Mental Health Nursing Services

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Introduction

The current trend in mental health systems is a strong movement toward implementation of a recovery model of care (American Nurses Association [ANA] 2014; Seed and Torkelson 2012; Substance Abuse and Mental Health Services Administration [SAMHSA] 2006). Recovery principles are rooted in the foundations of nursing practice. Components of the recovery model are consistent with the training and practice of nursing, such as providing individualized and person-centered care, viewing the individual holistically rather than narrowly defined by his/her illness or disorder, building upon the individual's strengths rather than focusing on his/her deficits, demonstrating respect, fostering hope, and enabling the individual to live a personally satisfying, meaningful life (SAMHSA 2006).

The recent emphasis on recovery supports psychiatric-mental health (PMH) nursing traditions of relationship-based care in which the focus is on the care and treatment of the individual with the disorder, and not the disorder itself. Through the use of therapeutic interpersonal skills, PMH nurses are instrumental in assisting individuals with mental disorders achieve their own recovery and wellness goals. The practice of nursing in an inpatient psychiatric hospital is particularly well suited to the mental health recovery model as nurses have the largest professional presence in this setting, often a continuous 24-hour presence (ANA 2014; Beech 2000; Turkington et al. 2006). However, the inpatient setting presents unique challenges that create tensions between recovery principles and nursing services. This chapter describes how PMH nurses can incorporate the recovery model in the provision of services in an inpatient psychiatric hospital from admission to discharge, along with some of the challenges they may face along the way.

To provide context for subsequent sections, the chapter begins with a brief description of various nursing roles, nursing's relationship to the recovery model, and the therapeutic nurse–patient relationship. This is followed by a brief description of the inpatient psychiatric hospital setting and individuals typically served in this setting. Then there is a discussion of treatment planning and the nursing process, and the vital role of the PMH nurse as an interdisciplinary treatment team member. Next, there is a discussion of some of the services nurses provide, including assessments and interventions, with an emphasis on how nurses can incorporate recovery principles into the provision of these services. The chapter concludes with a discussion of some

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challenges the recovery model poses for nurses providing these services in inpatient psychiatric hospitals.

Psychiatric-Mental Health Nursing

Psychiatric-mental health (PMH) nursing is defined as "the nursing practice specialty committed to promoting mental health through the assessment, diagnosis, and treatment of behavioral problems, mental disorders, and comorbid conditions across the lifespan" (ANA 2014, p. 19). There are two levels of practice of PMH nursing: the psychiatric-mental health registered nurse (PMH-RN), with educational preparation within a bachelor's degree, associate's degree, or a diploma program, and the psychiatric-mental health advanced practice registered nurse (PMH-APRN), with educational preparation within a master's or doctoral degree program. In addition, the PMH-APRN level has two subcategories: the psychiatric-mental health clinical nurse specialist (PMHCNS) and the psychiatric-mental health nurse practitioner (PMHNP). Nursing staff in mental health settings may also be comprised of positions other than RNs, such as licensed practical or vocational nurses, psychiatric technicians, and forensic technicians. While these other nursing staff are valuable team members that often spend substantial time with the individuals and report to the RNs, this chapter primarily focuses on the role of RNs.

The movement toward the integration of recovery principles in PMH nursing requires a paradigm shift away from a medical model, an approach that is largely inconsistent with recovery principles. The medical model has been described as not therapeutic, not empowering, and not conducive to healing, with a focus on the illness rather than the person with the illness (Chen et al. 2013; Deegan 2007; Seed and Torkelson 2012; Swarbrick 2006). In acute care and inpatient psychiatric units, PMH nurses who work primarily in a culture that emphasizes the medical model spend the majority of their time performing routine task-oriented duties such as administering medications to control or alleviate symptoms, keeping the unit safe (e.g., observing and monitoring individuals at risk), providing overly custodial care (e.g., setting strict limits or suggesting solutions instead of teaching problem-solving skills), completing excessive paperwork and other administrative duties, and attending numerous meetings (Mullen 2009; Seed and Torkelson 2012; Seed et al. 2010). While some of these duties are undeniably important, they are time consuming, narrow in scope, and often do not allow sufficient time for nurses to engage in frequent, quality interactions with individuals in order to establish a therapeutic relationship, the core of PMH nursing (Aston and Coffey 2012; Cahill et al. 2013; Mathers 2012; Mullen 2009).

In contrast to the medical model, the role of PMH nurses in the recovery model is not only to provide routine, task-oriented care and treatment, but also develop partnerships and assist individuals with their recovery goals. Examples of these goals may include renewing hope, becoming involved with meaningful activities, redefining self beyond illness, incorporating illness, managing symptoms, assuming control, becoming empowered, overcoming barriers to social inclusion, exercising citizenship, and being supported by others (Davidson et al. 2003).

Among many definitions, SAMHSA (2006) defined mental health recovery as a journey of healing and transformation, and described 10 fundamental components of recovery: hope, self-direction, individualized and person-centered, empowerment, holistic, nonlinear, strengths-based, peer support, respect, and responsibility. Regardless of the specific definition, the consensus is that recovery is what the individual does, and treatment and rehabilitation are what PMH nurses and other healthcare professionals do to facilitate the individual's journey along his/her path.

Like nursing in general, PMH nursing is both a science and an art. It is a science in that PMH nurses utilize a wide range of theories and research findings to guide their practice. They also use the nursing process as a critical thinking framework to serve as the foundation for clinical decision-making and to support evidence-based practice. When applied to PMH nursing, the

nursing process involves six areas: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation. PMH nurses use the nursing process to care for and treat individuals with actual or potential mental health problems, psychiatric disorders, co-occurring psychiatric and substance use disorders and risks, and co-occurring physical health problems, medical illnesses, or risks. Utilization of the nursing process in PMH is consistent with a recovery-oriented model as nurses use it to promote and foster health and safety, assess dysfunction and areas of individual strength, assist individuals to achieve their own personal recovery goals, maximize strengths, and prevent further disability.

PMH nursing is an art in that it is accomplished through interpersonal relationships, therapeutic intervention skills, and professional attributes. Examples of these attributes include self-awareness, moral integrity, and empathy, which enable PMH nurses to practice the purposeful, artful use of self in therapeutic relationships as characterized by respect, availability, hope, acceptance, advocacy, and spirituality, to name just a few. The therapeutic nurse–patient relationship concept is considered the hallmark of PMH nursing (O'Brien et al. 2013). Several characteristics define this relationship that align with recovery principles. For example, a therapeutic relationship is based on mutual respect, focused on the individual and designed to meet his/her needs, and collaborative, with both the individual and nurse contributing to growth, healing, and problem solving. The interactions are goal oriented, the goals are mutually established, and decision-making is shared. Furthermore, the relationship promotes the individual's independence to the greatest extent possible, where the nurse *works with* the individual versus *doing for* the individual (O'Brien et al. 2013).

O'Brien et al. (2013) described four qualities essential to the development of a therapeutic nurse–patient relationship. The first quality is *respect*. PMH nurses must accept individuals' beliefs and feelings with a nonjudgmental attitude, even if they differ from their own. Nurses need to also be self-aware of and examine any preconceived attitudes, beliefs, or judgments they have that may interfere with providing therapeutic care to an individual. While it is inevitable that differences will exist between PMH nurses and individuals, nurses must accept and respect these differences, attempt to understand the individual's perspective, and not impose their personal values. Nurses can demonstrate respect to individuals in numerous ways such as asking how they prefer to be addressed (e.g., first name, last name), assessing for religious or cultural factors that may influence care and treatment, being sensitive to touch and personal space, and involving individuals in decision-making and treatment planning.

The second essential quality is *trust*, which O'Brien et al. (2013) described as the foundation of all interpersonal relationships. Trust is particularly important for individuals with mental illness given their increased vulnerability, and it is essential for their PMH nurses to be honest, reliable, and dependable. Nurses must earn this trust, and it will evolve over the progression of the relationship rather than occur immediately. However, what takes a long time to build can be quickly undone by just one negative occurrence, so all nursing actions need to promote trust. Some examples include consistently following through with promises (e.g., be on time for appointments; give reinforcement for positive behaviors as agreed upon) and treating individuals fairly (e.g., in a psychosocial group, do not show unfair, subjective favoritism toward an individual).

The third significant quality is *genuineness*, or the ability for nurses to be themselves or to be real or authentic during interactions with individuals (O'Brien et al. 2013). This quality also refers to congruence between what nurses are actually feeling and their expression of these feelings. For example, if an individual shares a story about being sad and angry due to the recent death of a best friend and the PMH nurse's verbal behavior demonstrates caring and understanding but nonverbal expressions suggest apathy, this lack of genuineness could also impact the level of respect and trust in the relationship. In addition, if an individual asks the nurse something

and the nurse does not know, typically there is a greater chance the individual will respect the nurse admitting his/her limitations and providing an honest, genuine response rather than providing a false response.

The fourth quality O'Brien et al. (2013) discussed as an essential characteristic of the nurse–patient relationship is *empathy*, or the ability to put oneself in another person's place and see the world as he/she does. A PMH nurse who is empathetic has an objective understanding of an individual's emotions and is sensitive to the individual's feelings without actually experiencing the emotions. Empathy helps build trust in a relationship and differs from sympathy, which is a subjective experience, involves an actual sharing of experienced emotions, and may interfere with the relationship and the nurse's ability to provide effective, supportive care, and treatment.

These four qualities—respect, trust, genuineness, and empathy—are consistent with the first three provisions of the ANA *Code of Ethics for Nurses with Interpretive Statements* (ANA 2015), which state, "the nurse practices with compassion and respect for the inherent dignity, worth, and unique attributes of every person" (p. 1), "the nurse's primary commitment is to the patient, whether an individual, family, group, community, or population" (p. 5), and "the nurse promotes, advocates for, and protects the rights, health, and safety of the patient" (p. 9), respectively. PMH nurses that adhere to these provisions help promote a therapeutic relationship with the individuals they serve and thus assist these individuals in achieving their recovery goals.

Compared to a social relationship, the professional nurse–patient relationship is purposeful, structured, and time-limited, and nurses' self-disclosure of intimate, personal information is restricted. Multiple factors contribute to the development and success of the professional relationship such as development of trust, mutually determined goals, and establishment of boundaries early in the relationship. The nurse's use of therapeutic communication techniques during all interactions, both formal and informal, is also critical, such as while conducting an assessment, engaging in an informal conversation, conducting a formal individual counseling session, or facilitating a psychosocial rehabilitation group. Examples of therapeutic communication techniques include active listening (e.g., during an assessment interview or individual counseling session), effective nonverbal techniques (e.g., appropriate facial expression, posture, and eye contact that is culturally sensitive), effective verbal techniques, and skillful communication (e.g., constructive strategies for verbally obtaining and conveying information during an interview or to encourage engagement of an individual in treatment), and assertive communication, which promotes the use of *I* versus *you* statements and allows individuals to own their feelings and communicate their wishes and needs in a respectful, nonaggressive manner (O'Brien et al. 2013).

PMH nurses practice in a variety of clinical settings across the continuum of care, including but not limited to partial hospitalization (or day treatment) and intensive outpatient programs, residential facilities, community mental health centers, assertive community treatment (ACT) teams, home healthcare, psychiatric emergency departments, and inpatient psychiatric hospitals (ANA 2014; O'Brien et al. 2013). This chapter focuses primarily on inpatient psychiatric hospitals, a setting in which the majority (two thirds) of PMH nurses work (Hanrahan 2009). Individuals admitted to inpatient psychiatric hospitals may be voluntary or involuntary (civil) commitment (i.e., court-ordered). They may also be admitted through the criminal justice system with a forensic legal status for reasons such as emergency treatment due to dangerousness to self or others, evaluation of their competency to stand trial, restoration of their competency to stand trial, or evaluation of their mental state at the time of the alleged offense (Singh et al. 2016).

Individuals served in an inpatient psychiatric hospital often have a severe mental illness (SMI), which is a mental, behavioral, or emotional disorder that substantially interferes with or limits one or more major life activities (SAMHSA 2013b). SMIs tend to last for a long time (if not a lifetime) and may be characterized by periods of

relapse or reoccurrence. While many psychiatric disorders have the potential to persist and become chronic and severe, schizophrenia, major depressive disorder, and bipolar disorder tend to be most prevalent, and an individual may experience more than one mental disorder (Spaulding et al. 2016).

Treatment Planning and Nursing Process

Individuals residing in inpatient psychiatric hospitals face many complex issues that necessitate treatment teams to take an interdisciplinary versus a multidisciplinary approach to care and treatment in order to achieve desired goals and best facilitate the individual's road to recovery. Teams that adopt a multidisciplinary approach are more clinician centered and are characterized by several disciplines working parallel to each other in silos, doing their individual pieces of the process, writing separate treatment plans, and combining the separate plans into one big plan with little to no integration (Akhavain et al. 1999; McLoughlin and Geller 2010). This approach frequently results in fragmented, redundant, complicated, confusing, and inconsistent care that lacks alignment with the recovery model. Individuals are unable to track their own progress, and team members lose focus of who is doing what and why. In contrast, teams that utilize an interdisciplinary approach are more person-centered and are depicted by disciplines that work collaboratively and cooperatively toward common goals and combine efforts to formulate one synergistic treatment plan. In comparison to the multidisciplinary approach, the interdisciplinary approach is more streamlined, simple, clear, user-friendly, and consistent and is better aligned with the recovery model as it emphasizes the importance of individuals taking significant responsibility for their own recovery by taking active ownership in their treatment and rehabilitation plan and being a dynamic participant in the team collaboration process.

PMH nurses are core members of the interdisciplinary team, along with other disciplines such as psychiatry, psychology, primary care, social work, rehabilitation services, and activity therapy (Singh et al. 2016). Although all disciplines share common knowledge and skills in some areas, each member has a unique knowledge base and skills and brings his/her own perspectives and ideas to the table that enriches the treatment team. For example, utilizing the therapeutic nurse–patient relationship as their basis, PMH nurses bring expertise in assessing an individual's capacity to engage in activities of daily living and helping the individual cope as needed (O'Brien et al. 2013). Ideally, the planned synergy that results when overlapping strengths and knowledge of the various interdisciplinary team members are tailored and matched to the needs of the individual will enhance the outcomes of care and treatment and expand the comprehensiveness of these outcomes (ANA 2014). For example, Akhavain et al.'s (1999) review of the literature suggested implementation of a collaborative team approach enhanced quality of individuals' care as evidenced by positive outcomes such as reduced mortality rates, reduced costs, and self-reported improved quality of life.

In the inpatient psychiatric hospital setting, the treatment plan serves as a blueprint or roadmap for the individual's recovery from admission to discharge (Davidson et al. 2016; Singh et al. 2016). Based on the recovery model, rehabilitation and recovery principles are typically the framework that guides development of treatment plans in inpatient psychiatric hospital settings, and the overall aims of these plans are to assist individuals in stabilization of symptoms (as indicated) and to help them obtain the skills needed to be discharged from the hospital, to experience successful community reintegration, and to have enhanced quality of life. A few modifications to these aims may be necessary in some instances such as individuals admitted with forensic status or individuals with co-occurring mental illness and developmental disabilities.

In order to be effective, treatment plans should be person-centered and focus on the individual as opposed to just on specific diseases, disorders, or deficits of the individual. They should also be

tailored to the individual's needs and preferences rather than trying to fit the individual into a prewritten, cookie cutter plan. In addition, treatment plans should be meaningful to the individual and enable all team members to evaluate the attainment of goals and the effectiveness of interventions. Exact components of treatment plans vary among hospitals, but common elements typically include case formulation, diagnoses, discharge criteria and plan, discharge barriers/problems, goals and objectives, and interventions (Singh et al. 2016). In addition, while assessments are not theoretically a part of the treatment plan, they serve as the foundation for the plan's development, and reassessments must be conducted to evaluate the plan's effectiveness on a preset schedule (and more often as needed) to determine whether modifications need to be made. As core members of the interdisciplinary team, PMH nurses play a vital role in the development, implementation, and evaluation of the treatment plan.

When applied to PMH nursing, the nursing process involves six steps: assessment, diagnosis, outcomes identification, planning, implementation, and evaluation (ANA 2010, 2014). These steps essentially mirror those of the treatment planning process. Historically, inpatient psychiatric hospitals have required PMH nurses to write nursing care plans (separate from the team's treatment plan) that contain information to reflect each step in the nursing process. To be more consistent with recovery principles and the interdisciplinary approach to care and treatment, there needs to be a cultural shift away from separate nursing care plans and toward one fully integrated plan (Akhavain et al. 1999). This in no way suggests PMH nurses should stop using the nursing process as a critical thinking framework to assist individuals throughout their recovery journey.

Nursing Assessments

Assessment is one of the PMH nurse's most important skills as it helps define the individual's actual and potential problems, and it enables the nurse and individual to establish a relationship. Although assessment is theoretically the first step in the nursing process, it is in actuality a continuous process carried out during all steps (Berman et al. 2016). The PMH-RN utilizes a systematic and ongoing method to conduct assessments and collect, organize, validate, and document comprehensive objective and subjective data in many areas, including but not limited to psychiatric, substance, physical, functional, emotional, psychosocial, cognitive, cultural, age-related, sexual, environmental, spiritual/transpersonal, and economic (ANA 2014). PMH-RN assessments also involve obtaining information about the individual's "values, preferences, knowledge of the healthcare situation, expressed needs, and recovery goals" (ANA 2014, p. 44). The PMH-APRN has an expanded scope of practice that includes additional skills such as the performance of psychiatric and mental health diagnostic evaluations and the initiation and interpretation of diagnostic tests and procedures (ANA 2014).

Types and Functions of Assessments

PMH nurses conduct several types of assessments, including but not limited to initial, time lapsed, problem-focused, and emergency (Berman et al. 2016). Initial assessments are useful for establishing a comprehensive database for actual and potential problems and risk identification, reference, and future comparison, such as upon an individual's admission to an inpatient psychiatric hospital. The psychiatric admission nursing assessment typically consists of a biopsychosocial history, a mental status examination, and a physical assessment. PMH nurses may also conduct initial risk assessments to identify factors that place individuals at high risk for behavioral, psychiatric, and medical conditions (e.g., suicide, impaired skin integrity, falls). These risk assessments may be published scales in the literature such as the Braden Scale for Predicting Pressure Sore Risk (Bergstrom et al. 1987) or based on specific criteria determined by the hospital. In addition, nurses may also conduct

screens (e.g., nutrition) to identify individuals at potential risk for a health condition (based on predetermined criteria), to trigger a more comprehensive risk assessment, and to implement immediate interventions (if clinically indicated) to keep the individual and others safe until further evaluation can be completed. Specific components of admission assessments will vary depending on factors such as the RN's scope of practice.

Time-lapsed assessments are conducted subsequent to initial assessments in order to compare the individual's current status to baseline data (Berman et al. 2016). This assessment type is particularly relevant to recovery, which is characterized as nonlinear (SAMHSA 2006). In an inpatient psychiatric hospital, individuals' progress along the road to recovery is not a step-by-step process but rather based on continual growth, occasional setback, and learning from experience. Change often occurs slowly and must be closely monitored at designated intervals, such as monthly, quarterly, and annually. Time-lapsed nursing assessments may help identify and document progress, thus instilling hope that improvement is occurring. These assessments are also helpful in detecting changes that occur more rapidly. For example, when an individual is first admitted and assessments are conducted at change of shift (and more often as indicated), progress toward stabilization of symptoms and overall functional health can be monitored.

Problem-focused assessments are an ongoing process integrated with nursing care and are conducted to determine the status of a specific problem or issue identified during a previous assessment (Berman et al. 2016). For example, if an individual has an acute change in mental status related to electrolyte abnormalities, reassessments of mental status will be conducted as often as clinically indicated until the problem is resolved. This assessment type also applies when evaluating progress toward skills training (e.g., an individual learning how to safely and effectively self-administer an insulin injection). Emergency assessments are conducted during any psychological or physiological crisis in order to identify life-threatening or new or overlooked problems. Examples include assessing suicidal tendencies or potential for violence or assessing for airway, breathing, and circulation during a cardiac arrest.

Assessment Methods

PMH nurses use a wide array of methods to conduct the various nursing assessment types, of which the principal methods are interviews, observations, and examinations. Interviews are deliberate, purposeful conversations or communications between the nurse and individual and can serve multiple purposes such as to receive or provide information, identify problems, evaluate change, educate, or provide support, counseling or therapy. Nurses often conduct interviews when completing parts of the biopsychosocial history of the nursing admission assessment. Interviews can be structured (standardized questions) or unstructured (no standardized questions), and consist of both closed- and open-ended questions, depending on several factors such as the purpose of the interview and the needs of the individual. Often a combination of the techniques is best, and the nurse may need to adapt interview strategies based on the situation and the environment. When conducting interviews, PMH nurses should utilize therapeutic techniques described above (e.g., active listening, effective nonverbal and verbal techniques, skillful and assertive communication) that are consistent with qualities essential to development of a therapeutic nurse–patient relationship (i.e., respect, trust, genuineness, and empathy).

Nurses also gather data through observations by using their senses (sight, smell, hearing, and touch). This method not only involves noticing data but also selecting, organizing, and interpreting the data. For example, if the nurse smells foul body odor on an individual, he/she must determine what this finding is related to—poor hygiene, self-neglect, neglect by a caretaker, normal odor after physical exercise, etc. In addition, nurses conduct physical examinations using inspection, auscultation, palpation, and

percussion. When doing a complete exam, nurses should utilize a systematic approach such as head-to-toe or body systems, or they may just concentrate on a particular system for problem-focused exams. Other data collection methods may include asking the individual to self-monitor, such as daily mood ratings (e.g., Tusaie 2013) and intake and output measurement.

Sources of Data

PMH nurses obtain assessment data from both primary and secondary sources of information. The individual (primary) is usually considered the best source unless he/she is too ill, confused, or young to communicate clearly or reliably. The individual can provide subjective data no one else can offer. In inpatient psychiatric hospital settings, individuals often feel most comfortable sharing certain personal, sensitive information with the PMH nurse versus other healthcare team members because of the therapeutic relationship that develops between them due to close and frequent contact. However, it is often beneficial to also obtain data from secondary sources to not only supplement information the individual provides but to also validate or verify it in some instances, especially if there are concerns with reliability, accuracy, or completeness of information. At times individuals may also not be willing or able to provide information due to various reasons such as too ill upon admission, confusion, or paranoia of the nurse's intentions. Examples of secondary sources of data include but are not limited to family members or other support persons (e.g., friends, caregivers, shelter staff, clergy), other health professionals (e.g., verbal report from PMH nurse from another hospital; documentation of behavioral observations on a flow sheet by psychiatric technicians), past and current health records and reports (e.g., medical records, operative reports, social agency reports), laboratory and diagnostic analyses, and relevant literature (e.g., professional journals and reference texts). For individuals admitted with forensic status, the PMH nurse may also review court documents such as warrants, court orders, records from jail, and copies of previous forensic evaluations and obtain information from law enforcement officers.

Incorporation of Recovery Principles

There are numerous ways the PMH nurse can incorporate recovery principles into the assessment process. The assessment process itself, which is continuous in nature, is consistent with recovery being *nonlinear*, such as with time-lapsed assessments described above. For most individuals with SMI, the road to recovery is long and arduous, change is slow, and many barriers and obstacles confront them. Although *hope* is internalized, PMH nurses can foster hope through actions such as providing positive reinforcement during assessments, acknowledging when even the smallest amount of progress has been made toward a goal. Hope is an individual's catalyst for recovery and is an essential motivating factor along the journey (SAMHSA 2006).

Next, the nurse should always demonstrate *respect*, which involves acceptance and appreciation of individuals, including protection of their rights and elimination of stigma and discrimination (SAMHSA 2006). For example, the nurse should always obtain consent from the individual prior to approaching family members and other support persons for assessment data (except in the case of an emergency or unless he/she is not mentally able). PMH nurses should also be both culturally sensitive and culturally competent (O'Brien et al. 2013). Cultural sensitivity refers to nurses being aware of and respecting the individual's values and lifestyles even when they differ from their own, whereas cultural competence is a broader, multidimensional concept that involves knowledge, attitude, and skills. It is important for the treatment team to assess an individual's cultural and ethnic preferences and practices and whether there are any issues that may be pertinent to his/her illness or treatment (e.g., use of complementary alternative medicine, such as healing touch or herbs, prior to admission).

In addition, nursing assessments should be *strengths-based*, which involves building upon and valuing the individual's numerous capacities, talents, resiliencies, coping abilities, and inherent worth (SAMHSA 2006). One broad example discussed above is the recent paradigm shift occurring in inpatient psychiatric hospitals, moving away from the medical model (which primarily focuses on the illness or disorder) toward a recovery model (which focuses on the individual with the illness or disorder). A more specific example that applies to PMH nursing relates to medication non-adherence. Using a strengths-based approach, instead of focusing on and trying to suppress the deviant behavior (e.g., assessing how many times individuals do not comply with practitioner orders and why they do not comply), an alternative approach may be for the PMH nurse to focus on and try to enhance the adherent behavior (e.g., assess how many times individuals take the medication as prescribed; explore with the individuals what was different the times they took the medication compared to the times they did not take it; explore what they think contributes to them taking the medication on some days but not others; explore what strategies they think may help increase the number of times they would take the medication as prescribed). Involving the individuals in discussions such as these, asking their opinions and ideas, incorporates elements of several other recovery principles such as *individualized and person-centered* and *empowerment*.

With *empowerment*, individuals have the authority to choose from a variety of options, to participate in all decisions that may affect their lives, and to speak for themselves about their needs, wants, desires, and aspirations (SAMHSA 2006). One instance of empowering individuals during the assessment process is to offer them a choice of when and where to conduct the assessment and whether they would like to have a family member or other support person present. For example, if an individual is acutely ill and unable to tolerate much contact and exploration, when at all possible, the nurse should provide him/her a choice of several brief assessment interviews instead of one long interview.

Another illustration of empowerment is to offer individuals choices related to their personal safety. For instance, PMH nurses may conduct a Personal Safety Interview with the individuals and ask them questions that elicit choices and involve them in decision-making. For example, nurses may ask the individuals how staff could help them when they noticed they were getting irritated, upset, or angry. They may also ask if they have any preferences or concerns regarding who serves them, such as gender, race, language, and culture. These examples of empowerment also demonstrate *respect* toward the individual. Still another example of how PMH nurses can empower individuals, as well as promote *responsibility* (another recovery principle, where the individual is responsible for his/her own self-care) is to teach them self-care skills and involve them in self-monitoring. For example, a PMH nurse may teach an individual newly diagnosed with diabetes how to self-monitor blood glucose and record amount of food and fluid intake at each meal. The nurse would include the individual's self-monitoring data with data from other nurses and staff when collaborating with the treatment team to evaluate overall diabetes management.

The PMH nurse can also incorporate the recovery principle of *self-direction* into nursing assessments by asking the individual to describe his/her life goals or vision of recovery, including hopes, dreams, and aspirations. Although these goals may include what the individual wishes to do while at the hospital, it is much better to assist the individual to envision life following discharge. In collaboration with the treatment team, the PMH nurse should assess life goals upon admission and then periodically revisit and revise them as the individual's psychiatric condition improves. Furthermore, psychiatric nursing assessments should reflect recovery by being comprehensive and *holistic*, examining many aspects of the individual such as physical, psychological, emotional, behavioral, functional, intellectual, social, cultural, and spiritual (ANA 2014; Berman et al. 2016; O'Brien et al. 2013). They may also include assessing resources and supports (e.g., community, family, financial),

skills and strengths, and intervention needs (e.g., education, medication, therapy services), to name just a few. Specific content is determined by many factors, including content of other disciplines' assessments.

Assessments of individuals with SMI in inpatient psychiatric hospitals are multifaceted. Thus, to enhance effectiveness, treatment teams typically conduct assessments that are multidisciplinary versus interdisciplinary, where members from each discipline do their own assessments, evaluating the individual from a different perspective (Davidson et al. 2016). This approach results in several comprehensive, holistic assessments in which there is often much redundancy across disciplines. While redundancy may be useful in some instances, such as to verify reliability of information provided by the individual (e.g., chief complaint, what brought him/her to the hospital), other redundancy may be unnecessary (e.g., both the PMH-RN and psychiatrist conduct a complete mental status exam or both the PMH-RN and primary care practitioner [PCP] conduct a complete head-to-toe physical assessment). Not only is this overlap in work inefficient use of clinicians' time, but more importantly, it is not consistent with a recovery-oriented model of care.

An alternative approach to conducting some types of assessments that is more consistent with a recovery model is one of an interdisciplinary nature, in which assessments are more integrated and streamlined. This approach requires treatment team members to work collaboratively and to have role flexibility. Akhavain et al. (1999) described role flexibility as crossovers in responsibilities between members in which one discipline is not solely responsible for a task. Role flexibility can best occur when the role of each discipline is defined and understood by all members, and when there is an environment of trust and mutual respect and no inappropriate imbalances of power among members (e.g., no hierarchies based on perceived intellectual superiority). Role flexibility enhances the team's ability to provide holistic care and facilitates the use of shared knowledge and experience in a collegial atmosphere.

Utilization of Assessment Data

Utilizing an interdisciplinary approach in a recovery model, the team comes together to analyze and synthesize all relevant assessment data from each discipline and to develop an integrated treatment plan that includes diagnoses, problems, risks, and areas of focus for care and treatment. For each assessed treatment, rehabilitation, and enrichment need included in the treatment plan, the team writes an individualized, realistic, and simple goal as well as specific objectives or steps (written in behavioral, observable, and/or measurable terms) the individual can take to accomplish the goal. As much as possible, the team should involve the individual in writing goals and objectives, and they should be written in jargon-free language he/she will understand. In inpatient psychiatric hospitals, most objectives will be learning based (i.e., related to what the individual will learn), but some may also be service-based (i.e., related to certain treatments that will be provided to the individual by staff, usually nursing). Once objectives are clearly defined, the team develops interventions that specifically indicate what staff will do to assist the individual to attain each objective (Singh et al. 2016).

Nursing Interventions

Corresponding to the current initiative to integrate recovery-oriented practices into the delivery of mental health services, there has been an increased emphasis on evidence-based practice (ANA 2014; McLoughlin et al. 2013). Evidence-based nursing practice (EBNP) has various definitions throughout the literature, but most include that it is a problem-solving approach where nurses make practice decisions based on the best available research evidence, clinical expertise, and patient preferences (Nieswiadomy 2012; Schmidt and Brown 2012). Evidence-based findings are essential to provide quality care to individuals with mental illness and to help promote their recovery, but they are only meaningful when successfully integrated into practice.

Nurses need to conduct research to measure recovery-oriented practices in PMH nursing and evaluate effectiveness of interventions. While this research is starting to emerge, the literature is scant with only a few empirical studies that have been conducted, particularly in hospital settings (McLoughlin et al. 2013; McLoughlin and Fitzpatrick 2008).

PMH Nursing Interventions

PMH-RNs work with individuals, families, groups, and communities to assess their mental health and other co-occurring needs, carry out each step of the nursing process, and evaluate it for effectiveness. Their practice skills are generalized, and they provide interventions such as health promotion and maintenance, intake screening and evaluation, case management, health teaching, provision of milieu therapy, counseling, and psychiatric rehabilitation. PMH-APRNs, with more specialized practice skills, assess, diagnose, and treat individuals and families with psychiatric and behavioral problems and disorders (or the potential for such) using their full scope of therapeutic skills, including prescription of medications and administration of psychotherapy (individual, group, and family) and psychoanalysis. They may also serve as consultants, educators, clinical liaison, and direct clinical supervisors. In addition, they frequently deliver primary care services, which include the diagnosis and treatment of common health problems and the provision of preventive care (ANA 2014; O'Brien et al. 2013). Both PMH-RNs and PMH-APRNs may have other duties and responsibilities than those listed here, depending on factors such as specialized training, type of license, certifications, scope of practice defined in the state Nurse Practice Act, credentialing and privileging (for PMH-APRNs), and setting worked.

Psychopharmacological Interventions

Within their scope of practice, PMH-APRNs can implement psychopharmacological interventions, which include the prescription or recommendation of pharmacologic agents and the ordering and interpretation of laboratory and diagnostic testing (ANA 2014). Specific to psychotropic medications, while many benefits are associated with these drugs such as amelioration of symptoms and improved quality of life, the potential accompanying serious side effects such as tardive dyskinesia (TD) and extrapyramidal symptoms (EPS) raise several concerns and dilemmas, in which the benefits and risks must be weighed (O'Brien et al. 2013). As part of the recovery model, the prescribing practitioner needs to involve individuals in the decision-making process to the maximum extent possible, educating them on the options and giving them choices. This collaborative approach with the individual demonstrates respect and advocacy and has been shown to promote adherence with the prescribed regimen (Barber 2016).

While PMH-RNs cannot prescribe or order pharmacological interventions, they play an important role in their implementation. For example, with psychotropic medications, RNs not only administer the drugs but they provide education to the individuals, family/significant others, and support staff (e.g., psychiatric technicians). They also monitor closely for side effects and adverse drug reactions and immediately report problems to the practitioner. In addition, they conduct assessments to evaluate effectiveness of the medications and progress toward goals and report data to the treatment team.

Although pharmacotherapy is a well-proven treatment option for mental illness, research has shown that medication alone is often inadequate with limited efficacy. For example, medication is generally effective in treating acute episodes of mania and/or depression in bipolar disorder, but there is increasing evidence that many individuals do not achieve functional recovery with medication alone (Crowe et al. 2010). Furthermore, there often appears to be an overemphasis on medication in which medication has become the default approach in situations where other interventions could be utilized either alone or in conjunction (Mullen 2009). Therefore, consistent with a recovery orientation, psychosocial

interventions are often implemented alone or in combination with psychopharmacological interventions (as clinically indicated) to optimize rehabilitation and recovery.

Counseling and Psychotherapy

Both counseling and psychotherapy are standards of practice of PMH nursing (ANA 2014). Given that PMH-RNs are one of the largest workforces in regular contact with individuals in mental health settings (ANA 2014; Beech 2000; Turkington et al. 2006), they are well positioned to provide a wide array of counseling interventions. These interventions may be delivered in individual and group settings and include but are not limited to communication and interviewing, problem-solving activities, stress management, relaxation techniques, crisis intervention, supportive skill building and educational groups, assertiveness training, and conflict resolution (ANA 2014). PMH-APRNs may conduct individual, couples, group, and family psychotherapy. Psychotherapy is a formally structured relationship between the practitioner and the participant(s). Interventions may be brief or long term and use a range of therapy models such as psychodynamic, behavioral, cognitive, and supportive interpersonal therapies to "promote insight, produce behavioral change, maintain function, and promote recovery" (ANA 2014, p. 32).

It is critical for both PMH-RNs and PMH-APRNs to utilize effective communication strategies and techniques and the therapeutic nurse–patient relationship (as previously described) during counseling and psychotherapy interventions, respectively, so that optimal outcomes can be achieved in assisting the individual along his/her road to recovery. It is also important to research the effectiveness of these interventions in order to contribute to evidence-based nursing practice. For example, psychodynamic interpersonal therapy (PIT) is a psychological intervention that has an emerging evidence base and has demonstrated effectiveness as delivered by PMH nurses (Cahill et al. 2013; Guthrie et al. 2001; Paley et al. 2008). PIT is a model that primarily focuses on the therapeutic relationship and draws upon humanistic and interpersonal concepts (Guthrie 1999).

Cognitive-behavioral therapy (CBT) is another evidence-based intervention and is based on the idea that people's thoughts cause their behaviors and feelings versus external factors such as people, events, and situations (National Association of Cognitive-Behavioral Therapists [NACBT] 2014). CBT is a very general term and includes a range of techniques with similar characteristics. For example, CBT focuses on changing the way people think or teaching them a new way to react to people or situations. CBT incorporates several recovery principles as it involves a collaborative effort between the therapist and individual and characteristics of a therapeutic relationship, emphasizes the individual's goals, and encourages autonomy and responsibility by assigning them homework in between therapy sessions (NACBT 2014). While specialist therapists typically deliver CBT, research has shown that with proper training and supervision, PMH nurses can effectively implement cognitive-behavioral approaches (Beech 2000; Mullen 2009; Turkington et al. 2006).

Storytelling and Narratives

Individuals with severe mental illness are vulnerable and marginalized by society (SAMHSA 2013a, b; World Health Organization [WHO] 2010). As a result, their personal stories about illness, problems in living, and recovery often get lost or rendered useless and they are unable to tell them. These individuals are often dismissed as valid sources of knowledge and instead are subjected to the knowledge of experts (Clements 2012). However, personal stories are important sources of knowledge and can help individuals know they are not alone and there is hope. PMH nurses can implement various interventions to honor and empower these individuals and help them reclaim ownership and authority over their stories to make meaning of their own illness experience and to envision recovery in their own

terms. For example, individuals may verbally share a personal story during a one-to-one or group counseling/psychotherapy session. They may also write their personal narratives for others to read. Another strategy that research has shown to be effective in promoting storytelling is photovoice, a community-based participatory action research approach that involves individuals taking photographs and writing accompanying narratives or being interviewed about the content in the images (Wang and Burris 1994). These photographs and accompanying text/narratives provide rich qualitative data about individuals' experiences as they illustrate individuals' ideas, their concerns, and the realities of their lives.

Although photovoice was developed for implementation in the community and research has primarily been conducted in outpatient and community settings, it seems reasonable to expect that implementation of this arts-based approach would also have benefits in an inpatient psychiatric hospital setting. While a few modifications may need to be made (e.g., ensure no violations of privacy or confidentiality occur with taking pictures inside a hospital), using photographs and accompanying text/narratives may be an innovative strategy to explore in inpatient settings to facilitate individuals' recovery journey.

Health Teaching and Health Promotion

Health teaching and health promotion is another standard of practice of PMH nursing (ANA 2014) and is vital for nursing care of individuals with mental illness. PMH nurses provide health teaching to individuals and their families/other support persons in both one-to-one and group settings that are related to individuals' needs, recovery goals, and situations (ANA 2014). This teaching may include a wide array of topics such as psychiatric and substance use disorders, mental health problems, treatment regimens and related self-management strategies, relapse prevention, coping skills, resources, self-care activities, problem-solving skills, conflict management, crisis management, and stress management and relaxation techniques.

Psychoeducation (or illness management) is one specific example of health teaching and health promotion PMH nurses often provide, in collaboration with other treatment team members. Psychoeducation includes information about the illness or disorder, the treatment plan, medication and other treatments prescribed (e.g., nature of each treatment, intended benefits and risks, management of side effects), and any support services or advocacy groups that may be involved (Liberman 2008; O'Brien et al. 2013). Other components that have been found to contribute to the success of psychoeducation include supportive resources during crisis periods, assistance with problem-solving skills, and emotional support (Dixon et al. 2001).

Regardless of the topic taught, health teaching and health promotion should be recovery-oriented. PMH nurses need to implement strategies that are individualized and person-centered and demonstrate respect for the individuals, taking into consideration factors such as the individuals' values, beliefs, health practices, culture, spirituality, learning needs, developmental level, language preference, socioeconomic status, and readiness and ability to learn (ANA 2014). For example, if an individual is acutely symptomatic, the nurse should keep the content of health teaching simple and offer it in brief segments, repeating it as often as necessary to ascertain learning has occurred (e.g., ask the individual to repeat back in his/her own words what was learned). With the individual's permission, the nurse should also explore the option of including family/significant others in the education to help reinforce the content and support the individual. Individuals should also be active collaborative partners with the nurse. For example, with shared decision-making, the nurse may offer the individual a choice of how he/she wishes to receive content (e.g., written materials, videos). The nurse should also seek feedback and an evaluation from the individuals regarding effectiveness of the teaching strategies utilized.

Milieu Therapy

Milieu therapy, also a standard of practice of PMH nursing (ANA 2014), involves utilization of the environment as a therapeutic tool and is based on the belief that humans are affected by their physical, emotional, and social climate (O'Brien et al. 2013). In inpatient psychiatric hospital settings, PMH nurses play a critical role in collaborating with individuals with mental illness, their families and significant others, and other healthcare professionals to provide, structure, and maintain an environment that is safe, therapeutic, and recovery-oriented (ANA 2014). Milieu therapy includes many nursing interventions. For example, upon admission, PMH nurses orient individuals and their family to the care environment, which includes the physical environment, the roles of different healthcare providers, schedules of events pertinent to their treatment and care, how to be involved in their treatment and care, expectations regarding safe and therapeutic behaviors, and their rights and responsibilities particular to the treatment or care environment. PMH nurses also conduct ongoing assessments of the individual and use data collected to help guide and tailor interventions to provide and maintain a safe and therapeutic environment based on the individual's needs and situation at that time. For example, individuals who are acutely ill may respond best to a structured, consistent, and nonstimulating environment, whereas individuals who are well enough to be discharged may benefit most from a less structured environment that closely resembles real-life situations in the community.

PMH nurses commonly advocate that individuals be treated in the least restrictive environment necessary to maintain the safety of the individuals and others (ANA 2014). This is consistent with the recent emphasis in hospitals to reduce and ultimately eliminate use of seclusion and restraints. Upon admission, PMH nurses (in collaboration with other disciplines) should ask individuals about their past experiences with seclusion/restraint (S/R) incidents and if applicable, past successful strategies they have used to prevent or manage dangerous behavior, and what they find helpful in behavioral emergency situations that could prevent S/R from being used. S/R should only be used in emergency situations that pose an immediate risk of an individual harming him/herself, staff, or others and when lesser restrictive interventions (LRIs) are not practical or have been ineffective. LRIs may be medication administration, verbal, behavioral, recreational (e.g., physical activity), or diversionary (e.g., redirection) as well as environmental modifications to reduce stimulation (e.g., remove irritant/instigator from the area, remove individual to a quiet area or to a sensory or relaxation room).

Early intervention is critical, as soon as nursing staff notice the individual begins to act in a manner that may indicate the potential to escalate to becoming dangerous to self or others. In the event S/R must be used, PMH nurses need to do so in as much of a recovery-oriented manner as possible. For example, nurses need to protect and preserve the individual's rights, dignity, and well-being and consider how factors such as age, developmental level, cultural background, gender, and history of physical or sexual abuse may influence behavioral emergencies and affect the individual's response to S/R. Nurses should also educate the individual on the reason for S/R and the conditions necessary to remove the restrictions, involving the individual in formulating strategies to promote recovery of control and to expedite release.

Complementary and Alternative Therapies

The overall goal of holistic nursing is to heal the whole person, and it includes the integration of complementary and alternative modalities (CAM) into clinical practice (American Holistic Nurses Association [AHNA] 2015). Complementary therapies are used together with traditional treatment modalities, whereas alternative therapies are used in place of conventional treatment (O'Brien et al. 2013). With proper training, practice, and supervision, PMH nurses can provide a variety of CAM. For example, they

may give individuals a massage to promote a sense of peacefulness and relaxation or teach a yoga class. They may also deliver energy-based practices such as therapeutic touch and Reiki (see O'Brien et al. 2013). In addition, several CAM promote self-healing, self-care, and self-regulation such as breathing, centering, inner reflection, journaling, biofeedback, relaxation, and meditation. These practices enable individuals to release tension, to concentrate their attention, and to open themselves to new ideas and greater awareness for their recovery journey. Consistent with a recovery orientation, self-regulation practices greatly depend on individuals taking responsibility for their own healing and wellness versus most psychopharmacological and psychosocial interventions that are largely contingent on interventions of others.

Psychosocial Rehabilitation Mall

Traditionally, PMH nurses in inpatient psychiatric hospitals delivered most treatment and rehabilitation interventions on individuals' living units. With a unit-based approach, interventions are often sporadic and dependent on resources of each unit (e.g., staffing), they are limited in number, variety, and individualization based on assessed needs, and the individuals often do not participate in groups and instead may do activities such as sleep in their rooms or lounge in the day room. More recently, consistent with a recovery-oriented approach, nurses and other clinical and support staff often provide treatment and rehabilitation services in a psychosocial rehabilitation (PSR) mall, or "treatment mall", where programming is centralized (Singh et al. 2016; Spaulding et al. 2016).

PSR malls are usually an off-residential location in which individuals and staff leave their units, and services are provided in large central areas with all individuals and staff combined. PSR malls have several benefits such as they help normalize the treatment and rehabilitation experience for individuals, enhance efficient use of hospital resources, and increase opportunities to individualize treatment by expanding availability of services offered to all individuals. Services should be directly linked to individuals' assessed treatment, rehabilitation, and enrichment needs and include activities designed to assist with symptom management, personal skills development, and life enrichment. A wide array of services should be offered on the mall in broad categories such as psychiatric disorders, medical, legal, community, education, and leisure that individuals can select from and attend, based on their identified needs and interests. While most services on the mall are delivered in a group format, individual therapy may be provided based on unique circumstances and needs of the individuals.

As with all interventions, services PMH nurses provide on the mall need to be recovery-oriented. For example, to the greatest extent possible, services should be delivered in the context of real-life functioning and in the rhythm of the *individual's* life, not someone else's life or a hypothetical situation or hospital context. Thus, a PSR mall needs to extend beyond the context of a place or building, and its services should be tailored to the needs of the individuals, not to the needs of the program, the staff, or the hospital. Individuals should have input and be included in decision-making processes related to the mall such as what services are offered. Services should be provided in a respectful, culturally sensitive, strengths-based environment that promotes individuals' independence, increased wellness, enhanced quality of life, and ability to thrive in the community. Milieu therapy considerations need to also be taken into account (as previously described). For example, mall spaces should look and feel as close to community living as possible, they should be safe and functional environments that are therapeutic (e.g., low noise/activity level, welcoming, supportive), and they should have the capacity to safely and effectively administer medical/nursing care. In addition, information and skills taught in the PSR mall should be reinforced in the therapeutic milieu (e.g., residential unit) when applicable and feasible, which will make them more portable upon discharge.

Leadership

In addition to providing direct services to individuals, PMH nurses are well positioned to provide leadership interventions in inpatient psychiatric hospitals and the community at large that may indirectly affect individuals' recovery outcomes. For example, nurses may collaborate with other disciplines to assist in the development of hospital programs that help incorporate a recovery-oriented model of care. PMH nurses may also serve in hospital leadership positions ranging from being a core member of the treatment team to the facility director. In addition, nurses may serve on standing and ad hoc committees and task forces within the hospital and statewide, such as those related to performance improvement issues (e.g., reduce seclusion/restraint usage, reduce incidents of physical aggression and related injuries).

Challenges of Incorporating Recovery Principles

It is evident that PMH nurses can incorporate recovery principles when conducting assessments and delivering an array of interventions to individuals with mental illness in inpatient psychiatric hospitals. However, in some instances, nurses may face challenges that make it difficult to provide services consistent with a recovery-oriented approach. Although many of these challenges are not unique to nursing, some may apply mostly to PMH nurses.

Autonomy

Autonomy refers to an individual's freedom and ability to act in a self-determined manner. It represents a rational individual's right to express personal decisions independent of outside interference and to have these decisions honored (Butts and Rich 2016). While respecting one's autonomy is consistent with several recovery principles, there are some instances in inpatient psychiatric hospitals in which PMH nurses are unable to fully respect autonomy. For example, many individuals are involuntary (civil) commitment or forensic status, which by itself restricts their freedom. This restriction is further complicated by the limited insight many of them have. For individuals with forensic status, the increased oversight, accountability, security concerns, and stigma associated with the forensic system further add to the difficulty of incorporating recovery-oriented principles into nursing services (Pouncey and Lukens 2010; Simpson and Penney 2011). For example, oftentimes these individuals have restricted privileges and are on locked units with their off-unit activities limited unless accompanied by staff. They also may have less choice in their discharge goals as placement is often determined by the court system (Elm and Devine 2016). Despite these complications, individuals involved in the criminal justice system have many of the same needs as those without such involvement, and numerous nursing services can still be provided in a recovery-oriented manner. Even if nurses must limit one's autonomy, they can still provide care that is holistic, individualized, respectful, strengths-based, and hopeful (Shafer et al. 2016). For example, nurses should provide individuals with forensic status with choices when at all feasible and assist them to work on what needs to be done to gain as much autonomy back as possible (within legal restrictions).

Individuals may also have restricted autonomy related to being too unwell and experiencing acute symptoms that interfere with independent decision-making, such as upon admission or during an acute change in status. Healthcare practitioners must assess an individual's decisional capacity, or ability to consent to and refuse treatment (Butts and Rich 2016). In some instances, such as in an emergency situation where it is determined that an individual is too sick to decide on treatment, PMH nurses may have to administer a medication without an individual's consent or against his/her wishes (in accordance with a practitioner's order). This is an example of an ethical dilemma nurses face when

they must strike a balance between their duty to both manage the safety of individuals and promote their independence and autonomy.

With regard to autonomy, it is important to remember that recovery is a nonlinear process, and that individuals will have continual growth with occasional setbacks along their road to recovery (SAMHSA 2006). Depending on the individual's current mental status or state, he or she may not be in a position to fully apply the recovery principles of empowerment, responsibility, or self-direction. Therefore, when it is an issue of safety and well-being, it is the responsibility of PMH nurses and other clinicians to continually assess where the individual is along the continuum and based on their findings to do more for the individual when he/she can do less, and to do less for the individual when he/she can do more (Shafer et al. 2016). In other words, nurses should direct and provide care when individuals are in acute distress and eventually transfer decision-making and self-care to the individuals when clinically appropriate and when the individual is ready (ANA 2014).

Engagement

Another barrier PMH nurses encounter is individuals' lack of engagement in their care and treatment. In the context of recovery, engagement is the process of individuals fully participating not only in the process of treatment, but also in its content (Jackman 2014, 2016). For example, when asked questions as part of a nursing assessment interview, individuals may choose to only minimally respond (if at all) or to provide answers that lack depth or completeness. Individuals may also refuse to attend treatment team meetings, or if they do attend, they may not engage in discussions or actively partake in decisions about their plan of care. In these instances, it is essential for the nurse to capitalize on the therapeutic nurse–patient relationship he/she has built with the individual, to utilize effective communication techniques as previously described, and to provide positive reinforcement for small steps the individual makes with increasing engagement. In addition, a multitude of reasons may underlie the individual's lack of engagement, such as fear, low self-esteem, paranoia, poor motivation, loss of hope, discouragement, anger, and anxiety. It is important for the team to assess these underlying reasons, which in turn will guide additional interventions to help enhance the individual's engagement.

Individuals also often lack engagement in PSR mall groups. Their engagement is dependent upon several factors such as personal motivation, the goodness of fit between what they need and what is offered, the nature of the group, the facilitator's ability to make group process and learning interesting, boredom factor, and personal variables (Singh et al. 2016). As a group facilitator, PMH nurses can implement various strategies during the group to enhance engagement such as cold call and scaffolding. Depending on the underlying causes of lack of engagement, trained clinicians may also provide one-to-one individualized interventions to enhance group participation such as motivational interviewing and CBT.

Conclusion

PMH nurses who work in inpatient psychiatric hospitals play a vital role as an interdisciplinary treatment team member and are well positioned to deliver a wide array of recovery-oriented services. This chapter has presented many ways nurses can incorporate recovery principles into the provision of nursing services from admission to discharge, such as when conducting assessments, facilitating PSR mall groups, delivering health teaching and health promotion, and implementing milieu therapy. The recent emphasis to transform mental health systems from a medical model to a recovery model is an opportunity for PMH nurses to return to their roots and deliver holistic care that is person-centered with a focus on the therapeutic nurse–patient relationship—the hallmark of PMH nursing.

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