



Psychiatric and Mental Health Core Capabilities and Learning Outcomes Developed in Nurse Practitioner Programmes in Australia and the United States of America

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Abstract

Mental health/psychiatric need in the community have outstripped the availability of specialist practitioners. Accessibility, along with affordability of healthcare and stigma, is one of the main reasons for the unmet service need in this area. Nurse Practitioners are demonstrably safe and effective practitioners for whom prescribing is an important part of practice. Nurse Practitioners prescribe in both the United States and Australia. Little is known of curricula content related to mental health/psychiatric illness and associated treatments in Nurse Practitioner programmes. It is axiomatic that mental health/psychiatric treatment including prescribing is a central focus of specialist mental health courses, but little is known of primary care and family care curriculum content in this domain in the United States or courses preparing for primary care in Australia. As up to 25% people at any time are affected by mental health disorders the case is made for the need to set core capabilities in this area in all person centred and holistic curricula and the need to ensure learning outcomes are set and are achieved in curricula.

Keywords: Nurse practitioners; Mental health; Mental disorders; Primary care; Nurse practitioner; Curricula

Introduction

The motto that there is no health without mental health is widely accepted today [1] and yet we rely heavily on a highly specialised workforce to provide the necessary interventions. The foundational statement of mental health as being central to overall health is underscored by the point estimate of 25% of the population at any time experiencing a disruption of health directly attributable to a mental disorder [1]. The World Health Organization and World Organization of Family Doctors have recommended integrating mental health care into primary care to alleviate the huge burden of illness caused by mental health disorders. This burden was noted to include cost in terms of personal suffering and the impact of disability and economic stress on individuals and communities [2].

While mental health disorder is prevalent a large number of those affected do not seek intervention. For those whom do seek intervention many obstacles are faced including a relative shortage of specialist practitioners in both the United States (USA) and Australia. It is acknowledged that primary care/general physicians estimate that up to one third of their consultation time is spent on mental health related issues [3,4]. It is not clear from the literature what percentage of Nurse Practitioner (NP) time is spent, but it is assumed that the above estimation will generalise to any comprehensive primary/family care practitioner whose practice includes prescribing.

If a large part of primary care/family care NP time in primary care will be spent on treating mental health disorders, the question naturally occurs as to what time is devoted in curricula toward developing the associated capability? This question has not been addressed up to this point in time.

A comprehensive search of the databases of PsycInfo, PubMed, CINAHL, Cochrane Data base and Medline to determine what is known of NP curricula content in the USA and Australia devoted to developing mental health /psychiatric core capabilities using the terms;

mental health and psychiatric and nurse practitioner and curricula content, 2000-2015 revealed no published studies. While work has been undertaken to review undergraduate nursing curricula related to mental health content [5] this work is yet to occur internationally related to nurse NP programmes. This remains the case despite the large number of programmes offered. In Australia 17 universities provide the 18 accredited programmes [6]. In the USA there are hundreds of programmes graduating an estimated 17,000 NPs in 2013-2014 [7].

Patients report a high degree of satisfaction in general related to NP practice measured through a variety of methods. Many robust studies from several countries have been published that demonstrate that NP practice is safe and efficacious. One of the first of these, a randomised controlled trial (RCT) conducted in the USA, comparing primary care NP services to physician services, reported comparable patient satisfaction, health status at 6 months and physiological tests for diabetes and asthma between patients seen by the NP and the physician [8]. Interestingly, in this study hypertensive patients appeared to have better systolic BP control in the NP group [8].

Similar findings were reported in a UK RCT conducted around the same time where patients who saw a NP in the primary care setting had the same resolution of symptoms as patients who saw a physician [9]. Interestingly, while prescriptions issued referrals to other care

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providers and investigations ordered did not differ between NP and physician groups, patients seen by NPs received significantly more information about their illness and reported higher satisfaction, although consultations were longer in the NP group [9]. This finding in the primary care setting has been reported since in another RCT conducted in the Netherlands with comparable medical outcomes between NP and physicians, but higher patient satisfaction with NP services [10].

Similar to the primary care setting, patients report satisfaction with NP services and report finding it easier to communicate with NPs than medical practitioners in the emergency setting [11]. Additionally, and importantly, in this study there were no differences between NPs and medical practitioners on important injury outcomes and missed injuries [11]. Additionally, patients prepared for diagnostic cardiac cauterisation reported higher satisfaction with NP lead service compared to the same service from physicians in another RCT, with NP prepared patients having lower median time in the pre-admission clinic [12].

In summary, RCTs are unambiguous in their findings and growing in number. While, an observation in studies has been the higher patient satisfaction with comparable medical outcomes, it must be acknowledged that NP consultations sometimes appear to be longer than medical counterparts in studies [8,9]. However, in a study that controlled for length of consultation, higher patient satisfaction with NP services does not appear related to length of consultation suggesting that it is not how long NPs spend with their patients, but the quality of their services that patients are satisfied with [13].

From the above it is clear that it is not a case of whether NPs should provide mental health/psychiatric intervention as the safety and quality of practice, including prescribing, has been demonstrated and consumer satisfaction is clear in several contexts of practice and specialities. The question is related to the paucity of research to determine what proportion of NP curricula is devoted to developing capability in the assessment and treatment of mental health disorders and whether learning outcomes (if set) are achieved. This is important, as care of patients with mental disorders is not restricted to the specialist mental health setting or just mental health NPs. In 2010 in the most comprehensive survey to date of Australian NP prescribing practices it was identified that psychotropic medications were the third most frequently prescribed medication by NPs in Australia [14]. This finding was in the context of only six per cent of the sample being identified as specialist mental health/Psychiatric NPs.

Cashin [15] through work based observations of a stratified sample of Australian NPs and through the process to develop the Australian Nurse Practitioner Standards for Practice for the Nursing and Midwifery Board of Australia overall determined that in the process of becoming a NP rather than becoming more specialist than the advanced practice within the registered nurse scope demonstrated at the point of entry to the programme, NPs actually build a broader base of practice. What portion of this base is capability in identification and treatment of mental health disorders has not been determined.

Conclusion

The unmet community need for mental health/psychiatric intervention is vast. NPs are a group of practitioners who are safe and efficacious in general and consumers are satisfied by their practice. The question has not been answered as to whether NP curricula lead to learning outcomes that broaden the demonstrable mental health core

capability of the practitioner. Work is needed in both the USA and Australia to audit NP curricula to determine the volume and type of mental health/psychiatric content. Further work is needed to ascertain if learning outcomes set are achieved and capability is maintained post qualification.

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