The Clinical Nurse Leader: Helping Psychiatric Mental Health Nurses Transform Their Practice
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The Clinical Nurse Leader: Helping Psychiatric Mental Health Nurses Transform Their Practice

Mary S. Seed, Diane J. Torkelson, and Judith F. Karshmer

The national movement to transform the health care delivery systems must include a focus on mental health treatment. To address similar deficits across other practice domains, the Clinical Nurse Leader (CNL) role has been created. The CNL is a master’s degree that prepares a nurse to use a systems perspective to improve outcomes for a cohort of patient, deliver care based on best practices, and coordinate care in a multidisciplinary team. Applying the CNL role to mental health care could help psychiatric mental health nursing be at the forefront in the transformation of mental health care delivery. J Am Psychiatr Nurses Assoc, 2009; 15(2), 120-125. DOI: 10.1177/1078390309333063

Keywords: certification; health care reform; staff issues; relationships; roles; systems issues for the CMI

The 21st century has become the century of change in health care. Although forces in medical versus psychiatric care continue to evolve practice through a separate lens, leaders in both fields are calling for transformation of systems that deliver care. In mental health treatment, the Bush administration established a New Freedom Commission on Mental Health (NFCMH; 2003) that published a report outlining the strengths and weaknesses of the current mental health care delivery system. Concurrently, the Substance Abuse and Mental Health Services Administration formed the Annapolis Coalition on the Behavioral Health Workforce (ACBHW; 2007), which identified similar problems in care delivery but with a stronger focus on the needs of the mental health care workforce. Previously, the Institute of Medicine (2001), the American Hospital Association (2002), and the Joint Commission on Accreditation of Healthcare Organizations (2002) published a series of reports identifying the need to reorient health care delivery to reduce medical errors, increase patient safety, and improve health outcomes. Taken together, they clearly outline the need to address systems level issues that have an impact on the quality of physiological and behavioral health outcomes.

Psychiatric mental health nursing organizations and leaders are also changing nursing curricula and identifying core competencies to bring the profession in alignment with the changes in mental health delivery (American Psychiatric Nurses Association, 2008; Huckshorn, 2007; International Society of Psychiatric Nurses, 2008; McCabe, 2000). Each has called for dramatic changes in the way care is delivered. These changes will require a redesign in how clinicians are educated to provide care that is consumer oriented, grounded in research evidence, and based on positive patient outcomes. In response to these growing concerns, the American Association of Colleges of Nursing (AACN; 2007), in partnership with hospital executives, developed a new role to meet the needs of the changing health care system, called the Clinical Nurse Leader (CNL). The purpose of this article is to illuminate how the CNL, if used in both community and inpatient psychiatric facilities, could be instrumental in actualizing the call for transforming mental health care delivery.

Clinical Nurse Leader

The CNL is a generalist master’s degree–prepared clinician who oversees the care coordination of a...
distinct group of patients and actively provides direct patient care in complex situations (AACN, 2007). This role is responsive to the rapidly changing health care system and functions at the micro-system level. The CNL works at the point of care and focuses on a cohort of clients. This “system” level perspective, unrelated to specialty populations, directs the expectation that the CNL is responsible for patient care outcomes at the “unit level.” Although AACN has clearly conceptualized the “unit” in a variety of ways to include medical–surgical and psychiatric inpatient units, schools, outpatient clinics, or even single-resident occupancy hotels for the homeless, mentally ill, little has actually been written that articulates the role in the mental health care system. However, it is the case that the CNL possess the exact skill set to address the issues that have been outlined as problems in treating the mentally ill.

The CNL is prepared to put evidence-based practice into action to ensure that patients benefit from the latest innovations in care delivery. The CNL facilitates dissemination of current literature and education provided during in-services to assure that the latest evidence becomes part of standard practice. The CNL is responsible for evaluating patient outcomes in line with identified goals, assess cohort risk, and has the decision-making authority to alter treatment plans when necessary. The CNL works in collaboration with management to provide cost-effective care and is a coordinator of care delivered by the multidisciplinary team. A hallmark of the role is health promotion and prevention. The CNL is skilled in tracking trends on the unit, bringing stakeholders to the table within the organization and community to promote prevention and early screening of conditions and illness. The CNL is responsible for assessing and evaluating system issues at the unit level to prevent errors, improve unit efficiency, and promote positive patient outcomes (AACN, 2007).

The fundamental aspects of the CNL role can be found in Table 1. Education of the CNL is based on 14 core competencies (AACN, 2007) and includes but is not limited to content on systems theory, informatics, epidemiology, evidenced-based practice, leadership, communication, finance and budgeting, health care policy and ethics, health promotion, advanced assessment, pharmacology, and pathophysiology in mental and physical health. Additional materials on the CNL initiative can be found at the AACN Web site, http://www.aacn.nche.edu/cnl.

Initial CNL Outcomes

Since the inception of the CNL role in 2003, much has been published linking the role to improved patient and nursing outcomes. Largely focused on acute care settings, the patient outcomes showing improvement include decreased lengths of stay, reduced readmission rates, and reduced falls, pressure ulcers, and postsurgery infection rates (Hartranft, Garcia, & Adams, 2007; D. S. Smith & Dabbs, 2007; S. L. Smith, Hatos, et al., 2006; S. L. Smith, Manfredi, Hagos, Drummond-Huth, & Moore, 2006; Stanley, Hoiting, Burton, Harris, & Norman, 2007). In addition, these studies indicate that patient, nurse, and physician satisfaction with care significantly improved in units with a CNL. Initial data suggest that nurses working on units with a CNL have higher retention rates (Hartranft et al., 2007; S. L. Smith, Hatos, et al., 2006; Smith, Manfredi, et al., 2006). These changes in the patient and staff outcomes were attributed to the CNL's leadership ability to increase the coordination of care, increase work efficiency, and enhance team work. Nurses reported an increase in the amount of time spent with patients and their ability to give quality care (Smith, Manfredi, et al., 2006). These findings indicate that the implementation of a CNL for a cohort of patients can improve patient outcomes and safety and, therefore, reduce costs and improve satisfaction levels for the patients and the multidisciplinary team.

CURRENT MENTAL HEALTH CARE DELIVERY

National Agenda

The NFCMH (2003) outlined serious problems with the delivery of care for children and adults with mental health problems in the United States. Care is fragmented, disconnected, and burdened by financial constraints that promote inequitable treatment. Lack of knowledge about mental illness and disparities between ethnic groups continue. There is a significant lag in the implementation of evidenced-based interventions. Screening of mental health problems and mental health promotion continue to be underfunded and underutilized. The authors of this report propose that the problems faced by the mental health delivery system cannot be fixed with reform but that transformation in attitudes and current practices must occur.
The ACBHW (2007) identified equally serious problems in the mental health workforce. There are many disciplines involved in mental health care: nurses, psychiatrists, psychologists, social workers, licensed or unlicensed counselors, marriage and family therapists, and technicians or aides. The multidisciplinary approach to care has contributed to the fragmentation and disarray in the delivery of care because care is discipline focused rather than patient focused. Most alarming in the ACBHW report is the identification of the broad range of environmental issues that impeded the workforce’s ability to promote recovery and provide prevention and treatment services. Cost-cutting measures have reduced staff ratios, increased patient caseloads, and contributed to an increase in acuity levels. Administrative pressures to follow regulations and rules require an increase in documentation and more time away from direct patient care. Graduates are unprepared for the reality of the current practice setting. And in-service or continuing education efforts are ineffective in changing practice (ACBHW, 2007).

In response to these concerns, the NFCMH (2003) and ACBHW (2007) identified specific goals that can be addressed by a nurse with CNL education, a preparation that embraces implementation of an evidenced-based practice, informatics, and health promotion. These goals include (1) increase research implementation in mental health; (2) deliver care that is family and consumer oriented; focused on recovery; development of clinical competencies; (3) promote safe and competent care that is patient focused not discipline focused; (4) prevent medical errors, falls, infections.

In response to these concerns, the NFCMH (2003) and ACBHW (2007) identified specific goals that can be addressed by a nurse with CNL education, a preparation that embraces implementation of an evidenced-based practice, informatics, and health promotion. These goals include (1) increase research implementation in mental health; (2) deliver care that is family and consumer oriented; focused on recovery; development of clinical competencies; (3) promote safe and competent care that is patient focused not discipline focused; (4) prevent medical errors, falls, infections.

Additionally, the Annapolis Coalition made specific recommendations to change the work environment to be more conducive to the patient’s recovery. The

### TABLE 1. Clinical Nurse Leader Role

<table>
<thead>
<tr>
<th>Fundamental Aspects of the CNL Role</th>
<th>New Freedom Commission and Annapolis Coalition Goals and PMHN Leaders</th>
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</thead>
<tbody>
<tr>
<td>Leadership in the care of the sick in and across all environments</td>
<td>Eliminate disparities; incorporate mental illness treatment as essential to overall health; knowledge in neurobiological and biological disease and all medications.</td>
</tr>
<tr>
<td>Design and provision of health promotion and risk reduction services for diverse populations</td>
<td>Early mental health screening and assessment; eliminate disparities.</td>
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<td>Provision of evidence-based practice</td>
<td>Track trends, involve the community.</td>
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<td>Population-appropriate health care to individuals, clinical groups/units, and communities</td>
<td>Implementation of the best research evidence; expand research agenda.</td>
</tr>
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<td>Clinical decision-making</td>
<td>Deliver care that is family and consumer oriented; focused on recovery; development of clinical competencies.</td>
</tr>
<tr>
<td>Design and implementation of plans of care</td>
<td>Deliver clinically competent care; skills in lifelong learning.</td>
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<td>Risk anticipation</td>
<td>Promote safe and competent care that is patient focused not discipline focused.</td>
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<td>Participation in identification and collection of care outcomes</td>
<td>Prevent medical errors, falls, infections.</td>
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<tr>
<td>Accountability for evaluation and improvement of point-of-care outcomes</td>
<td>Focus on improving patient and unit outcomes; improve job satisfaction.</td>
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<tr>
<td>Mass customization of care</td>
<td>Improve work environment to enhance patient outcomes; improve job satisfaction.</td>
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<tr>
<td>Client and community advocacy</td>
<td>Deliver efficient cost-effective care.</td>
</tr>
<tr>
<td>Education and information management</td>
<td>Deliver family- and community-centered care.</td>
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<tr>
<td>Delegation and oversight of care delivery and outcomes</td>
<td>Improve the dissemination and implementation of current knowledge into practice.</td>
</tr>
<tr>
<td>Team management and collaboration with other health professional team members</td>
<td>Improve the coordination of care; increase job satisfaction.</td>
</tr>
<tr>
<td>Development and leveraging of human, environmental and material resources</td>
<td>Coordinate care among the multidisciplinary team so that all levels of expertise are used efficiently to improve patient care and outcomes.</td>
</tr>
<tr>
<td>Management and use of client-care and information technology</td>
<td>Manage unit resources to reduce errors, improve unit functioning, and reduce unit costs of care.</td>
</tr>
<tr>
<td>Lateral integration of care for specified group of patients</td>
<td>Enhance unit technology to improve care and increase access to care; enhance consumer use of technology.</td>
</tr>
</tbody>
</table>

Source. Fundamental aspects of the CNL role reproduced with permission from AACN (2007).

Note. CNL = Clinical Nurse Leader; PMHN = psychiatric mental health nursing.
CNL is prepared to examine and improve system issues at the unit level and take responsibility for care coordination. The CNL can be instrumental in moving mental health care delivery forward with a focus on improving patient outcomes and recovery.

Psychiatric Mental Health Nursing

To bring psychiatric mental health nursing (PMHN) into the 21st century, it has been suggested that the discipline reach agreement on essential core and clinical competencies for psychiatric nursing, measurable patient outcomes, and a research agenda to expand practice (McCabe, 2002). Progress has been made on the identification of essential core and clinical competencies. Using findings from the Institute of Medicine (2001) and New Freedom Commission on Mental Health (2003) reports, Huckshorn (2007) identified eight core competencies for PMHN. Furthermore, the International Society of Psychiatric Nurses (2008) and the American Psychiatric Nurses Association (2008) jointly developed BSN curriculum essentials for PMHN education. Although progress has been made with regard to these core competencies and curriculum changes, two areas of need continue to be apparent: the identification of a research agenda that links psychiatric mental health nursing practice to improved patient outcomes and the ability to address system issues that must be in place for psychiatric nurses to implement core competencies.

System issues include workforce concerns related to the significant shortage of nurses working in this specialty. Hanrahan and Gerolamo (2004) conducted a study to describe the demographic differences between psychiatric and nonpsychiatric nurses. They found that psychiatric nurses are significantly older than other nurses and that a much lower proportion of young nurses are choosing psychiatric mental health nursing as a career. Also, psychiatric nurses are harder to retain than nonpsychiatric nurses. According to the authors, one reason for this difficulty in retaining psychiatric nurses is because of the low levels of job satisfaction. Additionally, the Annapolis Coalition (2007) identified significant problems in the overall numbers in the mental health workforce and recommends efforts be in place to enhance the workforce’s education, retention, and recruitment.

To improve recruitment and retention in the PHMN specialty, it becomes imperative to increase job satisfaction. Initial research indicates that the CNL is well suited to meet this need. Medical units with a CNL present showed higher job satisfaction among the health care team, and nurses working on units with a CNL had higher retention rates (Hartranft et al., 2007; S. L. Smith, Hagos, et al., 2006; Smith, Manfredi, et al., 2006). Furthermore, Smith, Manfredi and colleagues found that nurses working with a CNL reported spending more time with patients and reported improved quality care. If psychiatric nursing was linked to improved patient outcomes, the role could be seen as more valuable by nursing students. It has also been suggested that positive role modeling of effective nursing practice would improve recruitment rates of new nurses into the field (Patzel, Ellinger, & Hamera, 2007; Puskar & Bernardo, 2003). Given the aging workforce and poor retention rates in psychiatric nursing, it is imperative to invigorate the practice domain to attract new nurses.

The role of the CNL in behavioral health and its ability to positively impact patient outcomes as well as the practice environment is apparent in the CNL’s ability to span the acute and community care settings. For example, a CNL working at a Veteran Administration Medical Center (VA) on an acute care psychiatric unit notices that soldiers returning from the Iraq War are being admitted for depression and recent suicide attempts. The CNL collects data regarding this unit trend and compares it with national statistics for other veteran psychiatric hospitals. With findings indicating that this rise in suicide attempts is highest in the immediate area but is occurring across the country, the CNL will assemble stakeholders to discuss the issue and problem-solve solutions. Stakeholders could include family members, patients, hospital administration, psychiatry, social work, appropriate clergy, and clinicians from outpatient or community psychiatric treatment.

Next, the CNL scans the literature and assembles the evidence to support best practices and in consultation with the team develops programs to help decrease suicide rates and screen for depression in soldiers returning from the war. The screenings allow for early treatment within the community. The CNL evaluates effectiveness of the interventions by tracking the incidence of suicide attempt admissions on the unit over the next 6-month period. If the community intervention is successful, the CNL, stakeholders, and administrators disseminate the intervention through an appropriate publication or
channels so that other VA hospitals are able to replicate it if needed. By implementing a secondary intervention for suicide and depression the CNL not only improves outcomes for soldiers but also significantly reduces the cost of care for the VA system. Because of this potential savings and improved outcomes for patients, advancing the CNL role has become a high priority for the U.S. Veteran’s Heath Administration as they currently have more than 80 VA Medical Centers embracing the CNL initiative (U.S. Department of Veterans Affairs, 2007).

Conclusion

Consideration of the goals set forth by the New Freedom Commission (2003), the Annapolis Coalition (2007), and PMHN leaders in comparison to the skill set embodied in the CNL role, it becomes apparent that the CNL can be powerful in transforming mental health care (see Table 1). The CNL will assist in delivering care that is evidenced based, promotes positive patient outcomes, and reduces the costs of care. The CNL can be part of the solution in reducing fragmented care, increasing efficiency and coordination of care in the multidisciplinary team, and promoting a healthy work environment. By improving the quality of the care given to patients and the quality of the work environment, the CNL role can be instrumental in increasing patient and nursing job satisfaction, which in turn could improve recruitment and retention rates in psychiatric mental health nursing.

Implementation of the CNL role is expected to vary across settings. It will be essential that as the role evolves ongoing innovations and evolution of the role be available in the nursing literature to help administrators, executives, and nurses implement the new role. Psychiatric mental health nurses with undergraduate degrees can consider returning to school to obtain a CNL-focused master’s degree, and advanced practice psychiatric mental health nurses can consider a postmaster’s CNL certificate. Information regarding the program and schools offering CNL education can be found at the AACN Web site, http://www.aacn.nche.edu/cnl. Administrators overseeing mental health treatment can embrace the role by hiring a CNL, establish goals of interest for a cohort of patients, and implement the role with a focus on outcomes as an important step in changing the approach to PMHN practice. In order for the role to advance within the context of behavior health, the impact for patients, nurses, and the efficiency and effectiveness of the multidisciplinary team are paramount and must become part of the emerging body of literature for PMHN to be at the forefront in the transformation of mental health care in the 21st century.

References


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