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Integrating the 2013 Psychiatric Mental Health NP Competencies Into Educational Programs: Where Are We Now?

Mary T. Weber [a,*], Kathleen R. Delaney [b], Diane Snow [c]

[a] University of Colorado, College of Nursing, Aurora, CO
[b] Rush University College of Nursing, Community and Mental Health Nursing, Chicago, IL
[c] University of Texas at Arlington, College of Nursing and Health Innovation, Arlington, TX

A B S T R A C T

Since the introduction of the revised National Organization of Nurse Practitioner Faculties (NONPF) Nurse Practitioner Core Competencies and Population Focused Psychiatric Mental Health Nurse Practitioner (PMHNP) Competencies, a national forum took place to hear from many PMHNP program directors in the field comparing how they have integrated the lifespan competencies and the master's (MS)/or doctor of nurse practice (DNP) essentials into their curriculum. In this paper, we will report first on the major areas of change in the structure and content of the PMHNP-lifespan curriculum as well as the comments made by many faculty from across the country as to challenges and innovative strategies used to meet these challenges. We will review some of the major issues in content, pedagogy, and evaluation methods as well as examples of how these curricular elements have been infused into select programs across the country. We conclude highlighting several key areas, suggested foci for change, and how the specialty might focus attention and accelerate the significant growth we are seeing in PMHNP programs.

BACKGROUND

In 2008, the APRN Consensus Model was accepted as a national model for licensure, accreditation, certification, and education (LACE) for all advanced practice nurses, with full implementation expected by the end of 2015 (APRN Consensus Work Group, 2008). The model specified four roles for advanced practice registered nurses (APRNs): certified registered nurse anesthetist (CRNA), nurse practitioner (NP), clinical nurse specialist (CNS), and nurse midwife. Branching from these four roles are six populations: family (family nurse practitioner), adult gerontology (gero) (primary and acute care), neonatal, pediatric (primary and acute care), women's health, and psychiatric mental health (PMH) (see Fig. 1). Since the release of the Consensus Model, nurse educators in advanced practice nursing programs have been focused on aligning APRN programs with the model's population targets.

A major change for PMH educators was the APRN consensus model mandate that PMH educators prepare graduates to treat clients across the lifespan. Previous to the consensus model, advanced practice psychiatric nurses (APPNs) could choose as foci (a) psychiatric nurse practitioner (PMHNP) adult, (b) PMHNP family (lifespan), (c) PMH CNS adult, or (d) PMH CNS child/adolescent. After acceptance of the consensus model, there would be one pathway into practice for the specialty: the PMHNP with a lifespan focus. Because all PMH certifications were to be lifespan focused by the end of 2015, the psychiatric mental health CNS adult/child and the PMHNP adult certification exams would no longer be offered, although recertification is still available if the PMHNP-adult or PMH CNS (adult or child) complete the requisite practice requirements.

The APRN Consensus model and its lifespan population stipulation had several significant implications for PMH APRN education (Drew, 2014) and created significant turmoil within the specialty (Delaney, 2009). However, the changes also brought opportunities to grow the PMH APRN workforce, albeit in a new direction (Hanrahan, Delaney, & Stuart, 2012). Now, as the LACE model has been fully implemented, changes in the PMH APRN certification structure are in place and the PMHNP-lifespan certification is now the entry into practice.

With the Consensus Model's lifespan stipulation for all PMHNP programs, it followed that the PMHNP competencies guiding the educational programs would also need to be revised and updated. In 2011, this revision process was initiated by the National Organization of Nurse Practitioner Faculties (NONPF). The 2003 PMHNP competencies (NONPF, 2003) were revised by a group of PMHNP experts representing multiple stakeholders, including the American Psychiatric Nurses Association (APNA), the International Society of Psychiatric Mental Health Nurses (ISPN), the American Association of College of Nursing (AACN), and NONPF.[1] Psychiatric mental health APRNs from across the country validated the competencies and contributed comments and suggestions. The 2013 PMHNP competencies included core competencies

* Corresponding Author: Mary T. Weber, PhD, PMHNP-BC, FAANP, University of Colorado, College of Nursing, 13120 East 19th Avenue, Mail Stop C288-18, Aurora, CO, 80045.
E-mail addresses: mary.weber@ucdenver.edu (M.T. Weber), Kathleen_R_Delaney@rush.edu (K.R. Delaney), snow@uta.edu (D. Snow).

[1] At the same time NONPF competencies for family nurse practitioners, women's health; neonatal, pediatric acute care and pediatric primary care were also revised by expert panels within those specialties.

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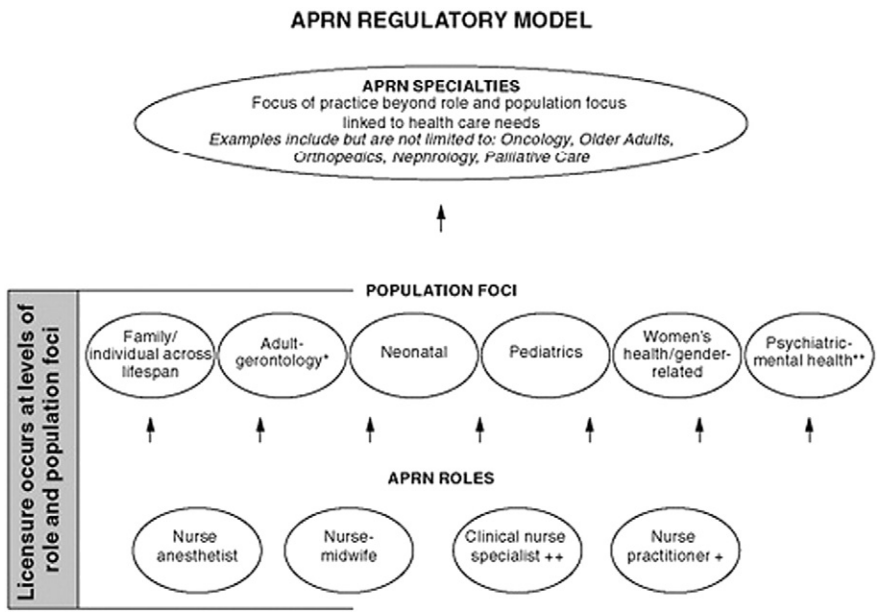

Fig. 1. APRN consensus model.

that were based on both the Master's and Doctor of Nursing Practice (DNP) Essentials for Graduate Education, Quality and Safety Competencies and Genomics competencies for the graduate NP. At the request of educational programs suggested content topics were also included in the revised competencies (NONPF, 2013).

The introduction of the 2013 PMHNP NONPF competencies dovetailed with the movement of all PMHNPs programs to a lifespan focus and for many the change to a DNP model of PMHNP preparation. Integration of the NONPF PMHNP 2013 competencies, the movement to a lifespan focus and the shift to a DNP curriculum have been challenging for many PMHNP programs across the country. During a NONPF armchair discussion the authors provided a forum to explore the success, challenges and barriers to implementing the PMHNP lifespan competencies (Weber, Snow, Delaney, & Vause, 2013). Also considered was the move to a DNP model of preparation. Issues were also raised by the audience including: didactic content, evaluation strategies and online challenges. Feedback and discussion gathered at the NONPF workshop afforded a sense of what areas of didactic and clinical training were presenting the greatest challenge in moving curriculum in line with the NONPF PMHNP-lifespan competencies.

In this paper we report first on the major areas of change in the structure and content of the PMHNP-lifespan curriculum as outlined in the NONPF competencies. We then consider the select areas that appear to present the greatest challenges and the approach several program directors are taking to address these challenges. Strategies to overcome barriers will also be noted. We conclude with suggestions for change in several critical areas and propose how the specialty might focus attention on these areas to accelerate the significant growth we are seeing in PMHNP programs.

PMHNP LIFESPAN COMPETENCIES: MAJOR CHANGES

The 2013 PMHNP competencies are significantly different from the previous edition of the PMHNP core competencies (2003) in that the revised version of the core competencies is in line with the doctor of nurse practice (DNP) essentials (AACN, 2006). Thus the competencies are no longer organized by the seven traditional NONPF domains but by the eight major areas of the AACN DNP essentials. Briefly these core competencies center on the following areas:

- Critiques and translates research and other forms of knowledge to improve practice processes and outcomes.
- Assumes complex and advanced leadership roles to initiate and guide change.
- Uses best available evidence to continuously improve quality of clinical practice.
- Integrates appropriate technologies for knowledge management to improve health care.
- Demonstrates an understanding of the interdependence of policy and practice.
- (NONPF, 2012).

Specific PMHNP competencies (NONPF, 2013) are consistent with the basic organization of all of the NONPF competencies but include competencies deemed essential for specialty practice. They include:

- Evaluates the appropriate uses of seclusion and restraints in care processes
- Applies supportive, psychodynamic principles, cognitive–behavioral and other evidence-based psychotherapy/-ies to both brief and long term individual practice
- Demonstrates best practices of family approaches to care
- Applies recovery oriented principles and trauma focused care to individuals
- Uses self-reflective practice to improve care
- Identifies the role of PMHNP in risk-mitigation strategies in the areas of opiate use and substance abuse clients
- Manages psychiatric emergencies across all settings
- Facilitates the transition of patients across levels of care
- Applies therapeutic relationship strategies based on theories and research evidence to reduce emotional distress, facilitate cognitive and behavioral change, and foster personal growth
- Uses appropriately individualized outcome measures to evaluate psychiatric care (NONPF, 2013).

These PMHNP competencies represent a significant departure from the 2003 PMHNP Competencies in its structure and crosswalk with current DNP and master's (MS) essentials.

In the next section, data are presented which were gathered by the authors during a workshop on the PMHNP competencies. The workshop afforded an opportunity to hear from 35 program directors and PMH faculty attending the session who reported on how they are faring with the adoption of the NONPF competencies including implementation challenges (Box 1).