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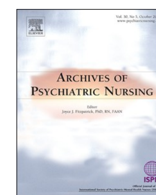
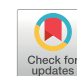


Integrating behavioral health and substance use models for advanced PMHN practice in primary care: Progress made in the 21st century



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ABSTRACT

The integration of behavioral health and substance use assessment and treatment has advanced in primary care settings in the 21st century yet the roles and practice of nursing remain unclear. This paper focuses on the Institute of Medicine (2011) Report on the "The Future of Nursing: Leading Change, Advancing Health", and to what degree specialty of Psychiatric-Mental Health Nursing has advanced as it pertains to behavioral health integration. Each of the four domains (practice, education, leadership and policy) in the Report will be highlighted with recommendations for how Psychiatric-Mental Health Advanced Practice Nurses can lead the way in 2020 and beyond.

Introduction

Behavioral health integration in primary care has advanced in the 21st century although the concept is not new to the discipline of nursing or specifically to advanced practice psychiatric-mental health registered nurses such as Psychiatric-Mental Health Nurse Practitioners (PMHNPs). All nurses learn early in their education and training that nursing practice is holistic and person-centered, which includes *caring* for the biological, psychological, social and spiritual needs of human beings (AACN, 2008; Nightingale, 1969). Advanced practice registered nurses in psychiatric-mental health have consistently considered the whole person even as this specialty role has evolved and grown over the past 65 years. A Psychiatric-Mental Health Clinical Nurse Specialist (PMHCNS) transcended from institutional care (state hospital) settings (in the 1950s) into the community (in 1970s) with subspecialties in child/adolescence, adult/geriatric and consultation/liaison before morphing into the role of a Psychiatric-Mental Health Nurse Practitioner (PMHNP) in the new millennium. Despite the multiple changes in nomenclature and evolution of the role of a PMHNP, the concepts of 'holistic caring' versus 'medical curing' have been a necessary boundary that differentiated the disciplines of nursing and medicine while promoting the growth of our separate, but distinct competencies as nurse generalists (e.g., RN) and nurse specialists (e.g., PMHNPs) as defined in the text: Psychiatric–Mental Health Nursing: Scope and Standards of Practice (2nd Edition) (ANA, 2014).

Recently, a movement called 'Whole Health Care', or Behavioral Health Integration (BHI) has been newly promoted and defined to address the behavioral and physical health care needs of individuals in primary care settings. Non-nursing disciplines such as psychology, social work and licensed marriage and family therapists (LMFTs) have embraced this subspecialty (BHI) in their graduate programs and subsequently focused on the science and practice of evidence-based '*behavioral medicine*'. For example, health psychologists examine how biological, social and psychological factors influence health and illness and use *psychological science* to promote health and prevent illness, while seeking to improve health care systems (APA, 2020). Similarly, social workers (e.g., LCSWs) have focused on helping patients make behavioral changes to improve their physical health and overall wellbeing in primary care and have coined the role 'Behavioral Health Consultants' (Mann, Golden, Cronk, Gale, Hogan, and Washington, 2016).

Behavioral Health Integration (BHI) and Whole Health Care have shown great promise for addressing and meeting the *Quadruple Aim,* which is to provide increased access to quality health care that is safe, cost effective and promotes provider/patient satisfaction (Bodenheimer, 2014). However, the central issue critical for PMHNPs to consider are the conceptual models of BHI that been studied, published and presented over the past two decades and in particular those that define the role of RN and NPs. Although some of the BHI models do include nurses and Nurse Practitioners, it is important to recognize that they also have limited and/or misrepresented the role of registered nurses (RNs) as 'helpers' and Primary Care Nurse Practitioners (PCNP) as 'physician extenders' or mid-level providers (Robinson & Reiter, 2009, 2016). In order to advance the role Primary Care NPs and PMHNPs, the discipline of nursing needs to consider and clearly define the role descriptions and scope and practice of nurses (RN and APRNs) as distinct and competent health care providers who are essential to an interprofessional healthcare team.

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Defining behavioral health integration in nursing

The International Society for Psychiatric Mental Health Nurses (ISPN) has adapted some of the constructs in Peek's (2013) Lexicon for Behavioral Health Integration. ISPN recommends using the term *Integrated Behavioral Healthcare* to underscore the vital role of nurses whose efforts systematically and with thoughtful intention, coordinate the physical and mental health care of individuals and families across the lifespan. Nurses (including Advanced Practice Nurses) who work in *Integrated Behavioral Healthcare* settings also ensure that the individual's healthcare co-occur at the same site whether it be in primary, specialty, acute/hospital and/or long-term care settings. Nurses who work in Integrated Behavioral Healthcare focus on increasing assess to Whole Health Care and providing that care for the *whole* person (Soltis-Jarrett, 2017).

This gap in knowledge prompted a group of Advanced Practice Registered Nurses (APRNs) in Psychiatric-Mental Health (PMH) to reflect, collaborate, present and publish the first of two position papers to clarify and articulate the assumptions, definitions and roles of nurses as it pertains to Behavioral Health Integration or Whole Health Care in the 21st century (Soltis-Jarrett, 2017). The second position paper was subsequently published to encourage APRNs to also consider the potential for, and the facilitation of, quality improvement, as BHI models and conceptual frameworks continue to evolve and progress in primary care in 2020 and beyond (Shell, 2019).

Without a clear definition of our role, we stand to once again assume the role of a 'handmaiden' or 'helper' rather than the leaders that we are and can mentor our young to be in this very noble discipline called Nursing.

Therefore, the purpose of this article is to present and discuss the previous ten years since the IOM (Institute of Medicine, 2011) Report on the "The Future of Nursing: Leading Change, Advancing Health", and to explore to what degree the role of a Psychiatric-Mental Health Nurse Practitioner (PMHNP) has advanced, as it pertains to behavioral health integration (BHI) in primary care and/or community health centers. This article will first set the stage to address the current issues that have impacted the role of PMHNPs, followed by an overview of the community health care movement and how the role of PMHNPs can be instrumental in filling the gaps where others in rural America (e.g., psychiatrists) have been declining, leaving and/or retiring. The last section will present some of the gaps and barriers that need to be addressed by the discipline of nursing in general and PMHNPs specifically. It will provide the opportunity to promote discussion and debate about the role of a PMHNP in primary care and behavioral health integration. Strategies will focus on the next 10 years as they relate to PMHNP practice, education, leadership and policy.

Setting the stage: what are the critical issues?

First and foremost, as previously mentioned, other disciplines (e.g., psychology, social work) have propelled their own notions and models of Behavioral Health Integration for primary care settings (Hunter, 2017; Robinson, 2016, 2009) that include nurses (RN, CNS, NPs), yet, poorly define the role and practice. These models also rarely identify PMHNPs or Primary Care NPs to be in leadership positions as members of the interprofessional health care teams (Soltis-Jarrett, 2017). The aforementioned BHI models include professionals (e.g., health psychologists, clinical social workers and/or licensed marriage and family therapists) who define their own roles in BHI as one where they partner with primary care providers, namely physicians, to offer behavioral health assessment, diagnosis and brief therapeutic interventions to address a long list of psychiatric problems and medical symptom management for individuals in primary care (e.g., depression, anxiety, obesity, diabetes and grief/loss) (Robinson, 2016, 2009; Soltis-Jarrett, 2017). Yet, on the other hand, primary care providers have reported that they are prescribing the bulk of psychiatric medications and are ill-prepared for psychiatric assessment and treatment (Greenblatt, 2018).

It is essential that PMHNPs are equal members of the treatment team, working side-by side with their primary care colleagues especially with the notable decline in psychiatrists over the past twenty years and the projected shortfalls predicted (Health Resources and Services Administration, Bureau of Health Workforce, 2015). This is critical because our colleagues practicing in primary care settings have been and continue to be somewhat more resistant to asking any questions about psychiatric symptoms or substance use because it then inevitably requires further assessment, treatment and referral, which takes time and expertise, while referral is an unspoken tragedy of unknowns; long wait times for the individual to be seen in specialty care and the risk of mortality due to the worsening of symptoms and/or behaviors (University of Michigan Behavioral Health Workforce Research Center, 2018). The issues to support these facts abound, due the ever-changing health care delivery system, the fluctuating economy and the ebb and flow of the primary care and behavioral health workforce. These shifting 'macro' systems then trickle down to the actual access to Whole Health Care (physical/behavioral), which currently is impacted by the: (a) rapid decline in the number of psychiatrists, particularly in rural areas, (b) lack of education and training in the healthcare workforce about mental health and substance use disorders and (c) marginalization of mental health and substance use disorders from mainstream health, wellness and illness care (Health Resources and Services Administration, Bureau of Health Workforce Analysis, 2015; National Academies of Sciences, Engineering, and Medicine, 2020). It has only been in the very recent past that primary care settings are now screening for depression, anxiety and substance use. And although some settings screen (e.g., using a PHQ-2 or PHQ-7), there is the subsequent question about 'what to do', if there is a positive score, again often requiring a referral to an outside psychiatric agency. And then there is the question of how often behavioral health screenings should take place. In most cases, primary care offices will implement these screening tools at well checks or at annual physical exams. PMHNPs know that screening is essential to each visit. If we compared behavioral health to other types of medical screenings, would primary care offices only screen temperature, blood pressure, respiratory and heart rate once a year?

It seems that screening for mental health and substance use disorders needs to be considered (if not mandated) to be the new *fifth vital sign* rather than its previous focus on pain. There is a plethora of evidence that demonstrates that if depression and/or anxiety is screened, assessed and treated in primary care, an individual's overall health and well-being improves and the cost of healthcare can be better managed (Milliman Research Report, 2018). Reducing an individual's pain with an opioid as a 'quick fix' has become a crisis that the CDC (Centers for Disease Control and Prevention, 2019) reports as the leading public health epidemic of our time (aside from the COVID-19 pandemic that surfaced while this manuscript was being reviewed). There are valid concerns that prescription drug misuse and abuse of benzodiazepines is the next (if not immediate) crisis that we are facing (Agarwal, 2019) in the US. To most PMHNPs, all roads do lead back to behavioral health integration and the need for mental health to be at the forefront of any care, whether it is in an acute, chronic/long-term or primary care setting. Mental health is, after all, one of the essential pieces of holistic care, yet is often siloed off, minimized or limited in nursing practice, education and research. A brief history of the evolution of behavioral health integration (BHI) in primary care will lay the groundwork in order to understand that BHI and nursing's role in this dimension of healthcare delivery is not a new idea, but rather one that was lost along the way (Soltis-Jarrett, 2016). Hopefully this brief review of the past will remind some and inform others of the need for PMHNPs and the whole of the discipline of nursing, to ensure that our roles are well defined and developed as part of these new models in the 21st century.

A brief history of behavioral health integration in primary care: 1944 to 1960 and beyond

Primary care as a concept was first described in 1961 as "primary medical care" with the extraordinary vision (at that time) of using an ecological model including health/illness statistics to guide general medical practice (White, 1961, 1997). White's vision considered the notion of (what we now call) 'population health' and how it can inform how health care providers understand the needs of their communities as well as plan for the necessary research that seeks to identify public health problems and most importantly, solutions to mitigate those problems (White, 1997). This idea in the early 1960s proliferated from the onset and impact of the Civil Rights Movement and President Johnson's 'War on Poverty'. It then subsequently strengthened again in 1965 when the Medicare and Medicaid programs were signed into law. The first 'neighborhood health centers' were funded by President Lyndon B. Johnson's Office of Economic Opportunity to address the unique needs of an identified community (or population) and were designated to offer comprehensive primary and preventive care for children and adults as well as dental, ***mental health and substance abuse***, pharmacy and supportive social services to help reduce barriers to care at that time. In later years, these neighborhood health centers became what we know today as Community Health Centers (CHC) or Federally Qualified Health Centers (FQHC); terms that date back to legislation and amendments for public health funding appropriated from the U.S. Public Health Service Act (Roosevelt, 1944). Amendments related to this 1944 Act include the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Affordability Reconciliation Act (Public Law 111-152), best known as the Affordable Care Act (ACA) of 2010.

The essential piece of this historical action in 1944 (Public Health Service Act) and the models of health care that followed in the subsequent decades, focused on the need to provide comprehensive, holistic care of individuals in their neighborhoods rather than miles away at academic medical centers (White, 1997). ***Key to this holistic comprehensive care for neighborhood health centers was to include mental health and substance use assessment and treatment***. Followers of history know that there were many obstacles and barriers that were placed in the way of these extraordinary actions to provide and promote preventative health care and wellness checks to individuals and families from cradle to grave. As well, the possibility of illnesses and disease states were not excluded, rather they were seen as a consequence of the environment or ecology—the circle of life. Politics and the ebb and flow of the economy intervened, particularly in the 1980s during the 'Reagan Era', and specific areas in healthcare funding were carved out and redirected away from primary care to save money and thereby, limited services.

Behavioral health integration as we are striving to recreate in the 21st century was amputated from primary care and placed on the bottom of the health care delivery 'wood pile' of services to be rendered only for severe and persistent psychiatric illnesses in a separate entity: community mental health centers. Even then, with this focus, individuals with severe and persistent psychiatric illnesses were only able to have their psychiatric problems assessed and managed, while their physical health lagged behind and often suffered. One wonders if this 'carve out' had not occurred, whether things would be different now as we face the worst public health crisis of our time and the untimely deaths of thousands of individuals who have knowingly or unknowingly succumbed to substance misuse, abuse and dependence.

Nursing's role in BHI: the impact of the decade of the brain and the APRN consensus model

"Life is what happens to you when you're busy making other plans". (Lennon, 1980)

Sage APRNs in PMH are also aware of the historical events that our advanced practice specialty has endured over the past few decades and how BHI was somewhat side-lined from our radar as well. Much of the political and economic changes tragically occurred while we were busy working and making other plans for the future of nursing (e.g., middle range nursing theories and conceptual frameworks) and in particular, psychiatric-mental health nursing. Although most PMH-APRNs worked on hospital psychiatric units or on consultation-liaison teams in general hospitals; many also worked in community mental health centers, partial hospital programs and outpatient clinics for roughly 40 years. From the 1960's through the turn of the 21st century, the focus was to provide the best practice for our patients and clients as they were known. The distinction between the two terms 'patient and client' were linked to the individual's place on the continuum of health and illness. Psychiatric nursing designated the in-patient, hospital-bound individual as a 'patient', while Community Mental Health Nursing (CMHN) conveyed that a 'client' was an 'outpatient', seeking community services that supported recovery and illness prevention (Koldjeski, 1984). There were no cures for severe psychiatric illnesses or substance use disorders, and we knew that it was much like the community health center's vision of the circle of life: to promote health and wellness, to the best of our abilities, from cradle to grave. Yet, the Presidential Proclamation 6158 from President GHW Bush (Jones, 1999), brought us the "Decade of the Brain" (1990–1999) which exploded brain science, health care and in particular, the potential origins and novel treatments for psychiatric illnesses and disorders. It also provided new insights into the future of nursing: genetics, new medications and treatments that could manage the symptoms of severe and persistent psychiatric illnesses.

At the same time, a shift had already commenced in nursing and roles were also being reviewed and recreated during the mid to late 1980s. Some forward-thinking academics sought funding in terms of NIMH traineeships (pre-HRSA) to educate APRNs to be duly trained as a PMH-CNS and Primary Care NP (either Pediatric, Family of Adult). Academic nurses started to see a new cadre of graduate nursing students enter into their classrooms wanting to be educated as Nurse Practitioners (NP), either post PMH-CNS education or as a blended role (CNS-NP) at the same time. These graduate nursing students were prepared and willing to fill the gaps where psychiatry and psychiatrists were unwilling to manage the whole (physical/mental) health of the psychiatric patient. Becoming an NP was synonymous with advanced health assessment, diagnostic formulation, prescribing medications and managing the physical health care of individuals and families. The decades long tradition of the PMH-CNS role was grounded in psychotherapy practice, community mental health programs of recovery, consultation-liaison and psychoeducation including teaching the patients (clients and families) about medications and treatments to promote health and well-being. Blending of the two roles (NP and CNS for PMH) was a critical point in the evolution of the PMH-APRN but was fraught with conflict as many PMHCNS' did not view their role as Nurse Practitioners and many did not want to prescribe medications (Delaney, 2005; Lego, 1996; McCabe, 1999).

The subsequent transformation of a PMHCNS to PMHNP was exciting to many because of the increased interest and movement toward the ability of the PMHNP to provide whole health care and increased access to psychiatric and medical assessment, diagnostic reasoning and treatment in both primary and specialty care.

The APRN Consensus Model and LACE Recommendations followed this role transformation of a PMHCNS to PMHNP and was also critical to this sensitive and personal process which impacted the whole discipline of nursing. The APRN Consensus Committee published a document which "*defined APRN practice, described the APRN regulatory model, identified the titles to be used, defined specialty, described the emergence of new roles and population foci, and presented strategies for implementation*" (APRN Consensus Model, 2008, page 5). The role of a PMHNP rose to the top of the pile and was then seen to be its own population foci, along the other advanced practice nursing specialties. Gradually, the

role of a PMH-CNS was to be 'retired', much to the chagrin of many nurses.

Throughout this period of time, there was a call for behavioral health integration in primary care, especially with the seminal work of Jürgen Unützer (Unützer, 2002) whose team demonstrated that the IMPACT (Improving Mood-Promoting Access for Collaborative Treatment) model was feasible for assessing and managing 'late-life' depression in primary care. The success of this model and its adaptation across the spectrum of health care was replicated, demonstrating that treating late-life depression in primary care also impacted and improved the management of pain (Lin, 2003), the symptoms of diabetes (Williams, 2004), symptoms of depression in minority patients in late life (Areán, 2005), the physical functioning of older adults (Callahan, 2005) as well as those with co-morbid medical problems (Harpole, 2005) and anxiety disorders (Hegel, 2005). IMPACT was also shown to be cost-effective (Katon, 2005). PMH-APRNs participated as team members in several of these studies, mainly as raters, screeners, case managers and/or implementing the brief psychotherapy interventions that were applied along with the antidepressant medications being prescribed. A reckoning of how this evidenced packed model (IMPACT) was going to be standardized led many to go back to specialty psychiatric care because of the focus on brief treatment and the need to limit the time that a provider spent with individuals in primary care (Joseph, 2017). The birth of the concept describing a Patient-Centered Medical Home (Agency for Healthcare Research and Quality, 2019; Schottenfeld L, 2016; Croghan TW, 2010) corresponded with the first IOM report called "*The Future of Nursing: Leading Change, Advancing Health*" (Institute of Medicine, 2011). So many challenges and numerous opportunities grew from these two documents. In substantive terms, the Future of Nursing Report (Institute of Medicine, 2011) stated and summarized what we had already known for years: That nurses needed to have a seat at the table and needed to be able to lead health care teams, particularly where other health care providers were not available, were not interested and/or were not culturally sensitive to their community's needs (e.g., rural or remote areas across the US). This likened the notion that nurses needed to be supported to work to the highest level of their scope of practice, having access to attain seamless, higher education and to have opportunities to maintain lifelong learning. Also critical to this process was the need for nurses to be equal partners with their physician colleagues and to take part in developing health care policy (IOM, 2011). While these recommendations were ambitious and exciting, there is still a lot of work to be planned and implemented to move the discipline of nursing forward using the initial recommendations cited in the 2011 IOM Report as well as including those from the new report planned for release in 2020. PMH-APRNs have taken the first step since 2011 to define behavioral health integration as it relates to the role and practice of nurses and PMH-APRNs (Soltis-Jarrett, 2017) and the need for quality improvement as we develop models of integrating behavioral health into main stream healthcare (Shell, 2019). Although these two seminal publications start the conversation moving the specialty of PMHN forward, it is important to reflect on the Future of Nursing Report (Institute of Medicine, 2011) to be able to identify where the gaps remain and how to link the concepts, challenges and barriers moving forward into the mid-21st century. Therefore, it is prudent to revisit the recommendations of the 2011 IOM Future of Nursing Report to illuminate the areas where we, as PMH-APRNs need to focus and advance the future of Behavioral Health Integration in Primary Care in 2020 and beyond.

Practice, education, leadership and policy: transformation or travesty for nurses and NPs?

The IOM Future of Nursing Report (Institute of Medicine, 2011) specifically offered recommendations in four domains (Practice, Education, Leadership and Policy) which will be used in this section to briefly present, discuss and argue that Behavioral Health Integration (BHI) is critical to the Discipline of Nursing and to PMHNPs, in particular, as we move beyond 2020. It is critical that PMHNPs take the lead, extend our good will and partner with, not only other professions, but within our own discipline of nursing as strength grows in numbers.

Nursing practice: BHI and the IOM report

Although Behavioral Health Integration (BHI) was not specifically mentioned in the IOM Future of Nursing Report (2011), the notion that "nurses should practice to the full extent of their education and training" (page 29) was particularly important as the US began to expand access to health care through the *Patient Protection and Affordable Care Act of 2010.* The fact that Nurse Practitioners (NP) were not clearly identified as key members of the health care team in this landmark legislation (Brooks-Carthon, 2015) was in and of itself, a red flag of warning that our nursing practice was side-lined and/or minimized even though, nurses continue to be the largest professional health workforce in the US (Smiley, 2018) and NPs are surpassing in numbers as primary health care providers as compared to Family Practice Physicians in rural, underserved areas across the country (Barnes, 2018).

The practice roles of nurses and Nurse Practitioners (NP) in behavioral health integration were initially documented in a groundbreaking text on behavioral health consultation and primary care in 2007. The role of nurses (RNs, LPNs) were defined as organizing the delivery of care and 'shepherding' individuals from the start of their primary care visit to its end (Robinson & Reiter, 2009) with little information about the knowledge and skills that nurses bring to primary healthcare. The implementation of diabetes education and discussion of preventative health goals and objectives were included in the nurse's role but "because the behavioral health consultant (e.g., psychologist or social worker) can do some of this as well, talking with the RN to coordinate delivery of these services is important", (Robinson & Reiter, 2009, p. 21). Nurse Practitioners on the other hand, were defined under the category of 'nonphysician providers' whose mission is to "***support the work of physician providers by acting as an extension of them, (hence the title physician extender***)" (2007, page 20). In this same primer for Behavioral Health Integration, an NP is one who is also defined as frequently seeing patients *with common or less serious problems*. In the 2nd edition of their text, Robinson & Reiter (2016) totally transformed their definition of NPs and placed them in a section called Primary Care Providers. They defined the role of NPs (and Physician Assistants) as one of uniform value to the primary care physician, and "who independently oversee all aspects of a patient's primary care" (2016, page 29). Further in the text, however, the authors still separate physicians from non-physicians again and focus on the notion that physicians manage the more complex cases. The roles of Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) were redefined as well in this 2nd edition and were described as being 'assigned' to triage patients, provide disease management education and care coordination. The role of a Behavioral Health Consultant (BHC), however, was further expanded upon and identified as the key person to provide behavioral health assessment and brief treatment; to assist with the care coordination and access to outside resources as well as to design and implement critical pathways for select populations (Robinson & Reiter, 2016). The authors have been instrumental in leading the literature (with several others) about BHI in PC in Washington State and Oregon and their work has been replicated, presented and discussed as well as transformed the whole of BHI, outside of nursing. This is a critical point that needs to be illuminated: why are others defining the role and practice of nurses and NPs in primary care? Where is the voice of nursing?

Nurses and NPs in primary care need to have their voice heard to determine the definitions of their roles, rather to have someone else (another discipline) define that role. And PMHNPs need to have a seat at that same table to clarify how their unique role can enhance the primary care team's workflow and subsequently the care of the primary

care patients and their families. As previously mentioned, PMHNPs and Primary Care NPs (PCNPs) have taken the lead and through several professional organizations have been able to share their views and develop innovative practices in primary care (Soltis-Jarrett, 2016; Soltis-Jarrett, 2017; Soltis-Jarrett, 2019a). Rather than be defined as a "physician extender" or "mid-level provider", PMHNPs need to ensure that they, like other APRNs, define their role and create innovative partnerships that extend beyond the specialty of PMHN, the hospital wards and/or outpatient clinics that focus only on the specialty of PMHN. And pertinent to this issue, it is essential to articulate this statement from the American Association of Colleges of Nursing (AACN), which summarizes the role of nursing practice on its website (and fact sheet):

> "*Though often working collaboratively, nursing* ***does not "assist" medicine or other fields.*** *Nursing operates independent of, not auxiliary to, medicine and other disciplines. Nurses' roles range from direct patient care and case management to establishing nursing practice standards, developing quality assurance procedures, and directing complex nursing care systems*".
>
> (AACN, 2019)

This vital assertion must be the focus of nursing practice today, and moving forward, it must be at the forefront of any project, training, education or scholarly product so that our voice is loud and clear. And although nursing knowledge (research) is essential to our evolving discipline, nursing academics and educators must ensure that nursing programs, whether at the pre-registration, masters or doctoral level, articulate this statement as without nursing practice, there would not be a discipline of nursing. How we educate and train nurses and APRNs is as vital to this process as to defining our own roles.

Nursing education: BHI and the IOM report

The Future of Nursing Report in 2011 stated that "nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression" (IOM, 2011, page 29). While this recommendation is essential, in theory, the specifics of how we educate our students as it relates to our current health care delivery system still needs to be underscored in terms of the quality of education versus the quantity. John Lennon's prophetic statement of being busy while life happens, could not be more vital now, as 70% of individuals who presented to primary care in 2010, presented with a behavioral health or substance use disorder (Collins et al., 2010), with rates growing exponentially as we transverse 2020 and beyond. Early analysis of a two-year project in a rural North Carolina community health center highlighted that nearly 90% of its patients reported symptoms of a behavioral health and/or substance use disorder (Soltis-Jarrett, 2019b). And the CDC's statistics related to opioid poisonings and death nationally should mandate that all nursing programs include quality addiction education and translation to nursing practice.

How are these environmental facts and population health statistics translated into our nursing education and pedagogy? Are pre-registration nursing students prepared for primary care settings and more importantly, are they prepared for assessing the problems associated with behavioral health and substance use disorders? How does APRN education and training ensure that their graduates from a Primary Care NP program are prepared and are able to assess and manage common behavioral health and substance use disorders? What content is provided in NP programs for Primary Care NPs to be able to comport and apply these skills?

Advanced practice nurses (such as Nurse Practitioners) have been siloed into what the APRN Consensus Committee designated as 'population foci' (e.g., Family, Adult/Geriatric, Pediatric, Psychiatric-Mental Health). These foci were used to address the specific needs of these specialized areas of advanced nursing practice as well as to clarify the roles and scopes of practice. And over the past decade, our education programs have advanced so that NPs can practice independently (e.g. not "assist" physicians and other disciplines), despite the regulations and policies that still exist state by state to limit aspects of APRN practice. However, we must continue to educate nurses and APRN specialties (population foci) to be prepared for the distinctive needs of the communities where nurses and NPs will work. This most definitely includes the vast and diverse regions of the United States.

This is another critical role for PMHNPs for the future. Interprofessional education has been deemed a strategic goal for all health professions (Panel, 2011) yet, within the specialties of APRN practice and education, knowledge is also being siloed to teach 'smart' and efficiently as well as keep the costs of tuition affordable. However, the Medical University of South Carolina's DNP program has been a leader in bringing together NP education that includes the deliberate training of PMH-NPs with their Primary Care NP peers (Lauer, 2017). To this end, this example of an innovative pedagogy gives Primary Care NP students the additional education and training to meet the complex needs of their patients in Primary Care as well as to learn to work with and respect their PMHNP peers. There are several other programs nationally that have been creative and instrumental in focusing on the population health statistics of the communities where their NP students live and will eventually work (Soltis-Jarrett, 2011, 2016, 2019a, 2019b). The ideal way to address this challenge is to review, rebuild and enrich the academic APRN pedagogy to ensure that as population health needs change, nursing educators are addressing those unique needs in the nursing programs. An example of this is that in 2020, all NP students should be required to be prepared and eligible to seek a DATA 2000 waiver after graduation as it will promote a greater awareness of the Opioid Epidemic and can seamlessly promote the implementation of Medication Assisted Treatment (MAT) in Primary Care. The American Association of Nurse Practitioners (AANP) offer links to free training and education as well as many other professional organizations. In addition, it is essential to offer courses (electives or required) to all Primary Care NPs that address the neurobiology of psychiatric and substance use disorders, screening tools for behavioral health integration as well as enhanced education related to diagnosis and prescribing of treatments for common behavioral health problems that almost always present in primary care yet are overlooked, undertreated or managed poorly (e.g., Major Depressive Disorder, Anxiety Disorders and Insomnia).

Over the past decade, the Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Division of Nursing has posted multiple opportunities for obtaining funding to transform and grow NP programs by increasing diversity, numbers and specialists in the workforce. This was a direct outcome from recommendations made by the ACA and the PHS Act as amended. Funding for these HRSA projects is competitive and requires faculty to partner with practice organizations such as FQHCs to offer and ensure appropriate sites for clinical training and education.

HRSA has also now required that grantees form consortiums to share information, resources and collegiality. These consortiums can be better organized and supported by HRSA staff, particularly for the grantees but the concept is a great opportunity to bring nurses together. Some grantees have developed Communities of Practice (CoP) where meetings are planned and facilitated via teleconferences to lead quality improvement and change across the partnerships (Okafor, et al., 2018). PMHNPs must move beyond their specialty organizations and institutions to be clear what nurses and APRNs do and why they do it well. A large part of being able to plan and implement these initiatives is to be able to lead, to communicate clearly and to have the confidence to define who we are and what we do.

To this end, the Nurse Residency Programs for new graduates of pre-registration programs have been shown to provide increased support and nurturance to new nurses who may work in settings that require additional skills and training. Despite some who do not feel that there is

a need for Nurse Practitioner Residency Programs, studies have reported that it is also critical for NPs to have that same mentoring and support after graduation from an NP program (Bush & Lowery, 2016). It is not uncommon for a new graduate of an NP program to be the only health care provider in a rural primary care setting and have to assess and manage large groups of individuals and families with very complex, co-morbid diagnoses in addition to living with poverty, food insecurity, domestic violence and unemployment. These factors combined are daunting to consider, yet why do we question why NPs develop their own health problems or why they are unable to stay in these much-needed positions in their own rural communities. Add to all of that, the fact that these NPs also need to pay off school loans and personal debt attributed to advancing their careers in graduate school, all in good faith to increase access to care and fill the gaps where physicians are lacking and/or retiring from the rural areas. In the past decade, there have been and continue to be multiple NP Residency Programs for Primary Care NPs and also for PMHNPs (Flinter & Bamrick, 2017).

Leadership and policy: having a seat at the table and being able to enact the changes

Nurses at all levels also need strong leadership skills, but as the original IOM (2011) report states, nurses have not held leadership positions that have enabled them to contribute fully in healthcare, policy or in developing innovative models of care (IOM, 2011). Although many recommendations were made, few examples were gathered in the first five years after the initial report (National Academies of Sciences, Engineering, and Medicine, 2016).

When specifically addressing Behavioral Health Integration (BHI) and nursing, some interprofessional teams have identified and developed strategies for practice and do acknowledge the importance of nurses and NPs in primary care. In some regions of the US, Psychologists and PMHNPs have also found ways to work together and provide BHI (Corso & Gage, 2016) as have other nurses on interprofessional teams.

Although the initial Future of Nursing Report called for health care organizations, nursing educators and nursing associations to train, support and encourage nurses to "lead" both in management as well as clinical settings, the findings from the Assessment of the Progress of the Future of Nursing Report in 2016 stated that there were few examples or ways of tracking the development (National Academies of Sciences, Engineering, and Medicine, 2016). This particular recommendation needs to be considered in 2020 and beyond. Opportunities for membership on Boards of Professional Organizations and Corporate Entities need to be explored and encouraged especially when there are not nurses on those Boards which focus on BHI. Making our voice heard requires a process of not only having a seat at the table but having the nurse member clearly articulate the practice, education and training of nurses and NPs so that others are aware.

Policy informs change and thus, impacts decisions. Without the input of nurses and NPs, the practice, education and policies related to BHI in primary care or any facet of healthcare, we stand to lose our roles and potentially the ability to keep those roles sustainable through funding sources, training grants and knowledge development.

Summary of recommendations 2020 and beyond

In summary, it is essential to identify and plan for this call to action to ensure that nurses and NPs as well as PMH-APRNs are at the table informing practice, education and policy as the 2020 Future of Nursing Report is disseminated and discussed. The following recommendations for nurses and NPs to consider as talking points are:

1. Nurses and NPs are the largest workforce in the US and can impact the greatest number of individuals, families and communities to promote, assess and manage whole health care which includes both physical and behavioral problems and disorders. Silos are not useful, practical or cost-effective.
2. PMHNPs are poised, educated and trained to work with interprofessional teams as equal partners to screen, assess and manage psychiatric and substance use disorders in a primary care, acute care and/or long-term care setting.
3. All nurses and APRNs need to be educated and trained to the highest level of their scope of practice in behavioral health and substance use disorders while in nursing education programs and/or as a lifelong process of continuing education once they are in the workforce.
4. PMHNPs need to be educated and trained how to work with their Primary Care NP peers as well as other professions. This includes providing opportunities for clinical courses being taught together with the specific objective of learning how to 'refer' to one another, develop collegiality and organize peer learning consortiums in their respective communities upon graduation. Isolation is a major factor in retaining talented nurses and NPs, promoting provider satisfaction and preventing compassion fatigue (burnout).
5. Nurses and NPs need to be aware of opportunities to join Boards of Professional Organizations, Healthcare Foundations and Corporate Entities to inform policy and change.
6. Nursing leaders need to mentor and support other nurses and colleagues rather than focus on 'feathering their own nests'. Competition needs to be reformatted as collaboration and collegiality.
7. Residency Programs are essential to NPs as they are to new graduates of Pre-registration programs. Residency Programs can provide the additional support, mentoring and transition to advanced practice which often occurs after graduation not in an NP program.

Behavioral Health Integration will advance in our health care delivery system in the 21st century and we are witnessing those events now. We must recognize and acknowledge what we as nurses and PMHNPs can bring to healthcare and strive to be an active participant in taking the lead rather than following behind. Although we may need to go off the path to forge our own ideas and innovations, it is important to get back on track and share what we have learned and how to take action. In the words of Rosalynn Carter; a leader takes people where they want to go. A great leader takes people where they don't necessarily want to go, but ought to be (Carter, 1984).

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