Inclusion of Psychiatric–Mental Health Advanced Practice Nurses in Federal Behavioral Workforce Planning

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Psychiatric–mental health (PMH) advanced practice nurses have the education, certification, and licensure to address the need for providers who can deliver the full scope of mental health services and thereby increase access to mental health care. Although the PMH nurse practitioner (PMHNP) segment of this workforce is rapidly growing, it has scant visibility in workforce planning and the evolving national behavioral health workforce database. An understanding of PMHNP characteristics and practice roles seems to be lacking. Addressing this limitation demands clear messaging around this workforce's scope of practice and data indicating how PMHNP capabilities meet mental health treatment needs.

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Psychiatric–mental health (PMH) advanced practice nurses have the education, skills, and qualification to increase access to mental health care. The national scope of practice for PMH advanced practice nurses stipulates diagnosis and management of mental disorders, prescribing and management of psychotropic therapies, conducting psychotherapeutic interventions, and performing outcome assessments as their professional activities (1). PMH advanced practice nurses have completed a graduate degree focused on developing competencies in these practice areas and leading to national certification and licensing as providers by state boards of nursing. A recent report on the behavioral health workforce commissioned by the U.S. Department of Health and Human Services has detailed the professional qualifications of one segment of the workforce, PMH nurse practitioners (PMHNPs) (2). Noting that PMHNPs are trained and educated to provide many of the same services as psychiatrists, the authors recommend greater use of PMHNPs as a primary strategy to increase the reach of behavioral health care to patients who need it.

Given the potential of this nursing specialty to improve access to mental health services, the lack of visibility of PMHNPs in workforce planning is concerning. For instance, PMHNPs are not mentioned in the recent Substance Abuse and Mental Health Services Administration (SAMHSA) report listing certified community behavioral health staff (3). The report highlights the need for "medically trained behavioral health care professionals with prescriptive authority" but does not refer to PMHNPs by title or as a potential workforce for delivering other services within this model. This omission is puzzling. The need for mental health providers is clear, as is the recognition that PMHNPs could be a significant workforce (4), yet they have scant visibility in national workforce planning.

Perhaps federal agencies do not understand PMHNP practice. Researchers have reported that administrators are often confused about PMHNPs' capabilities and scope of practice (5). Historically, federal behavioral health workforce reports often did not mention or have misrepresented or underreported the efforts and size of the PMHNP workforce (6). These issues could be contributing to the low visibility of this specialty in behavioral workforce planning and the surprising failure to incorporate PMHNPs in the evolving behavioral health workforce database (7). An essential first step in addressing this situation is clear messaging around PMHNPs' capabilities, accompanied by available data on how they are addressing mental health access issues.

PSYCHIATRIC ADVANCED PRACTICE NURSES

Recent data indicate that currently about 35,000 PMHNPs practice in the United States (8). This number increases to 39,374 certified advanced practice psychiatric nurses if psychiatric–mental health clinical nurse specialists (PMHCNSs) are included. Although PMHCNSs are commonly practicing in mental health services, a certification examination for them is no longer available, thereby

prohibiting new PMHCNS entrants into the workforce. This Open Forum primarily discusses PMHNPs because this segment of the workforce is the focus of current issues with the behavioral workforce database and planning.

Currently, 208 programs train PMHNPs in the United States (8). Most of these programs require students to have a bachelor of nursing degree and then to complete the PMHNP graduate degree, which takes an additional 2–3 years. The requirements for certification are consistent for all PMHNP programs: the programs must teach pharmacology, physical assessment, pathophysiology and diagnosis, and management courses designed for the specialty, as well as theory and application of evidence-based psychotherapeutic interventions. The overarching PMHNP approach is grounded in constructs of interpersonal theory. As a result, elements of the therapeutic relationship are taught to PMHNP students as a critical component of all other interventions (1).

Within the parameters of the national scope of practice, providers' state boards of nursing determine what services PMHNPs can provide. In 26 U.S. states and the District of Columbia, PMHNPs have full practice authority, permitting them to assess, diagnose, order, and interpret tests and initiate and manage treatments, including medication prescribing. Thirteen states are reduced-practice states, limiting one element of PMHNP practice (such as prescribing of certain medications) or requiring that PMHNPs have a collaborative agreement with another provider to deliver care. Eleven states are restricted-practice states, where state law requires career-long supervision, delegation, or team management by another health care provider for the PMHNP to provide care (9). The impact of nurse practitioner practice restrictions includes additional costs, administrative burdens related to obtaining and documenting supervision, and unsupportive practice environments associated with lower quality of care (9). Nursing leaders maintain that policies pertinent to authority of advanced nursing practice are political issues and are based more on entrenched interests within organized medicine than on evidence (9).

A recent survey of advanced practice psychiatric nurses (10), which included both nurse practitioners and clinical nurse specialists, revealed that 70% of the respondents practiced in outpatient settings, including federally qualified health care centers and community health centers. Respondents' major activities included providing diagnosis and management services (66% to most patients) and medication prescribing (76% to most patients). A significant portion (48%) reported combining prescribing with psychotherapy for most patients. Approximately 42% of the respondents had completed medication-assisted therapy training, 72% of whom had applied for a Drug Enforcement Administration waiver to prescribe buprenorphine. Most of the respondents reported treating patients who have Medicaid or Medicare coverage, with 44% stating that most of their clients were covered by federal insurance. These findings and recent data suggest that PMHNPs play an important role in providing care to underserved populations. For instance, in 2012–2019, rates of participation of psychiatrists in Medicare decreased while the number of PMHNPs providing care to Medicare beneficiaries more than doubled (11). PMHNPs are also filling the staffing needs of rural mental health clinics and those providing medications for opioid use disorder to underserved rural populations (12).

LACK OF PMHNP INCLUSION IN WORKFORCE PLANNING

As these findings indicate, PMHNPs are well positioned to fill the care chasm, particularly for underserved populations. The growth of this workforce holds promise for increasing access to mental health services (2, 4). Yet PMHNPs continue to be underrepresented in national workforce planning documents. The current Government Accountability Office (GAO) report on the behavioral health workforce (13) used two data sources: Health Resources and Services Administration records, which list PMHNPs as behavioral health providers, and SAMHSA records, which do not. When citing SAMHSA data, the GAO report names eight behavioral health specialists (e.g., psychologists and social workers), but PMHNPs are not listed in that behavioral health grouping. Instead, PMHNPs are listed in the category of "other providers who prescribe behavioral health medication." The GAO report notes 193,356 providers in this category. Because the name of this category is generic and the number of providers is large, one may assume that the category includes physician assistants and all primary care nurse practitioners who prescribe psychotropic medications. The SAMHSA report may define the nurse practitioner role in behavioral health solely as a "prescriber" because the report drew mainly on IQVIA Xponent retail prescription data to identify specific mental health services providers (7).

This narrowing of the PMHNP role and failure to use specific naming of the PMHNP specialty continued in the 2022 SAMHSA workforce planning document, which detailed staffing needs for more than 30 behavioral health care models (14). Several models in the report call for a prescriber, and the document identifies "advanced practice nurse" as one possibility for this role. Throughout the document, it is unclear whether this term refers to PMHNPs or any type of primary care nurse practitioner. This blurring of boundaries and the lack of specifics in reference to advanced practice nurses contribute to PMHNPs' invisibility in workforce planning and their lack of recognition as a profession that provides the full range of psychiatric services and could effectively fill several roles within mental health care delivery.

CONCLUSIONS

PMHNPs are an essential resource for addressing mental health care needs, particularly in states giving full practice authority. As shown here, PMHNPs are underrepresented

in workforce planning documents. In the newest national behavioral workforce database, because of "data limitations," PMHNPs are eliminated as a separate profession and folded into the larger category of advanced practice prescribers. Workforce planning and policy should be informed by a clear understanding of the scope of practice and capabilities of potential providers and an accurate depiction of their supply and practice characteristics. Strategies to advance inclusion of PMHNPs in planning and policy include clear messaging about this workforce's capabilities, particularly in interprofessional journals, and increasing dialogue with federal mental health agencies about how PMHNPs can contribute to the agencies' service missions. The PMHNP specialty must also contribute to research on how it is supporting mental health care. Such research efforts should include data on practice from the current information sources available for studying the psychiatric workforce, including national surveys, state licensure data, and data from credentialing and professional organizations compiling practitioner information (15).

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