The first psychiatric nurses working in the community setting were community health nurses who developed a specialty practice in mental health. They were able to move within the community, were comfortable meeting with clients in the home or neighborhood center, were competent to act independently, used professional judgment in sometimes unanticipated situations, and possessed knowledge of community resources.

The heritage of these nurses can be traced back to the European women who cared for the sick at home and American women who organized into religious and secular societies during the 1800s to visit the sick in their homes. By 1877, trained nurses worked as public health nurses visiting the homes of the poor in northeastern cities and generalist nurses made community visits to rural areas for health promotion and care of the sick (Smith, 1995).

In 1963, President Kennedy signed into law the Community Mental Health Centers Act, thus solidifying the shift of mental health care from the institution...
to the community and heralding the era of deinstitutionalization. Media focus raising public awareness regarding the horrors of psychiatric institutions, the mental health care needs presented by returning servicemen, and the development of psychopharmacological agents all acted as catalysts for needed change in psychiatric treatment philosophy (Marcos, 1990; Rochefort, 1993).

The 1960s were also the time when federal entitlement programs proliferated: Social Security Disability, Supplemental Security Income, Medicaid, Medicare, housing assistance, and food stamps. These social programs provided the means for moving the mentally ill out of institutions and into the community. Policymakers believed that community care would be more humane and less expensive than the historic hospital-based care.

Caring for seriously mentally ill (also called chronically mentally ill) clients in the community, however, presented many challenges. At the time, there were few choices for outpatient treatment, mainly a community mental health center or therapy in a private office. Government promises to expand funding for community services were not kept, and there were more clients than resources. In addition, many seriously mentally ill clients resisted treatment with available providers, and providers began to use scarce resources for the less disabled but more compliant population. Despite these problems, a second wave of deinstitutionalization took place in the 1980s after President Carter’s Commission on Mental Health highlighted the needs of the underserved and unserved seriously mentally ill group.

Over the past 30 years, with advances in psychopharmacology and psychosocial treatments, levels of psychiatric care in the community have multiplied into a continuum with many choices. The role of the community psychiatric registered nurse (RN) has diversified to include providing services in all of these treatment settings. In this chapter, you will learn about the role of the basic level RN in different multidisciplinary treatment teams across this spectrum. Many nontraditional nursing roles have developed outside of the recognized treatment sites. Psychiatric needs are well known in the criminal justice system and in the homeless population. In 1999, the U.S. Department of Justice estimated that 16% of people in jail (those in for short stays as opposed to the long-term prison population) reported a history of an emotional problem (McQuiston et al., 2003, p. 671). Repeated studies since the 1980s suggest that one third to one half of homeless people have severe psychiatric illness (McQuiston et al., 2003, p. 669). Psychiatric RNs are actively involved in forensic settings and in creative outreach efforts in public places.

School-based clinics have increased as communities have recognized the need for early detection and treatment for children. In addition to performing screening and mental health teaching, psychiatric RNs are a part of crisis teams that respond to episodes of school violence, either adolescent suicide or mass homicide. The issue of increasing violence has had great impact on community nurses in all settings, especially with the emergence of terrorism and bioterrorism (see Chapter 14). Educators now believe that all nurses need core competencies in emergency preparedness to be ready for human-created disasters (Gebbie & Qureshi, 2002). One example of this need for quick action was in the aftermath of the September 11, 2001, terrorist attack in New York City. The state department of mental health immediately established a program to provide free crisis counseling services to all city residents (Rudenstine et al., 2003).

As noted earlier, community psychiatric nurses practice in diverse settings among people who may or may not be diagnosed with a mental illness. The principles of the public health concept of prevention are useful to support all of these interventions. Primary prevention activities are directed to healthy populations to provide information and to teach coping skills to reduce stress, with the goal of avoiding mental illness. For example, a nurse may teach parenting skills in a well-baby clinic. Secondary prevention involves the early detection and treatment of psychiatric symptoms with the goal of minimizing impairment. For example, a nurse may conduct screening for depression at a work site. Tertiary prevention involves those services that address residual impairments in psychiatric clients, in an effort to promote the highest level of community functioning. For example, a nurse may provide long-term treatment in a clinic. Box 6-1 presents examples of community practice sites for the psychiatric mental health nurse.

**ASPECTS OF COMMUNITY NURSING**

Psychiatric nursing in the community setting differs markedly from psychiatric nursing in the hospital. The community setting requires flexibility on the part of the psychiatric nurse and knowledge about a broad array of community resources. Clients need assistance with problems related to individual psychiatric symptoms, family and support systems, and basic living needs such as housing and financial support. Outside of a traditional clinic or office, the setting is the realm of the client rather than of the health care provider. Community treatment hinges on enhancing client strengths in the same environment in which daily life must be maintained, which makes individually tailored psychiatric care imperative. The hospital repre-
sents a controlled setting and promotes stabilization, but strides made during hospitalization can be lost upon return home. Treatment in the community permits clients and those involved in their support to learn new ways of coping with symptoms or situational difficulties. The result can be one of empowerment and self-management, to the extent possible given the client’s disability.

### Psychiatric Nursing Assessment Strategies

Assessment of the biopsychosocial needs and capacities of clients living in the community requires expansion of the general psychiatric nursing assessment. For the hospitalized client, the nurse must understand community living challenges and resources to assess presenting problems as well as to plan for discharge. The community psychiatric RN must also develop a comprehensive understanding of the client’s ability to cope with the demands of living in the community, to be able to plan and implement effective treatment. Box 6-2 identifies the areas covered in a biopsychosocial assessment.

Four key elements of this assessment are strongly related to the probability that the client will experience successful outcomes in the community. Problems in any of these areas require immediate attention before other treatment goals are pursued.

- Housing adequacy and stability—If a client faces daily fears of homelessness, it is not possible to focus on other treatment issues.
- Income and source of income—A client must have a basic income, whether from an entitlement, a relative, or other sources, to obtain necessary medication and to meet daily needs for food and clothing.
- Family and support system—The presence of a family member, friend, or neighbor supports the client’s recovery and also gives the RN a contact person, with the client’s consent.
- Substance abuse history and current use—Often hidden or minimized during hospitalization, substance abuse can be a destructive force undermining medication effectiveness and interfering with community acceptance and procurement of housing.

Individual cultural characteristics of clients are also very important to assess. For example, working with a

#### BOX 6-1

**Possible Community Mental Health Practice Sites**

- **Primary Prevention**
  - Adult and youth recreational centers
  - Schools
  - Day care centers
  - Churches, temples, synagogues, mosques
  - Ethnic cultural centers
- **Secondary Prevention**
  - Crisis centers
  - Shelters (homeless, battered women, adolescents)
  - Correctional community facilities
  - Youth residential treatment centers
  - Partial hospitalization programs
  - Chemical dependency programs
  - Nursing homes
  - Industry/work sites
  - Outreach treatment in public places
  - Hospices and acquired immunodeficiency syndrome programs
  - Assisted living facilities
- **Tertiary Prevention**
  - Community mental health centers
  - Psychosocial rehabilitation programs

#### BOX 6-2

**Elements of Biopsychosocial Nursing Assessment**

- Presenting problem and referring party
- Psychiatric history, including symptoms, treatments, medications, and most recent service utilization
- Health history, including illnesses, treatments, medications, and allergies
- Substance abuse history and current use
- Family history, including health and mental health disorders and treatments
- Psychosocial history, including:
  - Developmental history
  - School performance
  - Socialization
  - Vocational success or difficulty
  - Interpersonal skills or deficits
  - Income and source of income
  - Housing adequacy and stability
  - Family and support system
  - Level of activity
  - Ability to care for needs independently or with assistance
  - Religious or spiritual beliefs and practices
- Legal history
- Mental status examination
- Strengths and deficits of the client
- Cultural beliefs and needs relevant to psychosocial care

*Strongly related to the probability that the client will experience successful outcomes in the community.*
person for whom Spanish is the primary language requires the nurse to consider the implications of language and cultural background. The use of an interpreter or cultural consultant, from the agency or from the family, is essential when the nurse and client speak different languages (see Chapter 7).

**Psychiatric Nursing Intervention Strategies**

In the hospital setting, the focus of care is on stabilization, as defined by staff. In the community setting, treatment goals and interventions are negotiated rather than imposed on the client. Community psychiatric nurses must approach interventions with flexibility and resourcefulness to meet the broad range of needs of clients. The complexity of navigating the mental health system and the social service funding systems is often overwhelming to clients. Not unexpectedly, client outcomes with regard to mental status and functional level have been found to be more positive and to be achieved with greater cost effectiveness when the community psychiatric RN integrates case management into the professional role (Chan, Mackenzie, & Jacobs, 2000; Chan et al., 2000).

Differences in characteristics, treatment outcomes, and interventions between inpatient and community settings are outlined in Table 6-1. Note that all of these interventions fall within the practice domain of the basic level RN.

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**TABLE 6-1**

**Characteristics, Treatment Outcomes, and Interventions by Setting**

<table>
<thead>
<tr>
<th>Inpatient Setting</th>
<th>Community Mental Health Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>Unit locked by staff</td>
<td>Home locked by client</td>
</tr>
<tr>
<td>24-hour supervision</td>
<td>Intermittent supervision</td>
</tr>
<tr>
<td>Boundaries determined by staff</td>
<td>Boundaries negotiated with client</td>
</tr>
<tr>
<td>Milieu with food, housekeeping, security services</td>
<td>Client-controlled environment with self-care, safety risks</td>
</tr>
<tr>
<td><strong>Treatment Outcomes</strong></td>
<td></td>
</tr>
<tr>
<td>Stabilization of symptoms and return to community</td>
<td>Stable or improved level of functioning in community</td>
</tr>
<tr>
<td><strong>Interventions</strong></td>
<td></td>
</tr>
<tr>
<td>Develop comprehensive plan of care with attention to sociocultural needs of client.</td>
<td>Develop comprehensive plan of care for client and support system with attention to sociocultural needs.</td>
</tr>
<tr>
<td>Enforce boundaries by seclusion or restraint, as needed.</td>
<td>Negotiate boundaries with client.</td>
</tr>
<tr>
<td>Administer medication.</td>
<td>Encourage compliance with medication regimen.</td>
</tr>
<tr>
<td>Monitor nutrition and self-care with assistance as needed.</td>
<td>Teach and support adequate nutrition and self-care with referrals as needed.</td>
</tr>
<tr>
<td>Provide health assessment and intervention as needed.</td>
<td>Assist client in self-assessment with referrals for health needs in community as needed.</td>
</tr>
<tr>
<td>Offer structured socialization activities.</td>
<td>Use creative strategies to refer client to positive social activities.</td>
</tr>
<tr>
<td>Plan for discharge with family/significant other with regard to housing and follow-up treatment.</td>
<td>Communicate regularly with family/support system to assess and improve level of functioning.</td>
</tr>
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**ROLES AND FUNCTIONS OF THE COMMUNITY PSYCHIATRIC NURSE**

As noted in Chapter 4, psychiatric mental health nurses are educated at a variety of levels: associate, diploma, baccalaureate, masters, and doctoral. Perhaps the most significant distinction among the multiple levels of preparation is the degree to which the nurse acts autonomously and provides consultation to other providers both inside and outside of the particular agency. The nurse practice acts of individual states grant nurses authority to practice, and the standards of psychiatric nursing developed by the American Nurses Association in collaboration with psychiatric groups also define levels of practice. Table 6-2 describes the roles of psychiatric nurses according to level of education.

**Member of Multidisciplinary Community Practice Team**

The concept of using multidisciplinary treatment teams originated with the Community Mental Health Centers Act of 1963. Psychiatric nursing practice was identified as one of the core mental health disciplines, along with psychiatry, social work, and psychology. This recognition permitted the allocation of resources...
to educate psychiatric nurses and emphasized their unique contributions to the team.

In team meetings, the individual and discipline-specific expertise of each member is recognized. Generally, the composition of the team reflects the availability of fiscal and professional resources in the area. Similar to the team defined in Chapter 5, the community psychiatric team may include psychiatrists, nurses, social workers, psychologists, dual-diagnosis specialists, and mental health workers. Recognition of the ability of nurses to have an equal voice in team treatment planning with other professionals was novel at the time the team approach was implemented in community mental health practice. This level of professional performance was later used as a model for other nursing specialties.

Some writers believe that the multidisciplinary team approach dilutes the nursing role, because nurses adopt the language of psychiatry and social services. But ideally, the nurse is able to integrate a strong nursing identity into the team perspective. At the basic or advanced practice level, the community psychiatric RN is in a critical position to link the biopsychosocial and spiritual components relevant to mental health care for the individual. The RN also communicates in a manner that the client, significant others, and members of the team can accept and understand. In particular, the management and administration of psychotropic medications have become a significant task the community RN is expected to perform. There is evidence that medications are most effective when the nurse approaches drug therapy seeking to empower the individual client (Marland & Sharkey, 1999).

### Biopsychosocial Care Manager

The role of the community psychiatric RN includes the coordination of mental health, physical health, spiritual health, social service, educational service, and vocational realms of care for the mental health client. The reality of community practice in the new millennium is that few clients seeking treatment have uncomplicated symptoms of a single mental illness. The severity of illness, especially in the public sector, has increased and is correlated with increased substance abuse, poverty, and stress. In addition, repeated studies show that the mentally ill have a higher risk for medical disorders than the general population (Dickey et al., 2002).

The 1980s brought increased emphasis on implementing case management as a core service in treating the seriously mentally ill client. In the private domain, case management or care management has also found a niche. The intent is to charge case managers with designing individually tailored treatment services for clients and tracking outcomes of care. Case management includes the following functions: assessing client needs; developing a plan for service; linking the client with necessary services; monitoring the effectiveness of services; and advocating for the client, as needed (Shoemaker, 2000). Nursing and medicine are the only mental health disciplines possessing the knowledge, skill, and legal authority to provide the full range of mental health care interventions. This scope of practice, coupled with issues of personnel cost and availability, underscores the critical need for community psychiatric RNs to participate in coordination of care activities.

A successful life in the community is more likely when medications are taken as prescribed. Nurses are in a position to help the client to manage medication, recognize side effects, and be aware of the interactions among drugs prescribed for physical illness and mental illness. Client-family education and behavioral strategies, in the context of a therapeutic relationship with the clinician, have been shown to significantly increase compliance with the medication regimen (Lacro & Glassman, 2004).
Many community psychiatric RNs originally practiced on site at community mental health centers. As financial, health care, regulatory, cultural, and population changes have occurred, the practice locations have changed. Nurses are providing primary mental health care at therapeutic day care centers, schools, partial hospitalization programs, and shelters. In addition to these more traditional environments for care, psychiatric RNs are also entering forensic settings and drug and alcohol treatment centers. Mobile mental health units have been developed in some service areas. In a growing number of communities, mental health programs are collaborating with other health or community services to provide integrated approaches to treatment. A prime example of this is the growth of dual-diagnosis programming at both mental health and chemical dependency clinics. Technology has begun to contribute to the venues for providing community care: telephone crisis counseling, telephone outreach, and even the Internet are being used to enhance access to mental health services (Wilson & Williams, 2000).

In the following sections, you will find descriptions of four different community psychiatric settings, with illustrations of the practice of the basic level RN in each team. Nursing interventions in these settings include most of those defined for basic practice, for example:

- Counseling—assessment interviews, crisis intervention, problem solving in individual, group, or family sessions.
- Promotion of self-care activities—fostering of grooming, instruction in use of public transportation, budgeting; in home settings, the RN may directly assist as necessary.
- Psychobiological interventions—medication administration, teaching of relaxation techniques, promotion of sound eating and sleep habits.
- Health teaching—medication use, illness characteristics, coping skills, relapse prevention.
- Case management—communication with family, significant others, and other health care or community resource personnel to coordinate an effective plan of care.

Figure 6-1 presents the **continuum of psychiatric mental health treatment**. Movement along the continuum is fluid, from higher to lower levels of intensity, and changes are not necessarily step by step. Upon discharge from acute hospital care or a 24-hour supervised crisis unit, many clients need intensive services to maintain their initial gains or to “step down” in care. Multiple studies show that failure to follow up in outpatient treatment increases the likelihood of readmission and other adverse outcomes (Kruse & Kohland, 2002).

Other clients with a preexisting community treatment team may return directly to their community mental health center or psychosocial rehabilitation program. Homeless clients may be referred to a shelter with linkage to intensive case management or assertive community treatment. Clients with a substantial problem with substance abuse may be transferred directly into a residential substance abuse treatment program (see Chapter 27). It is also notable that clients may pass through the continuum of treatment in the reverse direction; that is, if symptoms exacerbate, a lower intensity service may refer the client temporarily to a higher level of care in an attempt to prevent total decompensation and hospitalization.

**Partial Hospitalization Program**

Partial hospitalization programs (PHPs) offer intensive, short-term treatment similar to an inpatient level of care, except that the client is able to return home each day. Criteria for referral to a PHP include the need for prevention of hospitalization for serious symptoms or step-down from acute inpatient treatment and the presence of a responsible relative or caregiver who can assure the client’s safety (Shoemaker,
2000). Referrals come from inpatient or outpatient providers. Transportation is usually provided, and clients receive 5 to 6 hours of treatment daily. Programs operate up to 7 days a week, and the length of stay is approximately 1 month. The multidisciplinary team consists of at least a psychiatrist, RN, and social worker. The RN is supervised by the psychiatrist.

Treatment outcomes related to nursing care in a PHP, in the language of the Nursing Outcomes Classification (NOC) may include the following (Moorhead, Johnson, & Maas, 2004):

- Client identifies correct name of medications.
- Client identifies precursors of depression.
- Client exhibits impulse control.
- Client perceives support of health care providers.

The following vignette illustrates the role of the psychiatric RN in a PHP.

VIGNETTE

Jane Tyson is an RN who works in a PHP in a rural county. The PHP is part of the only community mental health center in this region, which has one state hospital and one private inpatient unit. Jane worked for 3 years in the state hospital before transferring to the PHP. Jane is the nurse member of the team, and today her schedule is as follows.

8:30-9:00: Jane arrives at the PHP and prepares a teaching outline for her coping skills group.

9:00-10:00: Jane meets with eight clients to teach about coping with depression, using a five-page outline to explain steps to decrease negative thinking. All group members have a diagnosis of major depression and are encouraged to ask questions and to give feedback to each other. Throughout the session, Jane assesses each client's changes in mood and behavior since the previous day.

10:00-10:30: Jane briefly checks with all the clients to ensure that they have taken their morning medications. Three clients have brought their medication boxes with them because she needs to directly observe them take their medication.

10:30-11:30: Jane has an intake interview with a newly admitted client. Ms. Brown is a 50-year-old woman with a history of major depression who was hospitalized for 1 week after a drug overdose following an argument with her boyfriend. Jane completes the extensive 10-page standardized interview form, paying extra attention to risk factors for suicide. When asked about substance abuse, Ms. Brown admits that she has been drinking heavily for the past 2 years, including the night that she took a drug overdose. When the interview is completed, the client is referred to the psychiatrist for a diagnostic evaluation.

12:00-1:00: During the client lunch period, Jane meets with the team for daily rounds. She presents the newly admitted client, and the team develops an individual treatment plan. In this treatment plan, the team notes discharge planning needs for referrals to a community mental health center and alcohol treatment program.

1:00-2:00: Jane co-leads a therapy group with the social worker for eight clients with a variety of diagnoses. Due to the short-term nature of the group with almost daily turnover, the leaders take a psychoeducational approach with a defined topic for each session. Today's group focuses on symptoms of psychosis, and members are invited to describe their individual experiences.

2:00-2:30: Next, Jane has a discharge meeting with Mr. Jones. He is a 48-year-old man with a diagnosis of schizophrenia who was referred to the PHP by his clinic therapist to prevent hospitalization due to increasing paranoia and agitation. After 2 weeks in the PHP, he has restabilized and recognizes that he must be 100% compliant with his antipsychotic medication regimen. Jane finalizes his medication teaching and confirms his aftercare appointments with his previous therapist and pharmacist.

2:30-3:00: Jane meets with Ms. Brown before she goes home to share the individual treatment plan and to begin a discussion of resources for alcohol treatment, including Alcoholics Anonymous.

3:00-4:30: After all clients leave, Jane completes her notes and discharge summary. She also makes case management telephone calls to arrange for community referrals, to communicate with families, and to report to managed behavioral care programs for utilization review.

Psychiatric Home Care

Psychiatric home care was defined by Medicare regulations in 1979 as requiring four elements: (1) homebound status of the client, (2) presence of a psychiatric diagnosis, (3) need for the skills of a psychiatric RN, and (4) development of a plan of care under orders of a physician.

“Homebound” refers to the client’s inability to leave home independently to access community mental health care because of physical or mental conditions. Psychiatric RNs are defined to include a range of nursing personnel from basic level RNs with a certain number of years of experience to advanced practice RNs (APRNs) (Carson, 1998). Other payers besides Medicare also authorize home care services. Clients are referred to psychiatric home care following an acute inpatient episode, either psychiatric or somatic, or to prevent hospitalization. The psychiatric RN visits the client one to three times per week for approximately 1 to 2 months, and usually sees five or six clients daily.

Family members or significant others are closely involved in most cases. Because many clients are older than 65 years of age, there are usually concurrent somatic illnesses to assess and monitor. The RN acts as case manager to coordinate all specialists involved in the client’s care, for example, physical therapist, occupational therapist, and home health aide. The RN is
supervised by an APRN team leader, who is always available by telephone.

Boundaries become important in the home setting, where there is inherently a greater degree of intimacy between nurse and client. It may be important for the RN to begin a visit informally, by chatting about client family events or accepting refreshments offered. This interaction can be a strain for the RN who struggles to maintain a professional distance. However, there is great significance to the therapeutic use of self in such circumstances, to establish a level of comfort for the client and family.

Treatment outcomes related to nursing care in psychiatric home care setting, in the language of the NOC, may include the following:

- Client uses relaxation techniques to reduce anxiety.
- Client describes actions, side effects, and precautions for medications.
- Client upholds a suicide contract.
- Client recognizes hallucinations or delusions.

The following vignette illustrates a typical day for the psychiatric home care RN.

**VIGNETTE**

Natalie Beaumont is an RN employed by a home care agency in a large rural county. She worked for 2 years in the state psychiatric hospital before joining the psychiatric home care agency. She visits clients in a radius of 50 miles from her home and has daily telephone contact with her supervisor. She stops by the office weekly to drop off paperwork, and she attends the team meeting once a month. The team includes her team leader, other field RNs, team psychiatrist, consultant, and social worker. Natalie chooses to make her visits from 8 AM to 3:30 PM and then completes her documentation at home.

**8:00-9:00:** Her first client is Mr. Johnson, a 66-year-old man with a diagnosis of major depression after a stroke. He was referred by his primary care physician due to suicidal ideation. Natalie has met with him and his wife three times per week for the past 2 weeks. He has contracted for safety and has been compliant in taking his antidepressant. Today she teaches the couple about stress management techniques. Case management responsibilities for Mr. Johnson include supervision of the home health aide who helps him with hygiene and coordination with the physical and occupational therapists who also treat him.

**9:30-11:30:** Natalie has an interview scheduled with Ms. Barker, a 45-year-old single woman with a diagnosis of schizophrenia who lives with her mother. She was referred by the inpatient psychiatrist after an involuntary hospitalization for repeatedly calling 911 with bizarre reports of violence in her back yard. She had not been in the hospital for 5 years but recently had dropped out of treatment when her private psychiatrist of 15 years retired. Natalie completes the extensive structured intake interview, including the mother’s feedback. She teaches them about the new antipsychotic medication Ms. Barker is taking and sets up the weekly medication box. Natalie explains that she will visit two times a week for the next 2 months. Her case management role will include identification of a new community psychiatrist for the client and a possible family support group for the mother.

**12:30-1:30:** Next, Natalie sees Ms. Graves, a 62-year-old widow diagnosed with major depression after the death of her husband and a move into an assisted living facility. Ms. Graves has diabetes and is wheelchair bound due to an amputation. She was referred by the nurse director of the assisted living facility. Natalie has met with her twice per week for the past 4 weeks, teaching about depression, grief, medications, and coping skills. Today her focus is on identifying a new social system, including increased contact with long-distance relatives, social activities at the facility, and spiritual support. With input from the director, Natalie learns of a grief counseling group at the local church run by a pastoral counselor and she recommends that resource to Ms. Graves.

**2:00-3:00:** Natalie’s last client for the day is Mr. Cooper, a 55-year-old single man with a diagnosis of panic disorder with agoraphobia. Mr. Cooper lives with his older brother and was referred by the brother’s primary care physician after the physician found out that the client had not been out of the house for 5 years since the death of his mother. Natalie has been working with Mr. Cooper for 7 weeks and has decreased visits to once a week. She has taught Mr. Cooper about his illness, medication, and relaxation techniques. He has progressed to being able to walk outside for 15 minutes at a time. Today’s plan is to attempt riding in the car with his brother for 10 minutes, in preparation for discharge when he will have to ride for 30 minutes to reach the community mental health center.

Following this visit, Natalie returns home to complete documentation, to call in a report to her team leader and the physicians, and to make other case management telephone contacts for community referrals.

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**Assertive Community Treatment**

Assertive community treatment (ACT) teams or mobile treatment units have sprung up in various areas throughout the United States to respond to those mentally ill clients who cannot effectively use traditional outpatient mental health services. Professional staff pursue and “woo” clients and support treatment in whatever settings clients find themselves in—at home or in a public place. Clients may be assessed and treated in fast food restaurants, receive one of the deconeoate medications (e.g., Haldol, Prolixin) in a restaurant bathroom, and at the close of a “session” be offered a milkshake and a meal as a reward. If adherence to a prescribed medication regimen is a problem related to understanding, medications are packaged and labeled with the time and date they are to be taken. Creative problem solving and interventions are hallmarks of care provided by mobile teams. The Evidence-Based Practice box describes clinical research related to ACT teams.
Assertive Community Treatment

**Background**
Over the past 20 years since deinstitutionalization, much research has focused on community treatment for schizophrenia and other severe mental illness (SMI). Clients with SMI have significant difficulties with self-care, social relationships, work, and leisure. There is now a body of evidence demonstrating that psychosocial treatment can improve the long-term outcomes for these clients.

**Studies**
More than 25 controlled studies have evaluated the effects of assertive community treatment (ACT) on clients with SMI. ACT is a model for case management to serve clients who are non-compliant with standard outpatient treatment. Elements of the model include provision of services in the community instead of on site in a clinic, use of multidisciplinary treatment teams with low client-to-staff ratio (10:1) and high frequency of contact (three to five times per week), shared caseloads with clinicians, and 24-hour coverage for emergencies.

**Results of Studies**
Most of the studies were conducted in urban settings with approximately 100 clients and follow-up over 18 months. ACT was compared to standard case management for effects on housing stability, time spent in the hospital, social adjustment, and cost effectiveness. With regard to housing stability, 12 studies showed positive effects of ACT. Time spent in the hospital was reduced by the use of ACT in 14 studies. Social adjustment was not consistently improved by ACT, with only three studies showing benefits. Because ACT considerably reduced hospital use, it was considered cost effective in the majority of studies.

**Implications for Nursing Practice**
The nurse is a member of the ACT team and administers medication, teaches skills in self-care and health maintenance, coordinates access to medical care, and makes referrals to community services such as housing. These interventions require the nurse to establish a supportive relationship with the client and to collaborate with the other team members to ensure 24-hour continuity of care.

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**EVIDENCE-BASED PRACTICE**

<table>
<thead>
<tr>
<th>Assertive Community Treatment</th>
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</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
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<tr>
<td><strong>Studies</strong></td>
</tr>
</tbody>
</table>

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Susan Green is a nurse who works on an ACT team at a large inner-city university medical center. She had 5 years of inpatient experience before joining the ACT team, and she works with an APRN, two social workers, two psychiatrists, and a mental health worker. She is supervised by the APRN.

**8:00-9:00:** Susan starts the day at the clinic site with team rounds. Because she was on call over the weekend, she updates the team on three emergency department visits: two clients were able to return home after she met with them and the emergency department physician; one client was admitted to the hospital because he made threats to his caregiver.

**9:30-10:30:** Susan's first client is Mr. Donaldson, a 35-year-old man with a diagnosis of bipolar disorder and alcohol dependence. He lives with his mother and has a history of five hospitalizations with noncompliance with outpatient clinic treatment. Except during his manic episodes, he isolates himself at home or visits a friend in the neighborhood at whose house he drinks excessively. Today he is due for his biweekly decanoate injection. Susan goes first to his house and learns that he is not at home. She speaks with his mother about his recent behavior and an upcoming medical clinic appointment. Then she goes to the friend's house and finds Mr. Donaldson playing cards and drinking a beer. He and his friend are courteous to her, and Mr. Donaldson operates in receiving his injection. He listens as Susan repeats teaching about the risks of alcohol consumption, and she encourages his attendance at an Alcoholics Anonymous meeting. He reports that he did go to one meeting yesterday. Susan praises him and encourages him and his friend to go again that night.

**11:00-1:00:** The next client is Ms. Abbott, a 53-year-old single woman with a diagnosis of schizoaffective disorder and hypertension. She lives alone in a senior citizen building and has no contact with family. Ms. Abbott was referred by her clinic team because she experienced three hospitalizations over 1 year for psychotic decompensation, despite receiving monthly decanoate injections. The ACT team is now the payee for her Social Security check. Today, Susan has to take Ms. Abbott out to pay her bills and to go to her primary care physician for a checkup. Ms. Abbott greets Susan warmly at the door, wearing excessive makeup and inappropriate summer clothing. With gentle encouragement, she
agrees to wear warmer clothes. She is reluctant to show Susan her medication box and briefly gets irritable when Susan points out that she has not taken her morning medications. As they stop by the apartment office to pay the rent, Susan talks with the manager briefly. This apartment manager is the only contact person for Ms. Abbott, and she calls the team whenever any of the other residents report any unusual behavior. Over the next ½ hours, Susan and Ms. Abbott drive to various stores and go to Ms. Abbott’s somatic appointment.

2:00-4:30: The last client visit for today is with Mr. Hunter, a 60-year-old widowed man diagnosed with schizophrenia and cocaine dependence. Mr. Hunter was referred by the emergency department last year after repeated visits due to psychosis and intoxication. Initially, he was homeless, but he now lives in a recovery house shelter and has been clean of illegal substances for 6 months. He receives a monthly decanoate injection and is socially isolated in the house. Now that he has received his Social Security Disability income, he is seeking an affordable apartment. Today, Susan has two appointments to visit apartments. After greeting him, Susan notes that he is wearing the same clothes that he had on 2 days earlier, and his hair is uncombed. She suggests that he shower and change his clothes before they go out, and he agrees.

At the end of the day, Susan jots down information that she will use to write her progress notes in clients’ charts on the next day when she returns to the clinic.

Community Mental Health Center

Community mental health centers were created in the 1960s and have since taken center stage for those who have no access to private care. The range of services available at such centers varies, but generally they provide emergency services, adult services, and children’s services. Common components of treatment at community mental health centers include medication administration, individual therapy, psychoeducational and therapy groups, family therapy, and dual-diagnosis treatment. A clinic may also be aligned with a psychosocial rehabilitation program that offers a structured day program, vocational services, and residential services. Some community mental health centers have an associated intensive case management service to assist clients in finding housing or obtaining entitlements.

There is a multidisciplinary team, and the psychiatric RN may carry a caseload of 60 clients, whom she sees one to four times per month. The basic level RN is supervised by an APRN. Clients are referred to the clinic for long-term follow-up by inpatient units or other providers of outpatient care at higher intensity levels. Clients may attend the clinic for years or be discharged when they improve and reach desired goals.

Treatment outcomes related to nursing care in a community mental health center, in the language of the NOC, may include the following:

- Client describes actions to prevent substance abuse.
- Client refrains from responding to hallucinations or delusions.
- Client keeps appointments with health care professionals.

The following vignette provides an example of one work day for the RN in a community mental health center.

VIGNETTE

Mary Smith is an RN who works at a community mental health center in a large university hospital in an urban setting. She has been an RN for 10 years and transferred to the clinic 2 years ago from the inpatient unit at the same university. She is a nurse on the adult team and carries a caseload of clients diagnosed with chronic mental illness. She is supervised by an APRN.

8:30-9:00: Upon arriving at the clinic, she finds a voice mail message from Ms. Thompson, who is crying and saying that she is out of medication. Mary consults with the psychiatrist and calls Ms. Thompson to arrange for an emergency appointment later that day.

9:00-9:30: Mary’s first client is Mr. Enright, who is a 35-year-old man diagnosed with schizophrenia, in treatment at the clinic for 10 years. During their 30-minute counseling session, she assesses him for any exacerbation of psychotic symptoms (he has a history of grandiose delusions), for eating and sleep habits, and for social functioning in the psychosocial rehabilitation program that he attends 5 days per week. Today he presents as stable. Mary gives him his decanoate injection and schedules a return appointment for 1 month, reminding him of his psychiatrist appointment the following week.

10:00-11:00: Mary co-leads a medication group with a psychiatrist. This group consists of seven clients with chronic schizophrenia who have been compliant in attending biweekly group sessions and receiving decanoate injections for the past 5 years. She leads the group discussion as the psychiatrist writes prescriptions for each client, because most of the members also take oral medication. Today Mary asks the group to explain relapse prevention to a new member. She teaches significant elements, including compliance with the medication regimen and healthy habits. As group members give examples from their own experiences, she assesses each client’s mental status. At the end of the group, she administers injections and gives members appointment cards for the next group session. After the clients leave, she meets with the psychiatrist to evaluate the session and to discuss any necessary changes in treatment.

11:00-12:00: Mary documents progress and medication notes, responds to telephone calls, and prepares for the staff meeting.
12:00-2:00: All adult team staff attend the weekly intake meeting, at which new admissions are discussed and individual treatment plans are written with team input. Mary presents a client in intake, reading from the standardized interview form. She also gives nursing input about treatment for the other five newly admitted clients. The new client she presented is assigned to her, and she plans to call him later in the afternoon to set up a first appointment.

2:00-3:00: Mary co-leads a dual-diagnosis therapy group with the dual-diagnosis specialist, who is a social worker. The group is made up of seven clients who have concurrent diagnoses of substance abuse and a major psychiatric illness. The leaders take a psychoeducational approach, and today’s planned topic is teaching about the physical effects of alcohol on the body. Mary focuses on risks associated with the interaction between alcohol and medications, and answers the members’ specific questions. Because this is an ongoing group, members take a more active role, and discussion may vary according to members’ needs instead of following planned topics. After the session, the co-leaders discuss the group dynamics and write progress notes.

3:30-4:00: Mary meets with Ms. Thompson, who arrives at the clinic tearful and agitated. Ms. Thompson says that she missed her appointment this month because her son died suddenly. Mary uses crisis intervention skills to assess Ms. Thompson’s status, for example, any risks for her safety related to her history of suicidal ideation. After helping Ms. Thompson clarify a plan to increase support from her family, Mary notes that insomnia is a new problem. She takes Ms. Thompson to the psychiatrist who is covering “emergency prescription time” for that day and explains the change in the client’s status. The psychiatrist refills Ms. Thompson’s usual antidepressant and adds a medication to aid sleep. Mary makes an appointment for the client to return to see her in 1 week instead of the usual 1 month, and also schedules her to meet with her assigned psychiatrist that same day.

4:00-4:30: Mary completes all notes and makes necessary telephone calls, for example, to other staff in the psychosocial rehabilitation program who are working with her clients and to her new client to schedule an appointment.

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ETHICAL ISSUES

As community psychiatric RNs assume greater autonomy and accountability for the care they deliver, ethical concerns become more of an issue. Ethical dilemmas are common in disciplines and specialties that care for the vulnerable and disenfranchised.

Psychiatric RNs have an obligation to develop a model for assessing the ethical implications of their clinical decisions. Each incident requiring ethical assessment is somewhat different, and the individual RN brings personal insights to each situation. The role of the nurse is to act in the best interests of the client and of society, to the degree that this is possible.

In most organizations that employ RNs, there is a designated resource for consultation regarding ethical dilemmas. For example, hospitals (with associated outpatient departments) are required by regulatory bodies to have an ethics committee to respond to clinicians’ questions. Home care agencies or other independent agencies may have an ethics consultant in the administrative hierarchy of the organization. Professional nursing organizations and even boards of nursing can be used as a resource by the individual practitioner. Refer to Chapter 8 for more discussion of ethical guidelines for nursing practice.

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FUTURE ISSUES

Despite the current availability and variety of community psychiatric treatments in the United States, many clients in this country in need of services still are not receiving them. The National Survey on Drug Use and Health in 2002 estimated that 17.5 million adults had serious mental illness (Aquila & Emanuel, 2003, p. 3). Less than half, however, received treatment in 2001 (Aquila & Emanuel, 2003, p. 6). Barriers to treatment have been identified by many authors and studies. The stigma of mental illness has lessened over the past 40 years; there is increased recognition of symptoms due to brain disorders, and well-known people have come forward to admit that they have received psychiatric treatment. Yet, many people still are afraid to admit to a psychiatric diagnosis (Pardes, 2003). Instead, they seek medical care for vague somatic complaints from primary care providers, who too often fail to diagnose anxiety (or depressive) disorders (Rollman et al., 2003).

In addition to stigma, there are geographic, financial, and systems factors that impede access to psychiatric care. Mental health services are scarce in some rural areas, and many American families cannot afford health insurance even if they are working. President George W. Bush’s New Freedom Commission on Mental Health identified national system and policy problems in 2002: fragmented care for children and adults with serious mental illness, high unemployment and disability among the seriously mentally ill, undertreatment of older adults, and lack of national priorities for mental health and suicide prevention (President’s commission, 2002).

To meet the challenges of the twenty-first century, Price and Capers (1995, p. 27) suggested that, in training the associate degree nurse, “educators must increase their focus on leadership development, include principles of home health nursing, increase content on gerontology, and introduce basic community health concepts.” Those RNs who elect to work with elderly psychiatric clients will be more and more in demand as the population ages, and the health care needs of this subgroup are increasingly complex (Hedelin &
The basic level community psychiatric nurse practices in many traditional and nontraditional sites. There are significant differences between inpatient psychiatric nursing and community psychiatric nursing. In the multidisciplinary team, the community mental health nurse functions as a biopsychosocial care manager. The continuum of psychiatric treatment includes numerous community treatment alternatives with varying degrees of intensity of care. The community psychiatric nurse needs access to resources to address ethical dilemmas encountered in clinical situations. There are still barriers to mental health care that the community psychiatric nurse may be able to diminish through daily practice.

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**KEY POINTS to REMEMBER**

- Community mental health nursing has historical roots dating to the 1800s and has been significantly influenced by public policies.
- Deinstitutionalization brought promise and problems for the chronically mentally ill population.

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**Critical Thinking and Chapter Review**

**CRITICAL THINKING**

1. You are a community psychiatric mental health nurse working at a local mental health center. You are doing an assessment interview with a single male client who is 45 years old. He reports that he has not been sleeping and that his thoughts seem to be “all tangled up.” He informs you that he hopes you can help him today because he does not know how much longer he can go on. He does not make any direct reference to suicidal intent. He is disheveled and has been sleeping at shelters. He has little contact with his family and starts to become agitated when you suggest that it might be helpful for you to contact them. He refuses to sign any release of information forms. He admits to recent hospitalization at the local veterans hospital and reports previous treatment at a dual-diagnosis facility even though he denies substance abuse. In addition to his mental health problems, he says that he has tested positive for human immunodeficiency virus and takes multiple medications that he cannot name.
   
   A. What are your biopsychosocial and spiritual concerns about this client?
   
   B. What is the highest-priority problem to address before he leaves the clinic today?
   
   C. Do you feel that you need to consult with any other members of the multidisciplinary team today about this client?
   
   D. In your role as case manager, what systems of care will you need to coordinate to provide quality care for this client?
   
   E. How will you start to develop trust with the client to gain his cooperation with the treatment plan?

**CHAPTER REVIEW**

**Choose the most appropriate answer.**

1. A significant influence allowing psychiatric treatment to move from the hospital to the community was
   
   1. television.
   
   2. the discovery of psychotropic medication.
   
   3. identification of external causes of mental illness.
   
   4. the use of a collaborative approach by clients and staff focusing on rehabilitation.

2. For psychiatric nurses, a major difference between caring for clients in the community and caring for clients in the hospital is that
   
   1. treatment is negotiated rather than imposed in the community setting.
   
   2. fewer ethical dilemmas are encountered in the community setting.
   
   3. cultural considerations are less important during treatment in the community.
   
   4. the focus in the community setting is solely on managing symptoms of mental illness.
3. A typical treatment goal for a client with mental illness being treated in a community setting is that the client will
   1. experience destabilization of symptoms.
   2. take medications as prescribed.
   3. learn to live with dependency and decreased opportunities.
   4. accept guidance and structure of significant others.

4. Assessment data that would be considered least relevant to developing an understanding of the ability of a persistently mentally ill 65-year-old client to cope with the demands of living in the community are
   1. strengths and deficits of the client.
   2. school and vocational performance.
   3. client health history and current mental status.
   4. client home environment and financial status.

5. Which action on the part of a community psychiatric nurse visiting the home of a client would be considered inappropriate?
   1. Turning off an intrusive TV program without the client’s permission
   2. Facilitating the client’s access to a community kitchen for two meals a day
   3. Going beyond the professional role boundary to hang curtains for an elderly client
   4. Arranging to demonstrate the use of public transportation to a mental health clinic

REFERENCES


