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The Evolution of the Advanced Practice Role in Psychiatric Mental Health in New Jersey: 1960–2010

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This historical perspective is focused on the contribution of Hildegard E. Peplau in laying the foundation for Advanced Practice Nursing and the development of the roles of Clinical Nurse Specialists and Psychiatric Nurse Practitioners. An overview is provided of legal developments within the state that enabled Advanced Practice Nurses to provide mental health services. A description of a recent specialized state-funded initiative is outlined, focused on the development and contributions of Psychiatric Advanced Practice Nurses in community settings in New Jersey. Implications for the Advanced Practice Nursing role in New Jersey are presented based on national and state initiatives.

Hildegard E. Peplau has inspired students and practicing nurses in psychiatric mental health across the decades. Her legacy—the specialty of professional nursing, psychiatric-mental health practice—is alive, more visible, and flourishing in New Jersey. Many of her major contributions have been discussed elsewhere; what we highlight in this article is the advancement of psychiatric mental health nursing practice and the autonomous and collaborative scope of practice of the Advanced Practice Nurse (APN) in the state of New Jersey as of 2010.

This article describes the development and implementation of the advanced practice role in New Jersey and provides an update on the utilization and impact that the Psychiatric Advanced Practice Nurse has had on individuals with serious mental illness and their families. The focus on the advanced practice role, the integration of prescriptive practice, and the expansion and utilization of the APN role in community settings for the most difficult and non-compliant clients are presented. Finally, state mandates for the next several years and the implications for the APN role in New Jersey are presented.

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BACKGROUND

Peplau's contributions to advanced practice nursing began with the development of the role of the clinical nurse specialist (CNS), developed by a special American Nurse Association (ANA) task force and published in the "Statement of Psychiatric Nursing Practice" in 1967 (ANA, 1967). In this document, the practice of the CNS was conceptualized as an advanced practice role dedicated to individual, group, and family psychotherapy. This was the foundation for the next step in the development of the scope of practice with the inclusion in the first Standards of Psychiatric-Mental Health Practice (ANA, 1973). Peplau was visionary by partnering advanced clinicians with graduate education and the development of master's of science degrees in nursing at a university level. Haber (2000) points to Peplau's challenge to utilize psychiatric nurses in non-traditional settings, such as in the home, which was supported by her seminal clinical work with families and family systems (Callaway, 2002). Peplau's vision was to have nursing on the same professional level as medicine, with similar goals but with a unique knowledge, research and advanced skill base (Callaway, 2002). The growing expansion of the psychiatric CNS role to a Psychiatric Nurse Practitioner role would eventually provide extended services, therapeutic and pharmacological, to individuals with mental illness in all types of home, community, and agency settings.

In 1965, the first nurse practitioner program in the United Stated was opened at the University of Colorado. In 1974, the first post-baccalaureate certificate program for nurse practitioners in New Jersey opened at Rutgers College of Nursing and Seton Hall University. During this period, a revised New Jersey Nurse Practice Act (1975; N.J.S.A. 45:5) was developed with a broader definition of nursing and included the term "nursing diagnosis." The New Jersey Board of Medical Examiners was clearly concerned by what they perceived as an expansion of the nursing role. Between 1974 and 1978, the Board

repeatedly charged Pediatric Nurse Practitioners and Adult Nurse Practitioners with practicing medicine without a license (Torre, 1981). In response, the New Jersey State Nurses Association (NJSNA) created a Steering Committee on Legal Issues Affecting Advanced Practice and, in 1986, the NJSNA membership supported a resolution to seek legislation for nurse practitioner (NP) titling and prescriptive authority.

The final bill, which became the Nurse Practitioner/Clinical Nurse Specialist Certification Act (Advanced Practice Nurse Certification Act, 1992; N.J.S.A. 45:11–45), passed and was signed by Governor James Florio in 1992. The law outlined the scope of practice and authorized the titling of and granted prescriptive privileges to Nurse Practitioners and Clinical Nurse Specialists (NPs/CNSs) who met specific educational and national credentialing requirements operationalized through New Jersey Board of Nursing regulations. This original bill passed only when NJSNA (with the permission of the NP/CNS community) reluctantly agreed to two compromises with the Medical Society of New Jersey: (1) Prescriptive authority would not extend to controlled substances; and (2) NPs/CNSs would prescribe drugs and devices only in accordance with a Joint Protocol, mutually agreed upon and signed by the APN and a collaborating physician. The NP/CNS statute required that the specific language of the Joint Protocol be worked out in regulations jointly developed by the New Jersey Board of Nursing and the New Jersey Board of Medical Examiners; it took seven years of closed door meetings between these two bodies before the Joint Protocol regulation was adopted. Note that the Joint Protocol was and is restricted to the APN's role in prescribing; it is not a general collaborative agreement covering all aspects of practice as is required by other states.

In 1999, an amendment to the NP/CNS statue changed the title of NP/CNS to Advanced Practice Nurse and granted limited authority to prescribe controlled substances. In 2004, an amendment to the APN law added unrestricted authority for controlled substance prescribing, requiring the completion of an additional six contact hours of continuing education in the pharmacology of controlled substances and modified the language of the original statute to be consistent with the evolving clinical practice of APNs.

Historically in New Jersey, CNSs had their own private practice and many belonged to the New Jersey State Nurses Association Society for Psychiatric Advance Practice Nurses. Many more nurses worked as CNSs in the state psychiatric hospitals. Today, the Society for Psychiatric Advance Practice Nursing is still a thriving organization and plays a key role in influencing and driving changes in psychiatric advanced practice.

By the mid-1980s, two master's programs were graduating Advanced Practice Nurses in New Jersey: Rutgers College of Nursing and the University of Medicine and Dentistry of New Jersey, School of Nursing. The programs evolved over the years with emphasis on role expansion to community settings for clinical experience. Managed care provided reimbursement to APNs in community settings and agencies took advantage of these practitioners who had advanced knowledge and skills. With tremendous numbers of clients discharged from state hospitals and awaiting clinical services, agencies began to understand that the APN in psychiatric mental health with prescriptive authority could fill a much needed gap in services, especially in the community setting.

NEW JERSEY'S INITIATIVE FOR PLACING APNS IN COMMUNITY SETTINGS

At the New Jersey Division of Mental Health Services, several master's prepared nurses held key positions in the administrative state structure and collaborated with faculty members from the graduate psychiatric nursing programs in the state. These key nursing leaders clearly understood that graduates of the psychiatric mental health nursing programs with these advanced skills and knowledge could influence service delivery in community settings. In March, 1991, these key nursing leaders at the state administration led the New Jersey Division of Mental Health Services (DMHS) to create for each of New Jersey's 21 counties, a psychiatric advanced practice nursing position to address needs of high-risk patients with serious and persistent mental illness. The DMHS funded this initiative at an approximate cost of $1.8M from funds re-directed from the closure of a state psychiatric hospital. The project was initiated after a statewide meeting with the Directors of Outpatient Services who were concerned about the serious backlog of patients not being seen and the resultant number of intakes, medication monitoring, and outpatient counseling services that required a wait for services.

Another key reason the APN initiative moved forward was the shortage of psychiatrists. The workforce shortage could be addressed by utilizing the psychiatric APNs who could focus on the most chronic populations seen in the community setting, often those who have high re-hospitalization histories. The APNs were specially educated nurses who were unique in that they had the legal authority to prescribe medication, utilizing joint protocols with collaborating physicians in accordance with the New Jersey Board of Nursing Regulations (1999; N.J.A.C. 13:36.7-10).

As a result of this confluence of circumstances, the New Jersey APN Initiative was launched. Proposals were sought from contracted community mental health organizations to expand the utilization of psychiatric APNs within their community service programs. The purpose of the Request for Proposals (RFPs) targeted serious and persistently mentally ill persons who have experienced psychiatric hospitalizations or were at risk of hospitalization or re-hospitalization. The proposed services of the APNs included: comprehensive assessments, diagnosis, and formulation and implementation of treatment plans. Additional RFPs had been circulated to the community agencies each year since 2000. Table 1 presents the 63 APN positions that have been added as the result of efficacy and the popularity of the role and its associated responsibilities.

TABLE 1
New Jersey Division of Mental Health Services-Community Mental Health Services: APN Grant Awards

Year	Number of Awards
1999	21
2002	5
2004	31
2006	7
Total	64

As a means of keeping APNs focused and connected to the statewide initiative, the DMHS supports this effort by providing APNs with annual free conferences and workshops and selected books and electronics to bring cutting edge updated knowledge and advanced skills to the patients that APNs serve. Each year a workshop or conference is convened in which all psychiatric APNs within the initiative and Clinical Nurse Specialists from inpatient units as well as graduate students with a specialty in psychiatric-mental health are invited. In 2009, the annual conference, jointly sponsored with the state academic health sciences university, hosted over 125 attendees.

CONTRIBUTIONS OF APNS THROUGH THE APN INITIATIVE

The New Jersey Psychiatric Advanced Practice Nurse Grant Program provided the necessary focus and momentum to have a positive impact on the health care delivery of individuals diagnosed with serious mental illness. The project outcomes confirmed that the APNs do have the advanced skills to address major challenging care and treatment issues for thousands of mental health consumers.

In September 2004, a random telephone survey of managers of programs and services who received grants from the New Jersey DMHS APN Grant Initiative was conducted. It was reported that APNs were, in fact, addressing a variety of issues that resulted in reduced incidents of unnecessary inpatient services and a longer tenure in the community. In written documents prepared by the individuals surveyed, the directors reported positive outcomes in service provision. Table 2 reports the positive outcomes—decreased "no show" rates, increased intake evaluations, decreased wait for services, increased medication compliance, and improved care and treatment through psychiatric psychoeducation programs, crisis intervention, health screenings, referrals, wellness coaching, and health education groups. In summary, the telephone survey demonstrated that the APN services are provided within a basic nursing context exemplifying a holistic approach to care, care

TABLE 2
New Jersey Community Mental Health Agency Survey: APN Services, September 2004, Summary of Telephone Survey Comments

Type of Comments
General
√ Extraordinary valuable services, ability to work with seriously ill attending to both their psychiatric and physical needs
√ Emphatically thrilled to have an APN, the facilitation/provision of medication monitoring services has profoundly contributed to client level of compliance
√ Nothing but positive; flexible services to meet client needs
√ Level of satisfaction with services is higher for APN clients
Community Tenure of Clients Improved
√ Data demonstrated reduced use of inpatient services and longer tenure in the community
√ Quick follow-up on "no show"; no show rates was 40% now is 20%
√ Intake evaluations down from 8 weeks to 2 weeks
√ Wait times for services has decreased from 6 weeks to 10 days
√ Medication management services provided within 2 days as opposed to 8–10 days
√ Ability to provide home visits and outreach services has been established
Physical Health Care Impact
√ APN provides a broader range of psychiatric education, crisis intervention, and health management services
√ Holistic approach to care is incorporated into the system of care
√ Health screens and referrals are provided to all clients
√ Improved accessibility to medical appointments, including dental and gynecology services
√ Coordination of medical services for physical health care was initially 35% and now with APN is 93%
√ Increased referrals for blood work
√ APN part of Solution for Wellness program and provision of health education groups

TABLE 3
APN Initiative Demographic Information

Item	Mean	*SD*	Minimum	Maximum
Salary	85,408	15,846	40,000	117,000
Hourly Rate	50.00	8.41	42.00	65.00
Years in Nursing	28.2	10.8	3	48
Years as APN	11.5	7.7	1	33
Years in Current Job	6.6	4.9	1	22
Hours Worked per Week	38.5	10.2	21	80
Caseload	136	110	20	450

management, and client education while maintaining a high level of client satisfaction.

UPDATE ON THE APN INITIATIVE

In 2009, a survey was done of all the APNs in the community initiative to better understand the current demographics, their work responsibilities, and the issues that they are facing in providing mental health services to individuals with psychiatric problems. The 2009 study was approved by the New Jersey Medical School Institutional Review Board and the NJ Division of Mental Health Services.

Results of the 2009 Survey

The survey was distributed to all the psychiatric APNs at the yearly conference; they were asked to complete and return the survey at the end of the day. All surveys were anonymous and 40 APNs completed the survey, 34 of whom reported being employed full-time and 6 who reported being employed part-time (see Table 3 for demographic results). APNs noted that their caseload ranged from a low of 20 to a high of 450 individuals. Within the 40 responses, 15 APNs indicated that they had a caseload of between 20 to 90 cases, 8 participants reported a caseload of 100 to 150, and 8 participants indicated that their caseload was between 225 and 450. To meet caseload demand, 26 APNs reported that they worked both evenings and nights, and 2 reported that they worked both days and weekends.

Reporting lines for Advanced Practice Nurses vary with the institution. The APNs were asked to whom they reported: 17 participants reported to a psychiatrist, 8 participants reported to a clinical administrator, 6 reported to medical director, one participant reported to a director of nursing, one participant reported to an APN, two nurses reported to a psychologist, one nurse to a social worker, and one noted "other." When asked where they primarily worked, 36 nurses noted that they worked in an outpatient setting, 2 nurses reported working in a partial care program, 2 nurses worked on a Program of Assertive Community Treatment (PACT) team, and 1 nurse indicated "other." This indicates that APNs are covering clients in more than one setting.

One question on the survey asked, "How often are your clinical services discussed with your physician based on your Joint Protocol?" Three APNs indicated once per day, 12 APNs noted once per week, 6 APNs reported once per month, 1 noted once per year, and 1 APN noted that these discussions took place only when needed.

According to the survey, the three most common psychiatric diagnoses that the APNs treat were Schizophrenia, Bipolar Disorder, and Major Depressive Disorders. Other frequent diagnoses reported were Substance Use, Posttraumatic Stress Disorder, and Generalized Anxiety Disorder. When asked to identify the top medical problems, the APNs indicated cardiovascular disease, diabetes, obesity, endocrine disorders, and seizures.

APNs were asked to identify barriers in linking clients to primary care settings and they reported that insurance, transportation, and reluctance on the part of the client as top issues. Other APNs noted that a lack of funds and long waits at the agencies were also problems faced by clients.

We were also interested in the APNs' role functions and asked them to identify their primary role functions. They indicated medication management, psychiatric evaluation, and psychotherapy were their main responsibilities. The APNs also reported that they did group therapy and crisis management.

The evaluation of treatment effectiveness, both for psychopharmacology and psychotherapy, is critical to successful client outcomes. Collection and evaluation of quantitative data is the single most important methodology to accomplish this goal. APNs reported employing an array of outcome assessment instruments. The most common instruments utilized in their clinical practice were the Beck Depression Inventory, Abnormal Involuntary Movement Scale (AIMS), the mini Mental Status Exam, mood charts, the Beck Anxiety Inventory, and ADHD instruments. Other assessments performed were for psychological trauma, drug and alcohol use (CAGE), suicide risk, dissociation, social functioning, and physical health (metabolic syndrome criteria).

NEW JERSEY STATUS ON MENTAL HEALTH AND IMPLICATIONS FOR APNS

New Jersey ranks eighth in the nation, spending $139.91 dollars per capita on total mental health expenditures (New Jersey Department of Human Services Division of Mental Health

Services, 2007). New Jersey is committed to ensuring that individuals with mental illness live in the most integrated community settings possible (in accordance with the American Disabilities Act (1990; 42 U.S.C. 126 [P.L. 110-325]) and the Olmstead v. L. C. decision (1999). The Olmstead legal decision held that hospitalized clients should have access to housing opportunities within a reasonable time frame and that inappropriate lengths of stay for many clients in state hospitals would need to be addressed.

The discharge of many of these clients into the community has and will continue to necessitate care coordination, intervention, and monitoring along with the cultivation of healthy lifestyles through person-centered planning. Clients will require programs based on self-directed learning principles and techniques that include daily life care needs and activities designed to promote wellness and stability of function. APNs are able to do outreach and work in community settings so that this population will be provided with necessary services and treatment. APNs support individuals' needs for self-directed services, community inclusion, employment, and educational goal attainment. In a recent systematic review, the results demonstrated that Advanced Practice Nurses should be incorporated into the health care system in the fullest possible manner within a treatment team approach to care delivery (Newhouse et al., 2011).

The New Jersey Home to Recovery Plan (New Jersey Department of Health Services-Division of Mental Health Services-January 2008) is a guide to developing opportunities for community integration for people who are currently in state psychiatric hospitals and are stable, but have special discharge needs that are not currently available in the community. New supportive housing models for individuals most at-risk for hospitalization are being developed and supported with statewide educational training initiatives.

Psychiatric advanced directives continue to be implemented in most treatment settings and require additional training for staff providers. New Jersey is one of 25 states in the US to have a Psychiatric Advance Directives Law so that individuals with mental illness can have more control over their illness (Swanson, Swartz, Ferron, Elbogen & Van Dom, 2006). This directive allows individuals to clearly delineate the best interventions to help them recover from their acute psychiatric symptoms. It also provides for the individual to designate an agent who may make decision about the person's treatment in the event of a psychiatric crisis. Training for this initiative will include motivational interviewing, person centered planning, applied stages of change theory, cognitive behavioral interventions, and facilitated skill development.

With a long tradition of providing holistic care and addressing the complex needs of individuals with psychiatric illness, APNs will continue to be called upon to serve complex cases such as with patients who exhibit behavioral instability, are geriatric, medically compromised/insulin dependent, or discharge-resistant.

SUMMARY

It is apparent that the New Jersey APN Initiative has been a successful means to increase care access and improve outpatient services for individuals with serious mental illness. Over 3,000 individuals are receiving a broad range of APN services primarily in outpatient programs focused on maintaining individuals within a community setting. An essential component of that care is medication management, including prescribing.

The expansion of nursing psychiatric practice in New Jersey can generate several lessons learned. First, academic psychiatric nursing practice has evolved to a professional discipline that has medicine as a collaborator and team member. Research and educational growth have enhanced professional stature and improved the quality of care provided to patients that we serve. Second, leadership involvement in national and local health care initiatives must be part of all practitioners and students. Third, the goal of professional autonomy should be the next step for Advanced Practice Nurses in New Jersey. Finally, it is apparent that the initial efforts by Hildegard Peplau to establish master's prepared advanced nurses in psychiatric mental health has succeeded in New Jersey where APNs in psychiatric mental health are integral to a successful client-focused community-based service system for those who are members of the most vulnerable populations.

Declaration of interest: Barbara Caldwell was a consultant to the State psychiatric hospital at the time this article was written.

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