Role and Competencies of Advanced Practice Mental Health Nurses

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Learning Objectives
The objectives of this chapter are to enable you to:

- Articulate the context and development of the APMHN role from an international and European perspective.
- Identify and define the rationale and international trends behind the development of APMH nursing competencies.
- Compare the different competencies and roles for APMH nurses in Europe and apply them to your own context.

1 Introduction

Since this book is about advanced practice in mental health nursing in Europe, a discussion on the possible role of advanced practice mental health nurses (APMHNs) and what competencies underlie their work is clearly important. Articulating and discussing what APMHNs can do from a legal, practical, and ethical standpoint and what their role could be and should be are therefore the tasks of this specific chapter. There

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are other chapters later in this book that focus in more depth on all the key components of the APMHN role, such as clinical practice, education, research, and leadership. Using some chosen examples, the reader is given an insight into how the APMHN role is approached in Europe and internationally. As APMH nursing roles were created and developed in the wider context of advanced practice nursing, some discussion on trends regarding the advanced practice nursing (APN) role is also unavoidable.

In discussing the roles and competencies for APMHNs in Europe, there is great diversity to be kept in mind, as competencies, practice, clinical training, education, and legislation governing nursing and mental health services vary across different European countries (see "Landscape of Advanced Practice Mental Health Nursing in Europe") [1]. This diversity is one of the strengths of European APMHNs, as it opens the doors for creativity and innovation as well as creating opportunities to share knowledge and learn from each other. This chapter will offer different viewpoints on APMH nursing which will encourage the reader to reflect and ask the appropriate questions within the context of their own clinical practice.

Throughout the literature terms such as generalist nurse, specialized nurse, and advanced practice nurse are used, sometimes interchangeably about mental health nurses. A generalist nurse is a nurse that does not have any formal specialization beyond entry-level education into the profession and an advanced practice nurse (APN) is a nurse, who according to the International Council Of Nursing (ICN) *Guidelines on Advanced Practice Nursing 2020* "…has acquired, through additional graduate education (minimum of a master's degree), the expert knowledge base, complex decision-making skills and clinical competencies for Advanced Nursing Practice" [1, p. 6]. A specialized nurse is a nurse that has some preparation beyond the generalist nurse but may not have postgraduate education in the chosen specialty [1]. A good example of this can be found in the USA in the form of the psychiatric mental health (PMH) nurse [2] who has specialty certification without the expanded scope of practice nor a requirement for a graduate degree. Another example can be found in countries where there is direct entry education for mental health nursing or where nurses graduate with a primary degree in mental health nursing at the point of first registration or licensure. This can be seen in the United Kingdom (UK) and the Republic of Ireland (Ireland) [3] and was for many years the case in the Netherlands [4].

2 Differentiating Roles and Levels of APMHNs in the USA and Europe

The licensure, accreditation, certification, and education (LACE) model was developed in the USA as an attempt to standardize the education, licensure, and certification of advanced practice registered nurses (APRNs) [5]. In recent years, Australia and New Zealand and many European countries, such as the UK, Ireland, and the Netherlands, have made notable attempts to do the same [1, 6]. In general a Master's degree is required for advancement to advanced practice nursing, and there is even movement in the USA for a clinical doctorate (the Doctor of Nursing Practice or the DNP) as entry level to advanced practice [7].

As North America could be considered the birthplace of the APMHN role [8], it may make sense when discussing terms to start there. In the USA, the term advanced practice registered nurse (APRN) is used to refer to advanced practice nurses. It is important to differentiate between the American term APRN and the previously defined term of the APN endorsed by the International Council of Nursing (ICN). Within nursing in the USA, there are four main advanced practice registered nursing roles, namely, (1) the clinical nurse specialist (CNS); (2) the nurse practitioner (NP); (3) the certified registered nurse anesthetist (CRNA); and (4) the certified nurse midwife (CNM) [5]. For APMHNs it can be argued that only the first two are relevant, the CNS and the NP roles.

A CNS is defined by the ICN as an "advanced practice nurse who provides expert clinical advice and care based on established diagnoses in specialized clinical fields of practice along with a systems approach in practicing as a member of the healthcare team" [1, p. 6]. Although in certain countries the CNS title sometimes refers to a type of specialized nurse rather than an APN, such as in Ireland where a distinction is made between the APN role and the CNS role in this manner [9]. A nurse practitioner (NP) is defined by the ICN as "an advanced practice nurse who integrates clinical skills associated with nursing and medicine in order to assess, diagnose and manage patients in primary healthcare (PHC) settings and acute care populations as well as ongoing care for populations with chronic illness" [1, p. 6]. The NP often has an expanded scope of clinical practice especially related to having their own caseload and a higher level of clinical autonomy, such as through prescribing, diagnosing, and treating illnesses, often through interventions that are historically under the purview of the medical profession. The CNSs hold a more specific focus on indirect care, such as quality improvement tasks including development and implementation of new policies or quality control standards, scientific endeavors including research and its dissemination, and other kinds of professional leadership including but not limited to clinical supervision [1]. The roles of the CNS and NP have become somewhat distinct in certain countries, emphasizing the increased clinical autonomy of the NP versus the CNS although many exceptions to this exist [6, 8–10]. One example is that of Iceland where there are many specialized nurses, but only one type of APN, the clinical nurse specialist, which then branches off into different specialty areas of nursing [11]. Other examples of hybrid models of CNSs and NPs include the Netherlands and in some ways Germany, although the level of APN is quite different there with more focus on the specialized nurse. Some European countries that have a more developed NP-oriented system have developed an advanced practice tool kit for further delineation and development of different advanced practice roles such as the National Health Services in the UK [1, 12].

3 The APMHN Role

Certification, licensure, and scope of practice issues are very similar in APMH nursing as in advanced practice nursing in general, albeit with some exceptions [1, 4, 5, 7, 13, 14]. In examining the role of the APN and/or APMHN, some examples could be helpful to give the reader different viewpoints from different countries on this subject.

Since its inception the APN role in psychiatric mental health (PMH) nursing in the USA has been through many changes. The first APMHN program was founded in 1954 in Rutgers University in New York, which was inspired and deeply influenced by Peplau's work on the role of the psychiatric nurse [8]. The focus of this program was on organizational analysis, consultation, and systems approaches, but true to Peplau's vision, the greatest emphasis was placed on developing psychotherapeutic skills centered on the nurse-patient relationship [8]. In the 1990s, there was a shift toward a more biomedical approach for APMHNs in the USA, when the "three Ps," namely, pharmacology, physiology/pathophysiology, and physical assessment, became mandatory in psychiatric mental health clinical nurse specialist (PMHCNS) programs, although the "fourth P" of psychotherapy was forefronted in many APMHN programs as well. In the early 2000s, the psychiatric mental health nurse practitioner (PMHNP) role was created in the USA, and the focus became even more biomedically oriented, which created a differentiation between the CNS and NP roles within the specialty of mental health. However, over time many realized that the competencies of the two roles were more alike than different, and as more lifespan-related certifications were created, these designators started to create more confusion than clarity on the APMHN role in the USA [8]—a confusion that both the American Psychiatric Nursing Association (APNA) and the International Society of Psychiatric Nurses (ISPN) were eager to address [14]. In 2011, the decision was made that new graduates specializing in APMH nursing would bear only one designator, psychiatric mental health nurse practitioner (PMHNP). The PMHNP would be prepared to provide comprehensive mental health nursing services, across the lifespan to service users throughout different service levels and organizations [14]. The PMHNP needed competencies in various individual and group psychotherapy models, diagnosing and prescriptive practice. The target date for this transition was set for 2015. At the same time, the decision was made to grandfather in all preexisting licensures in APMH nursing. Grandfathering refers to the intention to include a provision in new laws and regulations exempting those already within the system from the requirements of the new laws and regulations. In other words, those APMHNs already practicing under older certifications could continue to do so regardless of newer provisions that would only apply to those not already within the system [14]. This means that in the USA the role of the PMHCNS and PMHNP have essentially been merged into one designation. At the same time, within the USA, a call has been made for benchmarking of existing competencies within APMHN education [15]. But in the USA, it can be said that the biomedical view has been more dominant in the competencies for APMHNs compared to traditional system-focused CNS competencies not to mention more recovery-oriented principles [16].

In 2006, the Doctorate of Nursing Practice (DNP) degree was introduced in the USA, but the DNP is not a certification or licensure title but an academic one, not unlike clinical doctorates in other professions [15]. The DNP is a 3-year graduate level program offering the time and space to combine the competencies from both the more biomedically oriented NP program and the more system- and quality-improvement-focused CNS program. It can also allow APMHNs more freedom to

choose their emphasis and career trajectory based on system needs, the changing nature of service user need, and their own interests. Thus, enabling APMHNs to pivot between these areas of focus to achieve different set of competencies without having to reenlist in a new graduate program or recertify with a different licensure [7, 15, 17]. As the ICN indicated in its *Advanced Practice Guidelines 2020*, this may be a future step for APNs internationally which may bridge the gap between the two dominant APMHN roles, i.e., the CNS and the NP role [1]. The DNP has been suggested as entry level to practice for APMHNs as well as other NPs in the USA for 2025 [7].

3.1 Ireland and the APMHN Role

As noted in the opening chapter of this book, other notable work has been done in European countries to define and articulate the role and competencies of APNs including APMHNs. In 2017, The Nursing and Midwifery Board of Ireland (NMBI) published Advanced Practice (Nursing) Standards and Requirements where they outline five ethical principles, as well as domains of competence and standards of conduct which "guide each Registered Advanced Nurse Practitioners (RANPs) interaction with patients, colleagues and society" [18, p. 11]. This document is useful when looking at the APMHN role from a European perspective as the principles, competency domains, and accompanying standards of practice are echoed through the literature on APN competencies and includes items historically associated with both NP and CNS roles.

The five ethical principles include (1) respect for the dignity of the person; (2) professional responsibility and accountability; (3) quality of practice; (4) trust and confidentiality and finally; and (5) collaboration with others. Based on these principles, the NMBI divides the core competencies of APNs into six separate domains. The first competency domain is professional values and conduct, which includes the following standard of practice "The Registered Advanced Nurse Practitioner will apply ethically sound solutions to complex issues related to individuals and populations" (p. 16). The second domain is clinical decision-making which include utilizing "…advanced knowledge, skills, and abilities to engage in senior clinical decision making" (p. 17), a standard of practice which may or may not involve the prescribing of medications. The third domain is knowledge and cognitive competencies, to which the following standard of practice applies, "The Registered Advanced Nurse Practitioner will actively contribute to the professional body of knowledge related to his/her area of advanced practice" (p. 17). The fourth domain is communication and interpersonal competencies, which includes negotiating and advocating "…with other health professionals to ensure the beliefs, rights and wishes of the person are respected" (p. 18). This competency includes clinical supervision and mentorship, as well as other advocacy roles and factors. The fifth domain is management and team competencies, which includes managing "…risk to those who access the service through collaborative risk assessments and promotion of a safe environment" (p. 18). The sixth and final competency domain for RANPs is leadership and

professional scholarship competences, where the RANP "…will lead in multidisciplinary team planning for transitions across the continuum of care" [18, p. 19].

This model entails competencies which the individual APMHN can use, based on service user and system need along with personal interest and passions, to guide their chosen career trajectory. In this document APNs, including APMHNs, are encouraged to "be proactive in identifying areas where expansion in their scope may lead to improved outcomes for patients" [18, p. 6]. This inclusive language indicates an expectation or perspective that is positive toward role expansion, if it is being done for the right reasons, i.e., contributing to holistic care and improved service user outcomes.

3.2 The UK and the APMHN Role

When it comes to mental health nursing, the UK has been at the forefront for many years producing many documents and position statements of interest [3]. A recent publication by the National Health Services (NHS) titled *The Advanced Practice Mental Health Curriculum and Capabilities Framework*, not only focuses on the core competencies or capabilities of APMHNs but of all advanced practice mental health practitioners, regardless of professional or educational background [19]. The main drive behind this publication "is to enable practitioners to practice to their full potential and to optimize their contribution to meeting individual, family and carer needs through different models of service delivery and multidisciplinary working" [19, p. 3]. The core capabilities outlined in the document are presented under the following six domains: (1) person-centered therapeutic alliance; (2) assessment and investigations; (3) formulation; (4) collaborative planning; (5) intervention and evaluation; and (6) leadership and management, education, and research. Despite the multidisciplinary approach and inclusive nature of the "capabilities," most of the domains outlined can be found in abundance in the literature on principles and competencies in relation to the role of APMHNs and APNs. Within this document the specific focus on the therapeutic alliance is strongly aligned with the core values of APMH nursing [16, 20, 21]. Given the current emphasis on interdisciplinary teamwork within the mental health sector, having such core competencies that reach across different mental health professions to inform curricula may prove useful to other European countries and become a boon for APHMNs in European countries where the APMHN role is still underdeveloped and/or uncertified.

In addition to *The Advanced Practice Mental Health Curriculum and Capabilities Framework*, work has been done in the UK to develop an Advanced Practice Tool Kit [12]. Within the tool kit, advanced practice is defined as practice that "…includes the analysis and synthesis of complex problems across a range of settings, enabling innovative solutions to enhance people's experience and improve outcomes" [12, p. 1. The four pillars of advanced practice, (1) clinical practice, (2) leadership and management, (3) education, and (4) research (sometimes referred to as evidence based practice or EBP), also reflect the four pillars of advanced practice nursing and thus APMH nursing as articulated by the Royal College of Nursing in the UK [12, 20].

The APN role of the nurse consultant was first introduced in 2000 in the UK and bears mentioning here. It was "related to three professional groups: nursing, midwifery and health visiting, allied healthcare professionals and pharmacists" [22, p. 820]. The consultant is an interdisciplinary role with four core functions: (1) expert practice; (2) professional leadership and consultancy; (3) education, training, and development; and finally, (4) practice and service development, research, and evaluation. The expectancy for nurses assuming this role was that they would have a minimum of a Master's degree education and extensive experience in all four functions [22]. This role has been found effective especially related to traditional CNS functions such as quality improvement, effectiveness of healthcare services, and productivity [23].

4 Netherlands and the APMHN Role

From 1921, the education of Dutch specialized psychiatric nurses was separate from generalist somatic nursing, but unlike in the UK and Ireland, it was merged again with generalist nursing in 1997 [4]. After an incubation period of over a decade, the Netherlands introduced the legal framework for the NP role in 2011. This had initially entailed informal role expansion into specific tasks belonging to the traditional realm of medicine but from 2012 became a more formal process [24]. However, similar to elsewhere, the debate about their role and competencies still rages as well as discussion on the difference between the new NP role and the older specialist nurse role [4, 25].

At a similar time, the difference between the competency and scope of practice of the generalist nurse and the "nurse specialist" (referred to here as NP) was further clarified with a professional Master's degree made an entry-level requirement into advanced practice, similar to requirements for the APN role around the world [1, 5, 24]. A competency framework based on the Canadian Medical Association Direction for Specialists was developed as well by the national professional organization of nurses [26]. This framework entails core competencies based on seven key roles, namely, communicator, collaborator, leader, health advocate, scholar, and professional. With the seventh and final role at its axis, the medical expert makes the biomedical associations hard to ignore [27]. This dramatically changed the landscape of Dutch APMHNs practice, both through role expansion but also through role recognition and legitimation [4, 24, 25].

5 APMHN Competencies

Competence has been described by the European Federation of Nurses Associations [28, p. 33] as "…the intersection between knowledge, skills, attitudes and values, as well as the mobilization of specific components in order to transfer them to a certain context or real situation, hence coming up with the best action/solution possible to address all different situations and problems that can emerge at any moment,

making use of the available resources." For APMHNs competencies can be related to any of the following domains or pillars as previously reviewed: (1) clinical practice, (2) research, (3) management and leadership, and (4) education [20]. When looking at research on the roles, tasks and activities of APMHNs much similarity can be identified both within the general APN competencies and the more specific APMHN competencies indicating that these actually represent what APMHNs do in real-life clinical practice [21, 29]. The next section uses the four pillars to explore APMHN competencies, although it must be acknowledged that overlap does exist and cannot be avoided as practicing at an advanced practice level requires the integration of competencies across all pillars.

5.1 Advanced Clinical Practice

This is the first and most important part of the APMHN role and is where the heart of mental health nursing lies. For APMHNs the therapeutic relationship is the driving force behind all aspects of the clinical role and associated competencies. In advanced clinical practice, the APMHN not only focuses on the service user but also on the needs of the service users' family and significant others [30]. The APMHN needs to be especially mindful of the human rights principles and mental health promotion and recovery, when making complex ethical decisions and when cultivating the therapeutic relationship [31, 32]. Under this domain the competencies most specific to APMH nursing can be found, while in the other three domains, many of the competencies are in common with APNs in general. It is also under this domain the most variability can be found in the role of APMHNs between different countries, as rules and regulations that dictate the scope of practice determine to a certain extent the specific competencies of APMHNs in each country [1, 21]. For APMHNs some focal points belonging to this pillar are principles related to different models of care and interventions regarding the individual, families and groups, assessment and recovery planning, risk management and safety planning, and ethical decision-making processes, service user empowerment, and collaborative practice [13, 16, 21, 29]. In Table 1 the characteristics of the advanced clinical practice pillar according to the RCN can be found as well as the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England [19, p. 9, 20, p. 5]. The table illustrates well the core advanced clinical capabilities required to practice as an APMHN with fairly generic language accounting for the diverse landscape of APMH nursing found in Europe.

Expanding on the factors described in Table 1 involving a recovery-based approach, such as co-production and increasing service user and public involvement in their care, Stickley et al. [33] review the competencies (knowledge, skills, and attitudes) required in the advanced level education of mental health nurses related to recovery and social inclusion. Their findings suggest that the knowledge needed includes the CHIME framework, where the literature on recovery was synthesized revealing five themes, connectedness, hope and optimism about the future, identity, meaning in life, and empowerment [34] (see "Perspectives and Frameworks

Table 1 Clinical practice pillar

RCN (2018) characteristics of advanced clinical practice	Health Education England (2020)
1. Decision-making/clinical judgment and problem solving 2. Critical thinking and analytical skills incorporating critical reflection 3. Managing complexity 4. Clinical governance 5. Equality and diversity 6. Ethical decision-making 7. Assessment, diagnosis, referral, and discharge 8. Developing higher levels of autonomy 9. Assessing and managing risk 10. Nonmedical prescribing in line with legislation 11. Developing confidence 12. Developing therapeutic interventions to improve service user outcomes 13. Higher level communication skills 14. Service user/public involvement 15. Promoting and influencing others to incorporate values-based care into practice 16. Development of advanced psychomotor skills	1. Work autonomously within professional, ethical codes, and legal frameworks, being responsible and accountable for their decisions, actions, and omissions at this level of practice 2. Demonstrate the underpinning psychological, biological, and social knowledge required for advanced practice in mental health 3. Demonstrate comprehensive knowledge of, and skills in, systematic history taking and clinical examination of patients who are culturally diverse and/or have complex needs in challenging circumstances, to develop a co-produced management plan 4. Utilize clinical reasoning and decision-making skills to make a differential diagnosis and provide rationales for person-management plans, through critically reflecting on and evaluating their own role in relation to challenging traditional practices, new ways of working, and the impact upon the multidisciplinary team 5. Initiate, evaluate, and modify a range of interventions, which may include therapies, medicines, lifestyle advice, and care

Underpinning the Practice of Advanced Mental Health Nursing"). Other key concepts identified related to recovery, included knowledge on narrative theory and recovery as a journey or a process and tools to measure recovery process and outcomes. In addition, this review highlighted the importance of knowledge on diverse topics related to social inclusion and recovery, such as education on human rights, critical psychiatry, social model of disability, social inclusion, participatory models of shared decision-making and exploring the role of friendship, community, education, leisure, culture, arts and creativity in people's recovery, to name a few [33]. The attitudes needed for the mental health nursing graduate programs according to Stickley et al. [33] need to be framed within a humanistic approach, attitudes such as treating people with dignity and respect as opposed to disorders, believing in the persons potential, unconditional positive attitude and developing self-awareness and emotional intelligence. The skills suggested belonging to such programs include various derivatives of the points reviewed already, such as collaborative work with service users and families, power sharing and management of self, counteracting social isolation and using interventions to cultivate strengths and recovery of service users such as motivational interviewing and compassion focused therapy [33].

Mental health promotion competencies which focus on promoting wellness from a holistic standpoint, and not just treating diseases, require some more specific attention from APMHNs (see "Advanced Practice Mental Health Nursing and Mental Health Promotion"). Knowledge, skills, and attitudes belonging to the advanced clinical practice pillar that can play a role here include a positive and hopeful attitude, focusing on strengths instead of deficits and knowledge about different evidence-based interventions and coping mechanisms that support general well-being and wellness [31]. Lahti et al. [35] identified key themes of knowledge needed for advanced level mental health nursing programs across the lifespan. For children and adolescents, these included (1) child and adolescent development such as normal development, the development of family process and the impact of trauma; (2) knowledge of mental health promotion and prevention programs in areas such as bullying and child abuse; (3) recognition of early signs of mental health challenges; and (4) care and treatment of specific mental health challenges. For adults they identified the following: (1) lifestyle, such as importance of having an active lifestyle and life and work-related interventions; (2) family and intimate relationships, such as normal family processes, couple counselling, and sex education; (3) nursing care, such as education on mental health problems, comorbidities, and long-term care; and (4) mental health prevention and promotion; for example, physical activity programs. And finally the themes identified on knowledge required regarding the older person for mental health nursing graduate programs included (1) the developmental processes, such as what transitions and changes are to be expected during this lifespan; (2) mental health prevention and promotion; (3) recognition of abuse and neurological status; (4) care and treatment, such as treatment and care related to nutrition; and (5) active lifestyle, such as healthy aging, social involvement, and retirement. The authors also identified skills such as assessment of distress and clinical decision-making skills, psychological support skills and interventions to name a few. Finally, the attitudes identified included advocating human rights values along with moral reasoning [35].

All these areas help further articulate competencies for lifespan-related issues for APMHNs and clarify both clinical and educational expectations on these issues [35]. The same group of authors also reviewed the literature for knowledge, skills, and attitudes required for APMHNs to work with families and identified numerous factors that have an impact in this area. These include but are not limited to having the ability to empower and provide appropriate and non-shaming and validating knowledge regarding the burden and complexity involved with being in the carer role, as well as working with the complex ethical issues APMHNs are faced with when working with service users and their families [30].

In their review on master's level mental health nursing competencies related to the physical health of mental health service users, Jormfeldt et al. [36] describe three essential domains of knowledge for APMHNs: (1) specific knowledge about physical health risks connected with mental illness; (2) detailed knowledge about mental illness stigma and its effects on physical health; and (3) extensive

knowledge of mental health nurses' duty to promote mental and physical health in mental health service users. They further describe two main skills to ensure this: advanced therapeutic and pedagogical skills to motivate healthy living and teamwork and collaboration skills to counteract barriers to a healthy lifestyle among mental health service users [36]. In addition, they include two main attitudes that need to underlie in achieving equal health among mental health service users, namely, engagement in person-centered nursing practice to promote overall health and commitment to quality improvement in health promotion in mental health nursing. These domains of knowledge and accompanying skills and attitudes are a good example of ways to enhance and expand on clinical practice competences for APMHNs that, for example, can be found in Table 1. Identification of competencies such as these also help ensure proper training in undervalued or neglected areas of care for APMHNS such as can sometimes be found in the physical health area for mental health service users [36]. They can also be quite helpful in identifying competencies for the integration of mental health and physical health services and thus can facilitate the care coordination skills needed for APMHNs. Even though generalist nurses are more commonly in this role, such skills may be quite important for APMHNs as well [37].

The US-based National Organization of Nurse Practitioner Faculties (NONPF) has published specific competencies related to the APMHN role in the USA. These are not meant to substitute more generic APN competencies but rather expand on them for each subspecialty of APMH nursing [16]. The dimensions of practice are somewhat different to the pillars used to categorize competencies in this chapter, and a total of nine in number as opposed to four. For direct clinical care, there are at least 35 specific competencies that include generic APMHN competencies such as "Develops an age-appropriate treatment plan for mental health problems and psychiatric disorders based on biopsychosocial theories, evidence-based standards of care, and practice guidelines, includes differential diagnosis for mental health problems and psychiatric disorders and conducts individual and group psychotherapy." The more specific competencies include competencies such as "applies supportive, psychodynamic principles, cognitive-behavioral and other evidence-based psychotherapy/-ies to both brief and long term individual practice" and "uses self-reflective practice to improve care" [16, p. 69, 71]. NONPF also includes competencies related to building and maintaining the therapeutic alliance and recovery-oriented principles such as "applies recovery-oriented principles and trauma focused care to individuals" and "demonstrates best practices of family approaches to care" although more enhanced competencies on these issues are clearly needed for APMHNs and examples of which have already been reviewed previously in this chapter [16, p. 69, 71].

Combining work specifically focused on competencies, tasks, and activities of APMHNs with that which is focused more generically on APN practice, the reader should be able to construct a holistic picture of which of these may be applied in their respective country. But as previously stated, this domain of advanced clinical practice is most dependent on different rules and regulations that dictate APMHN

and APN practice in each country, so which of these apply to the readers context will vary greatly on situation and context. But clearly further development in this area is required as while competencies do exist to guide APMHN practice a comprehensive and inclusive competence framework for APMHNs has not really been developed outside the USA, and certainly not with a focused human rights and recovery approach, although a promising start has certainly been made in this direction.

5.2 Leadership

The international literature is replete with commentary on the centrality of nursing leadership in advancing health care reform and creating a culture of innovation in the workplace. As far back as 2011, the Institute of Medicine with their report on *The Future of Nursing* supported nurses to take on leadership roles to address changes in healthcare [38]. For over a decade, the ICN has been delivering programs to nurses around the world, aimed at developing the leadership skills necessary to implement organizational change for the purpose of improving nursing practice and achieving better health outcomes [39]. Nursing leadership is also central to the agenda of professional bodies such as the Royal College of Nursing (RCN) in the UK. More recently the World Health Organization [40] identified investment in leadership skills development as one of its key priorities in the global strategic direction for nursing and midwifery for 2021–2025. While leadership is a shared responsibility of all nursing roles, it is a core competency of advanced practice nursing [1] and a central pillar of the role. Lamb et al. [41] note that the contribution that advanced practice nurses make to the healthcare reform and quality is frequently not recognized, because their leadership activities are so embedded in the complex actions of care delivery that it is frequently viewed through the lens of clinical practice and not leadership.

Heinen et al. [42] in a recent review synthesis the evidence from 15 international research studies and 7 competency frameworks on leadership and advanced practice nursing. As an outcome they identified 30 core leadership competencies that they classified into the following 7 domains: (1) clinical, (2) professional, (3) health systems, (4) health policy, (5) clinical and health systems, (6) professional and health systems, and (7) clinical/health system and health policy. Most of the competencies relate to the first four domains; however, as six competencies incorporated more than one domain, the latter three domains were created, which highlights the complex and interrelated nature of leadership activity at this level.

In the clinical leadership domain, eight competencies focused on providing leadership in the delivery of excellent care included items like being an expert clinician; implementing innovations; improving the quality of care through monitoring standards; collaborating with professionals and other health agencies; and aligning practice with organizational goals [42]. Although evidence-based practice (EBP) and research are often viewed as a stand-alone pillar, enhancing EBP is included within this domain as the authors viewed supportive leadership critical to the

successful institutionalization of EBP. Similar to an earlier study by Elliott et al. [43], the competencies in the professional leadership domain ($n = 6$) focus on the development of the nursing profession through development and integration of APN roles into the healthcare system and participation in professional national and international organizations networks, working groups, committees, and peer-reviewed activities, all with a view to keeping up-to-date with changing evidence, technologies, and practices. The competencies within the health systems domain ($n = 8$) shift focus from direct care to leading and influencing at the strategic level, which is especially important for APMHNs, given how many professions are integral to the provision of high-quality services for mental health service users. Thus, the competencies in this domain focus on team working, delegation, creating a culture of ethical standards, and creating a shared organizational vision on quality including the implementation and monitoring of organization performance standards. The health policy domain has two competencies, to provide leadership in policy-related activities and the articulation of the values of nursing to key stakeholders and policy makers. The clinical and health systems domain includes competencies that are frequently omitted in other frameworks, such as competencies related to employing principles of business, finance, and economics to develop and implement quality initiatives at system-wide level, as well as creating positive, healthy working environments that supports safe care, collaboration, and professional growth. The professional and health systems domain had one competency that focuses on coaching and mentoring future generations. The one competency in the clinical/health system and health policy domain emphasizes providing leadership on evaluating and resolving ethical and legal issues that relate to information technology and communication networks [42].

Although this framework is not specific to APMHNs and some of the identified competencies need to be further refined, it does provide an understanding of the complexity of competencies required at this level. The framework also adds to the six characteristics of this pillar identified by the RCN [20, p. 5] and the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England (see Table 2) [19, p. 9]. In doing so it helps support the development of evidenced-based curricula and training programs on

Table 2 Leadership pillar

RCN (2018) characteristics of leadership	Health Education England (2020)
1. Identifying need for change 2. Leading innovation and managing change, including service development 3. Developing case for change 4. Negotiation and influencing skills 5. Networking 6. Team development	1. Identify, critically evaluate, and reformulate understanding of professional boundaries to support new ways of working within the context of organizational and service need 2. Exercise professional judgment and leadership to effectively promote safety in the presence of complexity and unpredictability 3. Demonstrate teamworking, leadership, resilience, and determination in managing situations that are unfamiliar, complex, or unpredictable

leadership for APMHNs. However, as the framework is not specific to APMHNs and while it does mention ethical standards and advocating "for" environments that promotes safety, it reads more within the paradigm of "doing for" people as opposed to doing "with." In this way it fails to make explicit that one of the critical leadership competencies of APMHNs is the ability to join forces with service users and carers to co-create the agenda for change, including the implementation and evaluation of all innovations. APMHNs have a critical role to play in promoting and supporting the development of service users' leadership while valuing the service user voice and their experiential knowledge and expertise [44]. As it is only through combining experiential and nursing knowledge will APMHNs be in a position to direct their leadership toward the human rights agenda (as discussed in chapter "Landscape of Advanced Practice Mental Health Nursing in Europe"), take on the advocacy dimension of their leadership role, and act to challenge and disrupt structures and process at the individual, team, service, systems, and policy level that continue to reproduce and widen divides that are the major determinants of poor mental health outcomes (see also "Advanced Practice Mental Health Nurses as Leaders" and "Advocacy and the Advanced Nurse Practitioner").

5.3 Research and Evidence-Based Practice

Although "research" is the third pillar of APN according to the RCN, we have chosen to add evidence-based practice not only because it is central to the practice and vocabulary of all nursing [45, 46], irrespective of position or role, but it is a more expansive and inclusive term. While some debate exists on what constitutes evidence, there is consensus that it incorporates the most valid and current evidence from primary research, systematic reviews, clinical guidelines, clinical expertise, and service user preferences [47, 48]. The ICN and various regulatory bodies for the nursing profession throughout Europe make it very explicit that nurses are expected to value research, use evidence-based knowledge, and apply best practice standards in their work, as the application of best evidence is central to quality care and enhanced outcomes for service users [1, 18, 20]. Furthermore, the importance of delivering evidence-based care to people experiencing mental health problems is reiterated in the guidelines published by organizations such as the National Institute of Health and Care Excellence (NICE https://www.nice.org.uk/). While specific research and evidence-based competencies have not been developed for APMHNs, the international literature on advanced practice roles identifies the need for all APNs to not only base their practice on the best evidence available but promote evidence-based nursing among other nursing staff through their clinical leadership role [49]. Gerrish et al. [49] in exploring the contribution of all advanced practice nurses to evidence-based care identifies five dimensions of what they term "evidence brokering" that can help APMHNs consider their role and competencies in the area of EBP, namely, (1) accumulating evidence which involves searching it out, networking, and acting as a conduit for organizational evidence; (2) synthesizing evidence, which involves bringing together different pieces and types of knowledge

Table 3 Melnyk et al.'s [50] evidence-based practice competencies for advanced practice nurses

1.	Systematically conducts an exhaustive search for external evidence to answer clinical questions (external evidence: evidence generated from research)
2.	Critically appraises relevant pre-appraised evidence (i.e., clinical guidelines, summaries, synopses, syntheses of relevant external evidence) and primary studies, including evaluation and synthesis
3.	Integrates a body of external evidence from nursing and related fields with internal evidence* in making decisions about patient care (internal evidence* = evidence generated internally within a clinical setting, such as patient assessment data, outcomes management, and quality improvement data)
4.	Leads transdisciplinary teams in applying synthesized evidence to initiate clinical decisions and practice changes to improve the health of individuals, groups, and populations
5.	Generates internal evidence through outcomes management and EBP implementation projects for the purpose of integrating best practices
6.	Measures processes and outcomes of evidence-based clinical decisions
7.	Formulates evidence-based policies and procedures
8.	Participates in the generation of external evidence with other healthcare professionals
9.	Mentors others in evidence-based decision-making and the EBP process
10.	Implements strategies to sustain an EBP culture
11.	Communicates best evidence to individuals, groups, colleagues, and policy makers

and aligning them with both service user and professional perspectives; (3) translating evidence which involves a number of processes including evaluating, distilling, and interpreting evidence to make it understandable to different audiences, including service users, family, public, and more junior colleagues with the mental health team; (4) generating evidence from research and audit; and finally (5) disseminating of evidence within and outside healthcare [49]. More recently in addition to EBP competencies required of all nurses, Melnyk et al. [50] identify 11 competencies (see Table 3) for advanced practice nurses, including APMHNs.

While Melnyk et al. [50] include skills such as critical appraisal and mentoring of others and highlights the importance of the APNs' role in integrating evidence from diverse sources, including the service users, and implementing strategies to sustain and EBP culture, the 11 competencies reflect Gerrish et al.'s [49] typology of accumulating, applying, translating, generating, and disseminating evidence. Although more expansive they also reflect some of the content of the RCN document (RCN [20, p. 5], and the additional capabilities required for all advanced practice mental health practitioners identified by the Health Education England (see Table 4) [19, p. 10]. However, like the leadership frameworks, competencies related to the coproduction of research agendas and the involvement of service users/family members/carers in all stages of the research or audit process are not made explicit. Yet patient and public involvement (PPI) in research from design to dissemination or thought to translation is core to all national and international research frameworks. Although the use of the term "patient" is contested in the mental health arena, ethically, PPI is advocated on the grounds that people have a right to have a say in decisions about research that may affect them and have a right to influence research that is paid for from public resources. Pragmatically, PPI is seen as benefitting the research process by enhancing the validity, design, applicability, or dissemination of the research. PPI is also considered important in ensuring the research

Table 4 Research pillar

RCN (2018) characteristics of research	Health Education England (2020)
1. Ability to access research/use information systems 2. Critical appraisal/evaluation skills 3. Involvement in research 4. Involvement in audit and service evaluation 5. Ability to implement research findings into practice—including the use of and development of policies/protocols and guidelines 6. Conference presentations 7. Publications	1. Critically appraise and apply the evidence base in influencing engagement, recovery, shared decision making, transference, and safeguarding 2. Develop and implement robust governance systems and systematic documentation processes, keeping the need for modifications under critical review 3. Demonstrate the application of quality improvement methodologies in improving service

questions, methods, and outcomes are relevant and appropriate to research participants and service users [51].

5.4 Education

This pillar includes education in a broad context, both as a part of clinical practice and also as part of larger educational systems. The European Federation of Nurses Associations (EFN) describes in the Workforce Matrix the Advanced Nurse Practitioner's (ANP) competence from the education viewpoint as competence to guide, counsel, and educate other health professionals about latest practice innovations, act as a mentor and role model, and actively engage in knowledge transfer with patient communities [28]. Similarly the Royal College of Nursing (RCN) [20, p. 5] in the UK describes the characteristics of the education competence of APNs which is compared to capabilities for the Health Education England's Advanced Practice Mental Health Curriculum and Capabilities Framework for the education pillar in Table 5 [19, p. 9].

When reflecting on these descriptions of the educational aspects of APNs in the context of APMHNs, notable differences exist. This is especially true regarding co-operation with service users and in the continuous development of APMHNs' own competence, which is an important part of the educational competence of APMHNs to guarantee the high-quality mental health care. These differences between APNs and APMHNs is understandable bearing in mind that the therapeutic alliance is the core of mental health nursing compared to other fields of nursing. In practice this means that in mental health care, collaboration with the service users, families, networks, and communities are based on the ideas of human rights and recovery which become a reality in the co-creation and co-production of knowledge. Therefore, the role of the APMHN is rather a facilitator and active partner than the traditional educator or teacher, where collaboration means respecting and valuing the different kinds of knowledge people have as well as a commitment to learn from each other (see "Educational Aspects in Advanced Mental Health Nursing Practice").

Table 5 Education pillar

RCN (2018) characteristics of education	Health Education England (2020)
1. Principles of teaching and learning, 2. Supporting others to develop knowledge and skills 3. Promotion of learning/ creation of learning environment 4. Service user/carer teaching and information giving 5. Developing service user/ carer education materials and teaching 6. Mentorship and coaching	1. Facilitate collaboration of the wider team to support individual or interprofessional learning and development 2. Critically assess and address individual learning needs that reflect the breadth of ongoing professional development across the four pillars of advanced clinical practice 3. Effectively utilize a range of evidence-based educational strategies/interventions to support person-centered care with individuals, their families and carers, and other healthcare colleagues

This approach, which is based on a human rights, social justice, and equality, is also important from the viewpoint of decreasing stigma where APMHNs have a key role to play [52].

The NONPF competencies that apply to education are distributed over all nine competency areas of the model but do include specifically for APMHNs competencies such as “providing psychoeducation to individuals, families, and groups regarding mental health problems and psychiatric disorders” [16, p. 66] and generically for all the NP specialty areas such as the following:

- Translates technical and scientific health information appropriate for various users’ needs
- Assesses the patient’s and caregiver’s educational needs to provide effective and personalized healthcare
- Coaches the patient and caregiver for positive behavioral change

The educator component of the role of the APMHN and related competencies are more often associated with the traditional CNS role than the NP role, although again overlap is noted in the literature [1, 21, 53].

When considering the education pillar, it is important also to be mindful of different types of learning. Although there are many different types of learning, most often the terms “formal” and “informal” learning are used. “Formal” is used to describe the organized and structured program or event, while the informal or non-formal learning refers to all other kinds of learning [54]. Formal educational practices of APMHNs can include different kinds of educational activities with service users, families, students, and other professionals. Educational activities with service users and family members may range from co-producing educational material to facilitating group discussion with service users or family members in-person or online. APMHNs having pedagogical competence to support these activities is

important as well as understanding the pedagogical principles underpinning the process of translating knowledge into practice (see “Knowledge Translation and Linking Evidence to Practice” and “Enhancing the Quality of Care Through Participatory Generation of Evidence”). Informal learning is important as well, as often without being conscious about it; APMHNs are role models in practice not only for students, novice colleagues, and other professionals but also for service users and family members. In a similar way, APMHNs are themselves learning all the time; thus, the continuous professional development or continuous professional growth of the APMHN is a crucial part of quality mental health practice. Given that the therapeutic alliance and therapeutic use of self is core to mental health nursing, self-reflection on one’s own inner processes as well as reflecting on the viewpoint of others is needed. Reflecting in and on practice and learning about the “self” with the support of the clinical supervision is a key competence (see “Maintaining Professional Competence”), which enables continuous professional development as well as role modelling to others the importance of continuous development.

Before concluding this section, it is important to note that in some countries a role called the clinical nurse educator exists, creating some confusion and overlap with APNs [53]. But as said about other competencies of APMHNs involving elements that do not entail direct care, the tasks, activities, and competencies related to educational aspects of the APMHN role need to be specifically guarded and cultivated, else they may start slowly disappearing from it.

6 Challenges Encountered by APNs in Enacting Their Role

When it comes to the role of the APN and APMHN in Europe and beyond, there are many lessons to be learned. Like in other places around the world, the NP role in Australia includes traditional medical roles on top of other advanced practice nursing and mental health professional roles, such as “prescribing medications, ordering of diagnostic tests, referral to specialists, admitting and discharging privileges, and the authorization of absence from work certificates” [55, p. 181]. In Australia some debate has taken place whether this constitutes role expansion or role extension for APMHNs. But in essence the difference between role expansion and role extension is that role expansion includes an expansion of skills and responsibilities already present in its essence, while role extension refers to functions traditionally belonging to another profession being assumed by the APN, e.g., prescribing medicine [55]. Both phenomena can be seen as role development based on the need of service users and/or healthcare services. Researchers have pointed out that there are many ways in which to perceive APMH nursing, either through competencies, role extension or expansion, or even the skill to effectively reflect on one’s own practice [56]. But clearly opinion about the APMHN role varies greatly depending on context, access to care, and geographical settings. Elsom et al. [55] point out that the development of the APMHN role is often and will continue to be quite haphazard and coincidental, based on the need, rather than on intentional development—something that entails just as many risks as it entails opportunities.

However, equating expanded practice with advanced practice may indeed be quite damaging for the APMHN role. Although the role may include role extension and/or expansion, it certainly does not need to do so. Therefore, competencies may be an effective way to ensure that roles do indeed include the required advance practice nursing skills to become an advanced nurse practitioner [55].

Lowe et al. [57] make a further compelling point about role clarity of the NP and stress the importance of an international approach to the issue, such as the attempt by the ICN in 2020 already reviewed earlier in this chapter [1]. The therapeutic alliance is the heart of APMH nursing and studies on the efficacy of the APN role demonstrate that this may be the very key to the success of APNs [55]. So, in the final analysis, the need for constructing competencies with the therapeutic alliance at its core could be a first step in protecting APMH nursing practice from mindless extension and intentionally developing it based on advance practice nursing competencies to meet the need in each system, for the good of service users, families, and communities.

There is a growing concern in the international and European literature that direct patient care time for CNSs is decreasing over time, rendering the role of the CNS all but invisible [58]. This is relevant to APMHNs especially as direct clinical care lies at the very heart of mental health nursing especially, with the therapeutic alliance at its very core. If APMHNs wish to provide high-quality, advanced level mental health care to the service user and their family and significant others, time to cultivate the therapeutic alliance should be set aside and ensured.

There is also concern about the development of the leadership role for APNs including the lack of clarity on the leadership role, not enough time for leadership tasks, lack of leadership skills, and lack of support from nursing management and other staff [59]. As the demand for a bigger caseload increases with the greater focus on advanced clinical competencies of the NP role, more effort needs to be placed on maintaining and enabling leadership competencies [59]. For APMHNs to be able to fulfill their leadership role and the associated competencies, both healthcare leaders and managers as well as the APMHN need to place effort in cultivating and supporting these competencies. The barriers to APNs and APMHNs to conduct research and audit are myriad as well. Nurse consultants have been shown to spend the majority of their time on activities other than research, audit, and evaluation [22]. APNs also run into trouble with lack of time and confidence with research, which regardless of role, research confidence, and competencies should be a special focus of all APN programs, including APMHN programs [23].

For the education part, time constraints and lack of training, privacy, and managerial support are some of the main barriers to fulfilling this part of the APMHN role, despite evidence that education can lead to increased feelings of empowerment as well as positively impact various other factors for service users [60, 61]. For APMHNs setting aside time and space for collaboration with service users remains an essential component of their role. However to actualize this, educational programs for APMHNs need to include appropriate pedagogical competencies, and healthcare systems and organizations must provide APMHNs with the time and space to fulfill this aspect of their role [60].

7 Future Issues for the Role Development of the APMHN

Work needs to be done to clarify the APMHN role for individual service users and family members as well as healthcare organizations, policy makers, and other healthcare professionals. Without role clarity and well-defined but inclusive competencies that are centered around recovery and human rights of service users, the rationale for APMHNs will be hard to articulate and argue for, as the biomedical approach already has enough champions within the mental health services. This rationale could be achieved in part through frameworks such as the participatory, evidence-based, and patient-focused process for guiding the development, implementation, and evaluation of advanced practice nursing framework (PEPPA), with the combined efforts of individuals, professional organizations, and healthcare organizations [62]. The PEPPA framework emphasizes service user input and opinion, as well as taking into consideration the needs of the healthcare system in a given context and thus may be a good fit for APMHN role development [63]. As more and more European countries start to develop APMHN educational programs and establish clinical certifications, with clearly delineated roles and competencies, the question of maintaining the quality and safety of established APMHNs is raised. Recertification and demands for maintenance of competencies vary in Europe both for generalist, specialized, and advanced practice nurses [1]. But recertification is one way to ensure quality and safety of APMHNs for service users, ensuring that at least minimal competencies are maintained through various educational programs, scientific efforts or continuing professional development, and education activities. The models that dictate exactly how this is done are myriad and lie beyond the scope of this chapter, but it should be sufficient to say that many such models exist and could be applied in different countries if a regulatory body exists and APMHN certification is in place. But as in so many other issues, the diversity of APMHNs in Europe is great, and one single approach or generic solutions are unlikely, irrespective of how enticing they may seem on the surface (see “Maintaining Professional Competence for Further Discussion”).

As the role of the APMHN develops and rights-based, recovery-oriented, and community-based care become more common, the demand for a clear interdisciplinary role collaborating with service users, family, community, and networks will likely increase. As discussed, some countries have answered this call by creating competencies and tool kits for advanced practice mental health professionals regardless of clinical background [19]. If APMHNs want to impact mental health services, they will need to have competences in promotion, prevention, and rights-based and recovery-oriented care and be able to respectfully work in collaboration with the other professionals, with people seeking help, their families, communities, and networks. This requires clinical humility on the part of APMHNs, an understanding and acknowledgment that some competencies as advanced practice mental health practitioners are not theirs alone.

It may be that the future of APHMNs lie in one role that encompasses both the traditional CNS role and the role expansion often associated with the NP role. Regardless clarity is needed on what standards and competences dictate the work of APMHNs and models that take into account the diverse legal and clinical settings where APMHN practice internationally (e.g., [57]).

8 Conclusion

In this chapter the roles and competencies of APMHNs from various perspectives have been reviewed. The different roles within advanced practice nursing have been discussed including the difference between generalist nurse, specialized nurse, and APN, as well as the difference between the CNS and NP role and their similarities as well as the four pillars of advanced practice nursing and the accompanying competencies. Some pitfalls in the development of the APMHN role have been addressed, making sure role expansion takes place for the right reasons and in the right way, i.e., based on competencies, not tasks, and with the need of the service user as its driving force. Finally, some of the challenges and opportunities these bring are reviewed.

The role of the APMHN in Europe varies greatly depending on multiple factors. This does not necessarily constitute a weakness but rather is an expression of the diversity that may be the greatest strength of European APMHNs. This also applies to the competencies of APMHNs in Europe, which are often a part of the bigger picture of APN competencies in general. In some countries the role simply does not exist, and in others some could argue; it has drifted too far from the heart of mental health nursing, the therapeutic alliance, and thus lost its way. Moving forward and intentionally developing the APMHN role in Europe should be a focal point for mental health educationalists and healthcare leaders in conjunction with other stakeholders, such as service users and family member groups and organizations. It is only through the acknowledgment of the multiple voices and views that the development of the APMHN will be guided by service user need centered on their recovery and human rights.

Reflective Questions

- How do the four pillars of advanced practice as defined by the RCN resonate with your own view on the roles and competencies of APMH nursing?
- Contemplate some examples of competencies for each pillar that are of special importance to the APMHNs in your country.
- When comparing your own work as an APMHN or APMHN student, what similarities or differences with the competencies described in this chapter do you find?

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