Advancing the role of advanced practice psychiatric nurses in today’s psychiatric workforce

The number of psychiatric prescribers per capita is at one of the lowest levels in history. Approximately 43.4 million persons (17.9%) in the United States have a diagnosable mental illness; 9.8 million (4%) are diagnosed with a serious and persistent mental illness, such as schizophrenia, bipolar disorder, and major depressive disorder (these figures do not include substance use disorders).

Of the 45,000 licensed psychiatrists, approximately 25,000 are in active practice. By comparison, there are approximately 19,000 practicing licensed psychiatric advance practice registered nurses (APRNs). Annually, approximately 1,300 physicians graduate from psychiatric residency programs and 700 APRNs from master’s or Doctor of Nursing Practice programs. Combining the 2 prescribing workforces (44,000) yields a ratio of 986 patients per licensed prescriber. Seeing each patient only once every 2 months would equate to 25 patients daily considering a 5-day work week. Recognizing that some patients need much more frequent follow-up, this is an impossible task even if these providers and patients were dispersed uniformly across the United States. Currently, ratios are calculated based on the number of psychiatrists per 100,000 individuals, which in the United States is 16. Most psychiatrists practice in urban areas, whereas psychiatric nurse practitioners are found primarily in rural and less populated urban areas.

Who can provide care?
Although the growing number of psychiatric APRNs is encouraging for the mental health workforce, their limited role and function remain a battle in the 27 states that do not grant full practice authority. This dispute has become so contentious that the Federal Trade Commission (FTC) has stated that the debate over scope of practice represents federal restraint of trade, while patients and their families suffer from lack of access to care.

Recognizing that 9 million patients age <65 who were enrolled in Medicaid in 2011 and treated for a mental health disorder (20% of enrollees) accounted for 50% of all Medicaid expenditures prompts the question, “Who is treating these patients?” According to the American Psychiatric Nurses Association, fewer than one in five mental health patients in the United States is seen by an APRN. With a ratio of only 986 patients per practicing psychiatrist or APRN, nurses are the most available mental health providers. APRNs account for 10% of private practice psychiatrists’ prescribing activity and 28% of Medicare beneficiaries’ mental health care. In Medicare’s 18-state program, APRNs provided 44% of all mental health care for enrollees age 65 and older.

Dr. Moller is a speaker for Alkermes.

Guest Editorial

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Disclosure

Dr. Moller is a speaker for Alkermes.
Who are APRNs?

The first master’s degree in nursing was created by Hildegard Peplau, EdD, at Rutgers University in 1954, using the title Clinical Specialist in Psychiatric Mental Health Nursing (PMH-CNS). As a master’s prepared clinician, the PMH-CNS could function independently, and many chose to open private practices. Other universities began to create clinical specialty programs in a variety of disciplines. In 1996, 41 states granted prescriptive authority to the PMH-CNS. Psychiatric nurse practitioners were first certified in 2000 to meet the statutory requirements for prescriptive authority of the other 9 states. However this created 4 PMH-APRN roles: Adult and Child/Adolescent CNS and Adult and Family PMHNPs.

Clinical specialists in most areas of health care—except for psychiatry— were primarily working in institutional settings, whereas nurse practitioners were hired principally in primary care community-based settings. The public grew familiar with the term “nurse practitioner,” but these professionals functioned primarily under institutional protocols, while the PMH-CNS had the ability to practice independently. In the mid-1990s, the 4 advanced practice nursing roles of nurse midwife, nurse anesthetist, nurse practitioner, and clinical nurse specialist were encompassed under 1 title: APRN. In 2010 the American Psychiatric Nurses Association endorsed one title for the psychiatric mental health advanced practice registered nurse (PMH-APRN), the psychiatric nurse practitioner, to be educated across the lifespan.

Today, the title PMH-APRN encompasses both the PMHNP and PMH-CNS; the majority specialize in the adult population.

Licensure, accreditation, certification, and education

In 2008, after several years of heated debate among members of >70 nursing organizations, a consensus model governing advanced practice nursing was ratified. This document outlined requirements for licensure, accreditation, certification, and education of the 4 primary advanced practice nursing roles. According to the model, the 4 nursing roles would address 1 of 6 major patient populations: neonatal, pediatric, adult-geriatric, family, women’s health/gender-related, and psychiatric. Licensure in each state would be converted to APRN from the existing 26 titles. Each student would have to graduate from a nationally accredited program. In addition to health promotion and advanced roles, educational programs would be required to include advanced courses in pathophysiology, pharmacotherapeutics, and physical assessment as well as population-specific courses in these same categories. In addition, supervised clinical hour minimums were established for the various population-specific programs.

Concomitantly, graduate educational programs were wrestling with the 2005 statement from the American Association of Colleges of Nursing (AACN) that all advanced practice nursing education should be at the doctoral level by 2015. Because of the knowledge explosion, nurses needed more than what could be achieved in a master’s program to meet practice requirements as well as leadership, systems evaluation, quality improve-

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ment, research, and program development. Currently, there are 264 Doctor of Nursing Practice programs in the United States with less than one-half having a PMHNP program.14

Nursing education at the collegiate level has been evolving, which is fostered and supported by the 2010 Institute of Medicine (IOM) Report on the Future of Nursing that identified 4 key recommendations to promote a workforce at capacity to help care for our nation’s growing population:

- Remove scope of practice barriers
- Expand opportunities for nurses to lead and diffuse collaborative improvement efforts
- Implement nurse residency programs
- Increase the proportion of nurses with a baccalaureate degree to 80% by 2020.

**The current status of advanced practice nursing**

Each of the 50 states is in varying levels of compliance with the 2015 mandates from the consensus model and the AACN. From the psychiatric workforce perspective, many state boards of nursing are concerned because titles often are linked to legislative statute or rules. Despite the 2010 IOM recommendations and the FTC, the American Medical Association (AMA) has stationed AMA lobbyists in the legislatures that are poised to open the nurse practice act to comply with the consensus model. The sole purpose of these lobbyists is to block independent practice for APRNs in the 26 states that are seeking this status and to remove independent practice from the states where it already exists. For example, in Washington the title is ARNP but to change it to APRN will require opening the state’s legislative action. The AMA is eager to remove the autonomy that has existed in that state since 1978. One of the reasons is because where the APRN is required to be in a collaborative or supervisory relationship with a physician, the physician can charge the APRN to be compliant with state regulations. (In some states, the APRN cannot see patients or be on call if the collaborator is on vacation).

This has turned into a cottage industry for many physicians. However, there

### Table: Top mental health professional shortage areas in 2017

<table>
<thead>
<tr>
<th>Location</th>
<th>Total mental health care HPSA designations</th>
<th>Percent of need met</th>
<th>Practitioners needed to remove HPSA designation</th>
</tr>
</thead>
<tbody>
<tr>
<td>United States</td>
<td>4,627</td>
<td>44.2%</td>
<td>3,397</td>
</tr>
<tr>
<td>Texas</td>
<td>412</td>
<td>45.25%</td>
<td>271</td>
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<td>Florida</td>
<td>165</td>
<td>25.75%</td>
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<td>California</td>
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<td>Arizona</td>
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<tr>
<td>Missouri</td>
<td>107</td>
<td>35.79%</td>
<td>100</td>
</tr>
</tbody>
</table>

HPSA: Health Professional Shortage Area

Source: Reference 15
are many who do not charge because they are able to add additional patients to the practice by adding an APRN and generate more revenue. Others do not charge because they are supportive and committed to the APRN role.

Some thoughts about our mutual field
Can we move past the guild issue and come together to respect our given scopes of practice? I see psychiatry far ahead of the curve compared with APRNs in other specialties. The PMH-APRN is a highly educated nurse with a specific scope of practice that provides skilled psychiatric care (assessment, diagnosis, prescribing, psychotherapy) from a nursing perspective. Independent practice certainly does not imply that we do not collaborate with one another in a professional manner.

Mental Health Professional Shortage Areas
As of January 1, 2017, there are 4,627 Mental Health Professional Shortage Areas (MHPSA) in the United States and Territories (Table), which translates to only 44.2% of the need for psychiatric practitioners being met.15 To eliminate the designation of a MHSPA there must be a population to psychiatric provider ratio of at least 30,000 to 1 (20,000 to 1 if there are unusually high needs in the community). Currently 3,397 practitioners are needed to remove the designation across the United States. The state in most need of providers is Texas with 271 clinicians required to meet the need.

Considering that approximately 700 PMH-APRNs graduate each year16 and 1,317 psychiatry residents17 entered PGY-1 residency in 2016, it will be decades—or longer—before there are enough new providers to eliminate the PMH-APRN is a highly educated nurse with a specific scope of practice that provides skilled psychiatric care from a nursing perspective.
I encourage the APA to unite with psychiatric APRNs to remove unnecessary barriers to practice and promote a unified and collegial workforce. This will transmit a strong message to the most underserved of our communities that psychiatrists and psychiatric nurse practitioners can emulate the therapeutic relationship by virtue of presenting a unified force. Imagine psychiatrists and psychiatric nurse practitioners going arm in arm to lobby county commissioners, state legislators, and Congressional Representatives and Senators. Together we could be a true force to be reckoned with.

References