursing is an essential component of the generic nursing program. Registered nurses have had undergraduate education in mental health promotion as well as knowledge of specific mental disorders as defined by the Diagnostic and Statistical Manuel of Mental Disorders (DSMIV) so as to be able to identify cases of psychosis, depression, demen-
Advancing the Role of the Psychiatric Mental Health Nurse in the Community

tia, anxiety and substance abuse. Community health nurses in some areas of the province provide selected mental health care to communities. These nurses are the first to acknowledge that their generalist knowledge is inadequate preparation for the full scope of practice of the P/MH specialty. Younge and Bochma (2006) indicate that inherent in a specialty focus is that extensive and expert knowledge is required to function effectively within a specialty. Therefore, P/MH nurses who have higher education, clinical experience and competent skills to provide quality mental health care are the most appropriate nurses to integrate comprehensive mental health nursing into communities (ARNNL, 1994).

Competencies for Entry to Practice as a Community Based P/MH Nurse

Many argue that there has been a dilution of the P/MH nursing curriculum content in the undergraduate baccalaureate program (Chan, Buchanan, Forchuck, Moore, Wessell, 1998; Cutcliffe & Mckenna 2000a; 2000b; Norman 2005 as cited in Lowe, 2006). Nurse educators at all levels debate about the most appropriate educational preparation for RNs for the future. They explain that it is impossible to know all of the new available research in any one area, therefore, education should be a ‘process’ and not a ‘product’ (Younge & Boschma, 2006, p. 115). It is argued that students who are taught the process of learning critical thinking and decision making will develop the skills and competencies needed for nursing practice in many settings. Nonetheless, in order for nurses to be prepared for future health care challenges (i.e., people involved in war combat, environmental challenges, threat of terrorism) their education must mirror the needs of society and address the effect of global issues as it relates to health and nursing practice.

Another curriculum challenge is finding suitable clinical placements that provide nursing students with the opportunity to experience the depth and full scope of practice of P/MH nursing practice. Lowe (2006) explains that as a result of the centralization of health services there is a lack of community mental health care professionals to provide preceptorship for students. Lowe (2006) contends that as a result of unavailability of placements, mental health clinical experiences might be considered “insufficient, inappropriate and unsuitable” which can potentially lead to a deficiency of clinical competency (p. 153). In certain provinces preceptorship models have been implemented in which the expert nurse mentors the novice nurse in order to facilitate the learning of the roles and responsibilities in a particular area of practice. Nurse preceptors report that the responsibility of mentoring increases their workload significantly and that to effectively mentor the novice nurse extra staff is needed. If we are to prepare nurses to respond to the rapid changes and global sociopolitical issues, we must ensure that the basic curriculum prepares nurses on both a theoretical and practice level to meet these challenges.

...inherent in a specialty focus is that extensive and expert knowledge is required to function effectively within a specialty.

...P/MH nurses who have higher education, clinical experience and competent skills to provide quality mental health care are the most appropriate nurses to integrate comprehensive mental health nursing into communities...

...for nurses to be prepared for future health care challenges (i.e., people involved in war combat, environmental challenges, threat of terrorism) their education must mirror the needs of society and address the effect of global issues as it relates to health and nursing practice.
Continuing Education

Continuing education encompasses: ongoing professional development, post-basic diploma preparation in P/MH nursing, degree programs (BN, MN, PhD) and CNA certification. Nurses must be committed to the philosophy of life long learning. Agency support is inadequate for the full range of continuing education opportunities. The Centre for Nursing Studies is developing a post-basic diploma program in P/MH nursing for registered nurses. This option will provide specialized knowledge that will prepare nurses to work in the P/MH specialty area. There is a need for advanced preparation at the master or doctoral levels, however, the opportunities for advanced preparation are limited in the numbers and types of graduate programs available. In addition, spaces and seats are limited. This restricts the availability of advanced practice P/MH nurse specialists and is a barrier to advancement of evidence-based research.

Certification is an important indicator to patients, employers and the public that the certified nurse is qualified and competent in a nursing specialty (CNA, 2007). In Canada, CNA defines certification as,

“a voluntary and periodic process (recertification) by which an organized professional body confirms that a registered nurse has demonstrated competence in a nursing specialty by having met predetermined standards of that specialty” (CNA, 2007).

Certification culminates in an examination, which after passing, an individual is awarded a credential. Certification is maintained by requiring hours of continuing education in that specific field of study (CNA, 2007). Unlike certification in the USA, the Canadian Nurses Association Certification designation does not credential nurses.

Credentialing

Gallop notes that while “the educational programs of P/MH nurses and clinical challenges are similar, the recognition of advanced practice psychiatric nursing in the USA and Canada is quite different” (Gallop, 2007, ISPN News and Events section, ¶1). Gallop points out that in Canada, there is no formal credentialing process for advanced P/MH nursing practice like other professionals, such as psychologists. Gallop explains that this has a profound effect on the professional development of the discipline as P/MH nurses’ specialist skills are rarely recognized in a formal sense. It has been the experience of nurses working in mental health care that when another professional with credentialing appears, they are deemed “more qualified”, and the nurse has been replaced (Gallop, 2007, ISPN News and Events section).

Furthermore, recognition for advanced practice nursing is absent in third party payment for some nursing services. Consumers of self-employed registered nurses who provide mental health counseling are denied reimbursement for counseling services. In comparison, reimbursement is made when another health care practitioner
with the same competencies as the self-employed registered nurse provides the service. This inconsistency limits client choice and direct access to registered nurse services (ARNNL, 2000). Consequently, due to the lack of formal recognition of P/MH nurses’ specialized care, many nurses who wish to have the opportunity to practice independently enter into other disciplines where they have an opportunity to operate in desired roles and bill third party payment.

**Future Vision**

In emerging health care environments, strategies to shift services away from larger institutions to community solutions based on choice and entitlement holds promise for the future (Lurie, 2005). Changes in demographics such as an increase in the aging population and changes in social phenomena such as emphasis on individualism (versus collectivism) will require nurses skilled in healthy aging knowledge, mental health problems, such as, grief and loss, and mental illnesses, such as, depression and dementia (CHMA, 2007). The approach of mental health services will be interdisciplinary, multisectoral and multi-faceted with improved performance measurement, and research across sectors. An important component of the mental health system are the broad determinants of health which play a significant role in people’s health. The formation of the Provincial Regional Interdisciplinary Teams will facilitate connection and collaboration among organizations, jurisdictions and sectors of the mental health system. Professionals will work less as individual health care providers and more as part of an interdisciplinary team in accordance with his/her competencies and skills, respecting the functions of others. The emphasis will be on providing integrated client-centered care that is coordinated and outcome-focused to promote health, prevent illness, care for illness, and manage health problems (Davis, 2006). New ways of working will require innovative solutions such as the Interprofessional Education Project to increase the collaboration skills of health care providers (McVicar, Deacon, Curran & Cornish, 2005).

According to Peplau (1994) throughout its history, the discipline of P/MH nursing has evolved in response to changing circumstances driven by professional, political and social agendas (as cited in Chambers, 2006). Future-oriented community-based P/MH nurses will continue to practice holistically with integrated views of wellness and illness, mind and body, the biomedical and the behavioural, focusing on an entire episode of illness rather than the acute part and its particular meaning for the people affected (Andolina, 1997). More qualitative research into mental health promotive and preventive measures will balance the limitations of quantitative methods in the social sciences. Themes of recovery and stigma reduction will be fundamental in mental health reform (Lurie, 2005).

As the emerging needs of the population change, traditional ways of working are supplanted by new roles. Changes in mental health legislation will result in greater roles for nurses. Under the new mental health legisla-
Advancing the Role of the Psychiatric-Mental Health Nurse in the Community

In the future, nurses will have new roles that provide them with legal authority to ensure treatment. Nurses will necessarily question whether these new roles will compromise underlying ethics and values of respect for self-determination. Shifts in health care policy to primary health care will require that nurses work to full scope of practice in providing increased community care, health promotion and prevention programs. New services such as crisis/home treatment and roles such as nurse consultant will be developed. As community partners, nurses will continue to strengthen partnerships with mental health and addiction community organizations and to advocate for individual/family/community social and health care needs to ensure that national/regional priorities reflect these needs.

To realize this vision the following Strategic Directions and Recommendations are proposed:

**Strategic Directions and Recommendations**

**Strategic Direction 1**

**Promote and Value the Scope of Practice of Psychiatric Mental Health Nurses (PMHN) in the Community**

It is recommended that ARNNL and Special Interest Group Psychiatric/Mental Health Nurses (PSIGNAL):

1. Advocate the valuable contribution PMH Nurses bring to clients/consumers of community-based PMH services in NL and in realizing the Provincial Policy Framework: Working Together for Mental Health.

1.2 Support community-based PMH nurses in articulating their roles and the positive impact on client health outcomes.

1.3 Share this position paper with Government, Regional Health Authorities, Regional Directors of Mental Health and Addictions Services, Provincial Wellness Advisory Council, Newfoundland and Labrador Nurses Union, Schools of Nursing, ARNNL Advisory Committee on Nursing Administration, employers, human resource departments, Consumers Health Awareness Network of NL, the Schizophrenia Society NL, the Alcoholic Anonymous, the Gamblers Anonymous, the Canadian Mental Health Association, and other relevant groups/persons; and discuss the contribution PMHNs can offer to clients/consumers with complex needs in the community and those of the community as a whole.

1.4 Educate Government, Regional Directors of Mental Health and Addictions, Regional Directors of Education, special interest groups, employers, managers, and nurses on the unique and shared/collaborative contribution PMHNs working in interprofessional collaborative partnerships can offer to clients in the community.

1.5 Educate registered nurses about the Competencies for Registered
Nurses in Community-Based Psychiatric Mental Health Nursing.

1.6 Ensure undergraduate nursing education programs continue to prepare nurses to meet the competencies for PMHN.

**Strategic Direction 2**

**Expand Psychiatric Mental Health Nursing Services in the Community.**

It is recommended that ARNNL and PSIGNAL:

2.1 Advocate to increase the number of community-based psychiatric mental health nursing positions.

2.2 Support community-based psychiatric mental health nurses to work to their full scope of practice as outlined in the policy paper.

2.3 Advocate that the Canadian Nurses Association lobby national health insurance companies to provide reimbursement for service provided by self-employed nurses.

**Strategic Direction 3**

**Promote the Availability of a Continuum of PMHN Education Opportunities from Entry Level to Advanced Practice.**

It is recommended that ARNNL and PSIGNAL:

3.1 Explore the availability of university recognized specialty education programs to support advanced competency development in community-based PMH Nursing.

3.2 Promote opportunities for employment in advanced practice roles in community-based PMHN, e.g. clinical, consultant/collaborator, educator, leader, and researcher.

3.3 Advocate to government, regional health authorities and employers for continuing education funding and advanced practice opportunities to enable community-based PMH nurses to develop, maintain and/or acquire necessary knowledge and competencies.

3.4 Advocate that regional health authorities provide mandatory preceptorship programs in the workplace for novice nurses and support preceptorship for nursing students, and that appropriate staffing adjustments be made to support the development of the mentoring relationship.

**Conclusion**

Community-based P/MH nurses in this province have established relationships with consumers that demonstrate they are skilled professionals who listen, understand and respond in a respectful manner. ARNNL acknowledges the tremendous value of registered nurses working in community psychiatric-mental health nursing positions. Accordingly, community-based P/MH nurses must continue to set their course on an expanding trajectory
guided by the emerging needs of the population, demographics, technology, practice patterns, evidential practice, and predicted changes that will occur in healthcare and the external environment throughout the twenty-first century.
References


Whitehorne, K. (2005). *Illuminating praxis: Applying theory to define a nurse’s role*. Unpublished manuscript, Memorial University of Newfoundland at NL.

Changes made to the Framework for Therapeutic Relationships – Figure 1 are highlighted below:

Appendix B

Competencies for Nurses in Community-Based P/MH Nursing

Community-based P/MH Nurses require a broad range of competencies (specific knowledge, skills, attitudes/attributes) to be effective in their roles. The following competencies are adapted from the Psychiatric/Mental Health Nursing Certification Exam Development Guidelines (CNA, 2005a).

Knowledge

Community-based P/MH nurses have a sound knowledge base in nursing theory, art and science as well as mental health, mental illness and aspects of community health/public health as it relates to the social determinants of health. This includes knowledge of:

- the art and science of nursing practice including principles/concepts/dimension
- the art of therapeutic relationship
- mental health and related sciences
- the developmental stages, process and milestones of normal physical, cognitive, social, and emotional development across the lifespan
- mental illness and effective nursing interventions including the following: anxiety; psychosis; alterations in mood; alterations in cognition; disturbances in personality; eating disturbances; alterations in attention, learning and development; safety concerns; psychological trauma; co-occurring disorders
- the process of addiction; knowledge of psychoactive chemicals; medical, psychosocial and family-systems models of substance abuse
- systems, services, procedures, supports and treatments, and options at points of screening, intake and assessments
- the biological sciences, psychopharmacology so as to understand better the mechanisms of medications, neurological basis of certain illness and the underlying pathophysiology of multiple diagnosis, and complementary therapies
- the synthesis of theoretical models and practices in mental health services including: bio-psychosocial models, systems theory, consultation theory, crisis intervention theory, recovery-based family systems and trauma models, wellness orientation models, loss/grief theory and adult learning theory; cognitive and behavioral approaches, narrative approaches, principles of community development and community capacity building and broader social determinants of health
- program planning, development, implementation and evaluation
- principles of interprofessional collaboration

Skills

In performance of the role of the community-based P/MH nurse, the following skills are used:

- assessment of individual and family health, screening and diagnosis
- mental status assessment
- assessment of the person’s response to illness and treatment, e.g., neuroleptic management syndrome, lithium toxicity, EPS
- crisis assessment, and crisis intervention
- a range of verbal and non-verbal communication skills to establish and maintain a therapeutic relationship
- assessment of the influence of the therapeutic relationship on the following: family dynamics; group dynamics; and milieu/environment
- establishment of boundaries for the therapeutic relationship
- an individualized approach in developing goals with individuals
- identification and utilization of appropriate interventions for each of the phases of therapeutic relationship
Advancing the Role of the Psychiatric-Mental Health Nurse in the Community

- identification and building on client strengths and resources for the promotion of coping strategies and problem-solving
- evaluation of therapeutic goals; negotiation and making compromises
- assessment of safety risk factors with a vulnerable population (e.g., person’s history, environmental factors)
- selection of the appropriate nursing interventions to work with individuals experiencing the following behaviors: suicidality; self-harm; self-neglect; addictions; homicidal ideation or behaviour; aggressive behaviour (e.g., toward objects or others); abuse (sexual, physical, emotional, verbal, neglect); assault (sexual, physical); anxiety and aggression; alterations in mood, thoughts and perception
- medication administration, education, and monitoring response to treatment
- implementation of appropriate health promotion, rehabilitation, relapse prevention and recovery strategies
- the relationship between documentation and accountability
- assertive communication, advocacy and political strategies

Attitudes and Personal Qualities

In performance of the role of the community-based P/MH nurses:
- respect self and takes care of self
- respect diversity by eliciting client’s beliefs, wishes, values, cultural beliefs and practices in all aspects of care
- respect client’s right to self-determination and the collaborative decision making process with client, colleagues and other members of the interprofessional team
- respect the functions of others, as collaborative partners of the team
- are receptive to continuous learning
- are self-directed and motivated to take responsibility for their own learning
- committed to values of social justice and equity
- respectful and sensitive of different cultural values, beliefs and practices
- are self-aware of personal and professional beliefs and values
- are open to giving clients opportunities to be responsible for themselves as individuals
- enters into a fiduciary relationship with people and has a legal, moral and ethical responsibility to maintain boundaries with people
ARNNL is the regulatory body and professional organization representing all Registered Nurses and Nurse Practitioners in the province. In pursuit of its vision, Excellence in Nursing, ARNNL exists so there will be public protection, quality health care, and healthy public policy.