The Psychiatric Family Nurse Practitioner: A Collaborator in Family Practice

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The potential of the psychiatric family nurse practitioner (Psych.F.N.P.) to contribute to family practice through physical care and mental health care exists in the here and now. This role is a synthesis of 2 advanced practice roles, the psychiatric clinical nurse specialist (Psych.C.N.S.) and family nurse practitioner (F.N.P.), both of which continue to have great utility independently. This synthesis is a practical application of concepts that have evolved to meet the changing patterns of health care delivery. At this time, dual certification as a Psych.C.N.S. and F.N.P. best reflects the broad practice expertise of the psychiatric family nurse practitioner. The experienced psychiatric family nurse practitioner provides direct care for both physical and psychological needs of patients in a family practice setting.

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Peplau[1] suggests that nursing care experiences with individuals, groups, families, and systems contribute to the evolution of the role of nurse and serve as the essence of the profession as a whole. This essential knowledge and experience are not always clear to those not of the nursing profession, who may only be aware of some parts of nursing and may at times view nursing with bewilderment, or even worse, disdain. Through discussion of advanced practice nursing, some unique features of primary care, and concepts of collaboration, this article will explore the potential of merging the traditionally separated disciplines of psychiatric clinical nurse specialist (Psych.C.N.S.) and family nurse practitioner (F.N.P.) into one clinician known as the psychiatric family nurse practitioner (Psych.F.N.P.).

ADVANCED PRACTICE NURSING

A clinical nurse specialist (C.N.S.) is a registered nurse, who, through study and supervised practice at the graduate level (master's or doctorate), has become expert in the knowledge and practice of a selected clinical area of nursing.[2] In order to fulfill the clinical nurse specialist's role, a nurse must have a client-based practice focusing on the patient/client and family and fulfill the subroles of expert practitioner, consultant, educator, and researcher. The psychiatric clinical nurse specialist also assumes the role of therapist.[3] Allowing for some variability in educational preparation, specialization, experience, and state practice laws, the psychiatric clinical nurse specialist is prepared in individual, group, and family therapies; psychoeducation and principles of adult learning; pharmacologic interventions; and substance abuse care. These skills have much potential for population-based care, analysis of care effectiveness through study and research, and correcting care deficits through changing the patterns of response of individuals, families, and the care delivery system.

Other advanced nursing roles include the nurse practitioner (N.P.) and family nurse practitioner. The nurse practitioner provides primary health care through nursing and medical services. The nurse practitioner's focus incorporates health promotion, disease prevention, and traditional medical activities such as performing assessments, ordering and interpreting laboratory workups, and prescribing medications.[3] The family nurse practitioner provides care for individuals and families throughout the life span. Although historically the nurse practitioner has been educated through a variety of programs, a minimum of a master's degree is the national standard.

Attaining certification through examination by the American Nurses Credentialing Center, or other approved process of accreditation, is required after degree attainment in most states. Certification is frequently a prerequisite for prescriptive privileges and state-sanctioned advanced practice. Laws governing practice vary from state to state, and the multifaceted struggles related to advanced practice nursing are many.[4] There exists no one certification examination that addresses the varying practice of the psychiatric family nurse practitioner. There are dilemmas in graduate nursing education related to the integration of the diverse curricula required for this diverse clinician. At present, dual certification as a Psych.C.N.S. and F.N.P. best reflects the expertise of the psychiatric family nurse practitioner. Discourse about titling and role descriptions and caution about merging

these 2 roles are evident in the literature, reflecting the beginning stages of role development of this evolving clinician.[3,5,6]

PRIMARY CARE

The demand for mental health interventions for a variety of conditions at the primary care level has changed over the years with both increased risks and benefits.[7] The conceptualization and treatment of anxiety and mood disorders at the primary care level have also changed, and the complexity of mental health care in family practice would startle most experienced mental health clinicians. The profile of mental health needs in primary care is complex and varied; primary care patients with mental disorders use more medical resources and have higher disability, illness, and mortality rates than other patients.[8] At times, patients' cultural contexts disregard mental health care, if indeed there is any belief in the need for such care; others agree to this type of care, but only within the context of the relationship of trust developed over time in the primary care/family practice setting.

With the experienced eyes of a psychiatric family nurse practitioner in the primary care setting, one would notice that the severity of psychosocial stressors during patient encounters in everyday practice is staggering. There is great need for counseling, patient education, and knowledge of community support to intervene effectively with patients and their families. The broad mental health background of the clinical nurse specialist is used during every patient encounter to understand the context of care and the approaches that will serve the patient best.

Today, the focus of service in the primary care setting is the patient, which is invaluable to those patients who do not have the motivational, emotional, or financial resources to pursue the mental health aspects of care, including counseling and medication management that historically have been unavailable in primary care settings. The removal of traditional barriers to continuity of care, especially the stigma still associated with mental health care, has provided many patients with necessary care while leaving patient care in the hands of the primary care provider. The hallmarks of a primary care mode of service delivery are its seamless process across the life cycle with clinician and record continuity and the delivery of culturally competent care with services characterized by mutual trust, respect, and accountability between clients and providers.[9]

COLLABORATION

For mental health providers to collaborate successfully in primary care, an understanding of primary care delivery is essential. Integrating mental health focus in the everyday encounters of primary care yields a biopsychosocial context for the chief concern of the patient and allows an opportunity for reframing at the beginning of care. Reframing is a technique that takes a situation and lifts it from one context and places it in another, offering an alternative understanding of that situation and providing new and different responses to it. This technique offers opportunities for self-agency and produces outcomes that have been historically unavailable to the patient.[10] A recent encounter with a 50-year-old patient with chronic problems of hypertension, diabetes, and depression illustrates the potential of the integration of care. Because the patient was stuck in repetitive, guilt-provoking, and unsuccessful pleas with her mother for some respite from the burdens of caregiving for her, the need for self-care was reframed as a necessary part of continued service to the mother instead of desire on the patient's part to care for herself. As a result, the patient was able to go to the library one afternoon a week for the first time in years and is gradually increasing her exercise with daily walks. All prior attempts to have this patient care for herself failed because the power of her guilt was not taken into consideration in the approaches to her care. Through a longitudinal course of care, it can become clear to patients that we have only some of the answers to their life dilemmas. Through our interpersonal relationships and therapeutic interventions, patients can begin to discover their own strength for responding to life and illness experiences.

Through collaboration between the family physician and the psychiatric family nurse practitioner, a spectrum of services historically fragmented are consolidated for patients and their families. Collaboration, a relationship of interdependence, requires the recognition of complementary roles.[11] Collaboration requires a commitment by physicians and nurses to serve one another while serving their patients and the system. There are different levels of collaboration, and all have some utility in every day practice.[12] Although there are still significant barriers from external forces to optimal care delivery, interdisciplinary barriers can be overcome through mutual respect between the psychiatric family nurse practitioner and the family physician. This respect is mutually earned through clear communication, expert clinical practice, and the willingness to meet the demands of providing nontraditional care. Patients and families are also involved in this collaboration because care providers take the time to explain the strengths and limitations of providing mental health care in the primary care setting. Nontraditional treatment with certain psychotropic medications, counseling, psychoeducation, bibliotherapy, brief therapy, and traditional referrals are all used to meet the patient's mental health needs.

The psychiatric family nurse practitioner's consultation skills and organizational perspective also contribute to the evolution of those parts of the care delivery system and external forces that need to accommodate change.

Working with office staff and patients to help them understand scheduling of counseling time for patients as opposed to the traditional office visit time is one example. Larger barriers to collaboration, such as contract versus traditional employer arrangements and gaining third party reimbursement, are still in negotiation. On January 1, 1998, direct Medicare reimbursement to nurse practitioners and clinical nurse specialists was enacted into law, and other rules are now in place to prevent discrimination against advanced practice nurses.[13] Establishment of an economic contribution to practice adds other value in collaborative efforts; attention to the system of care itself is particularly important to meet the majority of health care needs of a patient population. With the inordinate focus on patient care outcomes in health care today, the structures and processes that are imperative prerequisites for optimal patient care outcomes to occur are often forgotten.[2]

In the Gestalt approach to mental health, the notion that the whole is more than the sum of its parts establishes a base for expanding our understanding of others and ourselves. One goal of Gestalt therapy is to gain awareness and through this awareness learn that one can change.[14] The role of the psychiatric family nurse practitioner is a work in progress.

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