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American Psychiatric Nurses Association

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PSYCHIATRIC-MENTAL HEALTH NURSING

WORKFORCE REPORT

The First Study Specifically Targeting the Psychiatric-Mental Health Nursing Workforce

ACKNOWLEDGMENTS

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Key Findings of the 2022 APNA Psychiatric-Mental Health Nursing Workforce Survey

PSYCHIATRIC-MENTAL HEALTH REGISTERED NURSES (PMH-RNs):

- Among all age groups of PMH-RNs, the 20-29 age range comprises the smallest percentage of nurses.
- The PMH-RN workforce has a different racial/ethnic and gender composition than the general RN population, with double the number of Black or African American nurses and a greater proportion of multiracial nurses and males in the PMH-RN population.
- About half of the sample reported a Bachelor of Science in Nursing (BSN) as their highest degree, and 82% of respondents ages 20-29 indicated their initial degree is a BSN
- The hospital is the primary employment setting for a majority (62%) of PMH-RNs.
- The majority of respondents (61-71%) reported that they assess physical health status, assess mental health status, and educate patients and families for most patients. About 40% of PMH-RNs reported that they are providing counseling and developing therapeutic relationships to most patients, which has historically been a key component of the PMH-RN role.
- Less than two-thirds of respondents reported feeling either safe or very safe in their work settings. Patient acuity (59%), level of administrative support (56%), staffing ratio (55%), and level of staff training (54%) were cited by a majority of respondents as factors that influenced their feelings of workplace safety.
- Pre-tax annual income from primary employment was in the $50,000-99,000 range for 65% of respondents.

PSYCHIATRIC-MENTAL HEALTH ADVANCED PRACTICE REGISTERED NURSES (PMH-APRNs):

- The average age of PMH-APRNs is 54 years, with more than half of the respondents in their 50s or 60s.
- 27% of respondents plan on retiring in the next six years, with a greater percent of intended retirements among Clinical Nurse Specialists.
- Although the majority of PMH-APRNs identify as white (84%), the proportion of respondents that identified as Black or African American in the PMH-APRN sample is slightly larger (10%) than the broader NP population, but lower (3%) in terms of PMH-APRNs who identify as Latinx.
- More than two-thirds of respondents reported a Master of Science (MSN) as their highest degree, and their initial PMH-APRN preparation.
- Most respondents (70%) practice in outpatient settings that include mental health clinics, community-based programs, federally qualified healthcare centers (FQHCs), and community health centers.
- Approximately 42% of respondents completed Medication for Addiction Treatment (MAT) training and 72% of these subsequently applied for a U.S. Drug Enforcement Administration (DEA) X-waiver to prescribe Buprenorphine for opioid use disorders.
- A majority of respondents treat patients who hold commercial insurance or Medicaid/Medicare, with close to half stating most of their clients were covered by federal insurance.
- Pre-tax annual income from primary employment was in the $100,000-150,000 range for 47% of respondents.

Workforce Survey Methodology

The American Psychiatric Nurses Association (APNA) convened a Workforce Task Force comprised of six members to develop a comprehensive survey of the Psychiatric-Mental Health (PMH) Nursing workforce. The goal of the survey is to understand the demographic, education, employment characteristics, and earnings of PMH nurses working throughout the United States. The primary data source for this report was from a voluntary survey offered to contacts in APNA's database, registered nurses, and advanced practice nurses with current certification by the American Nurses Credentialing Center (ANCC).

The Workforce Task Force began survey development on September 7, 2018. Separate surveys were developed for Psychiatric-Mental Health Registered Nurses (PMH-RNs) and Psychiatric-Mental Health Advanced Practice Registered Nurses (PMH-APRNs) to reflect the unique scope of each role. To inform survey development, the Task Force examined the following sources: American Psychological Association 2015 survey; APNA minimum data set (MDS); Health Resources and Services Administration National Sample Survey of Nurse Practitioners; National Workforce Survey of RNs; Nursing Minimum Data Set; Minimum Data Set for the Behavioral Health Workforce developed by the University of Michigan; and the American Psychiatric Association Draft Workforce Survey. This approach ensured a systematic and comprehensive examination of the types of data that other behavioral health disciplines collect. Both surveys were reviewed by a researcher with content and methodological expertise in workforce research. Each survey was pilot tested with 100 individuals. Survey items were revised to improve readability and clarity. Each survey included a glossary of terms to ensure consistent interpretation among participants.

The PMH-RN survey included 51 questions and the PMH-APRN survey included 52 questions. Surveys were administered from October 21, 2020 to February 24, 2021. The PMH-RN survey was completed by 4,088 PMH-RNs and the PMH-APRN survey was completed by 5,158 PMH-APRNs. The combined response rate for the surveys is 12.1%. Statistical Package for the Social Sciences (SPSS) was used for data management and analysis. Frequencies, percentages, and cross tabulations were used to summarize the data. A consultant was engaged to assist with statistical analysis.

The findings should be considered in light of the study limitations. First, the sample is comprised of PMH-RNs and PMH-APRNs who are contacts in the APNA database and/or certified by ANCC who may not be representative of the full Psychiatric-Mental Health Nursing workforce. Second, the response rate is low suggesting potential nonresponse bias. Finally, the survey was administered during the COVID-19 pandemic when social distancing and other restrictions were in place which could have influenced the findings. Despite these limitations, this is the first research study that specifically targets the PMH nursing workforce.

Psychiatric-Mental Health Registered Nurse Survey Findings

EXECUTIVE SUMMARY

Overview

Data on the characteristics and supply of Psychiatric-Mental Health (PMH) Registered Nurses (RNs) and Advanced Practice Registered Nurses (APRNs) are essential to expanding access to behavioral health care and informing workforce projections. The first section of this report contains data on the demographics of the current PMH-RN workforce and their educational preparation, employment characteristics, and earnings.

Demographics

The PMH-RN workforce is aging similarly to the nurse population as a whole. The average age of PMH-RNs is 51 years, with more than half of the respondents in their 50s or 60s. Only 4% of PMH-RNs are in the 20-29 age range. The top two reasons respondents reported as barriers to becoming a PMH-RN are (1) individuals felt they needed medical-surgical experience and, (2) a faculty member told them they needed medical-surgical experience prior to becoming a PMH-RN.

Although the majority (77%) of PMH-RNs are White, the proportion of respondents that identified as Black or African American (13%) in the PMH-RN sample is double that of the national RN sample. Further, a greater proportion of PMH-RNs identified as Multiracial (4%) compared with the national RN sample. Finally, males comprise a greater proportion (12%) of the PMH-RN population compared with their male counterparts in the general nursing population.

Education

About half of the sample reported a Bachelor of Science in Nursing (BSN) as their highest degree, and 82% of respondents ages 20-29 indicated their initial degree is a BSN. Rates of certification vary by race and age with the highest proportion of certified nurses identifying as older and White. Nurses who are certified in a specialized area of nursing are recognized as having advanced knowledge, skills, and expertise. PMH-RNs noted that the top reason for not obtaining certification is because it is not valued by their employer.

Employment Characteristics

Compared with a national sample of RNs, more PMH-RNs (89%) reported a hospital as their primary employment setting. Further, the majority of respondents (between 61 and 71%) reported that they assess physical health status, assess mental health status, and educate

patients and families for most patients. However, approximately 60% reported that they are not providing counseling and developing a therapeutic relationship with most patients, which has historically been a key component of the PMH-RN role.

Earnings

Pre-tax annual income from primary employment was in the $50,000-99,000 range for about two-thirds of respondents. Income from primary employment tended to increase with age up to 70 years and then decreased. Nurse administrators most frequently reported earning greater than $100,000, followed by nurse managers and those working in correctional facilities. PMH-RN respondents who reported earning less than $75,000 disproportionately identified as American Indian and Alaskan Native and PMH-RNs employed in rural counties. PMH-RN respondents who reported earning less than $50,000 more often reported working in school-based clinics and in home psychiatric care.

FULL DATA FROM THE APNA PMH-RN SURVEY

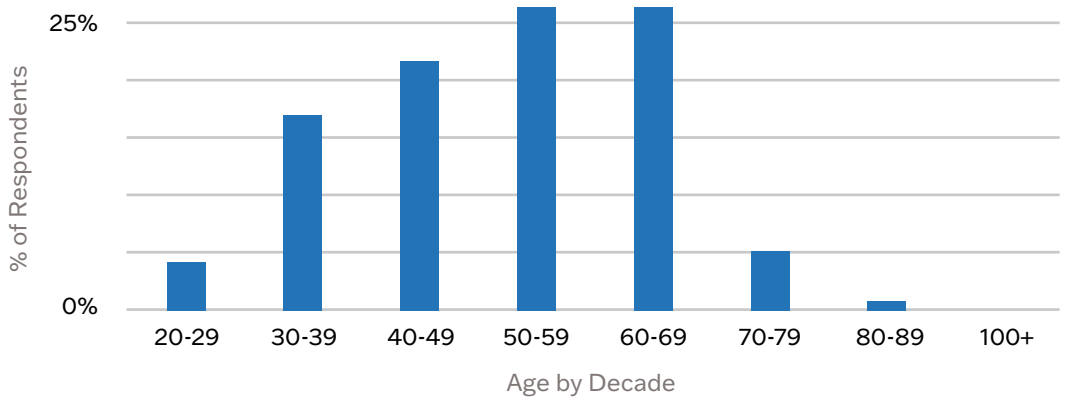
APNA survey findings are compared with data from the 2020 National Workforce Survey which reflects a nationally representative sample. This survey is produced by the National Council of State Boards of Nursing (NCSBN) in partnership with the National Forum of State Nursing Workforce Centers.

DEMOGRAPHICS

Age

The average age of the 3,494 PMH-RN survey participants is 51 years (SD=12.5; median=52), ranging from 22 to 101 years old. The average age of PMH-RN survey respondents is consistent with the average age of RNs reported nationally, which is 52 years old (NCSBN, 2020). More than half of the respondents (53%) are in their 50s or 60s. In a national sample of RNs, 8% of nurses are between the ages of 20-29 (NCSBN, 2020) while only 4% of PMH-RNs in our sample are in that age range. (Figure 1 presents the age distribution of participants by selected decades.) Age is calculated by participant responses to date of birth. The large proportion of PMH-RNs in their 50s and 60s represents a significant context for many other observations in this report.

Age of the Workforce
Figure 1



Gender, Sex, and Sexual Orientation

Of 3,491 PMH-RNs, 87% reported their gender as female, 12% reported male gender, and 0.4% reported either non-binary or transgender. Similarly, 87% were assigned female on their original birth certificate while 12% were assigned male. The percentage of respondents reporting male gender is slightly higher than the 9% of RNs reporting male gender in a nationally representative sample (NCSBN, 2020). Of the PMH-RNs that responded, 8% identify as sexual minorities such as gay, lesbian, and bisexual.

Race/Ethnicity

Of 3,462 PMH-RNs responding, more than three-quarters (77%) identified as White (See Table 1). About one quarter of respondents identified as racial or ethnic minorities, and 4% identify as multiracial. Similarly, in a national sample, almost 81% of RNs identified as White. However, the second most frequently identified race among the national sample was Asian (7%) (NCSBN, 2020), compared with 6% of respondents in the PMH-RN sample identifying as Asian. In the PMH-RN sample, the second most frequently identified race was Black or African American (13%) compared with only 6% of RNs in the national sample (NCSBN, 2020).

The United States Census Data show that 18% of the population identifies as Hispanic and any race. The Census Data measures ethnicity and race separately through two items while our survey asked respondents to identify their race with Latinx as one of the options. Only 4% of respondents identified as Latinx suggesting a significant underrepresentation of this ethnic subgroup compared with the general population. (See Figure 2 for racial distribution among the sample of PMH-RNs.) Almost 4% of PMH-RNs identified as multiracial compared with 2% of RNs in a national sample reporting two or more races (NCSBN, 2020) and about 3% of the population reporting two or more races in the 2019 United States Census Data.

Of 3,386 responding PMH-RNs, almost one quarter speak at least one language in addition to English; 3% speak two or more languages in addition to English. The most common language spoken in addition to English is Spanish which was reported by 11% of RNs.

PMH-RN Racial Distribution

Figure 2

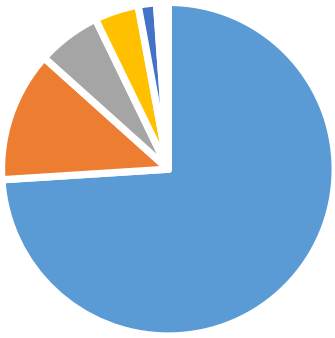


Table 1: **Race/Ethnicity**

White	77.2%
Black or African American	13.2%
Asian	6.4%
Latinx	4.5%
American Indian or Alaska Native	1.8%
Native Hawaiian or Pacific Islander	0.7%
Prefer not to answer	0.5%

Race/Ethnicity by Age

PMH-RNs that identify as White are likely to be older, on average, than any other racial group. This is consistent with general demographic trends in the US population. (See Table 2)

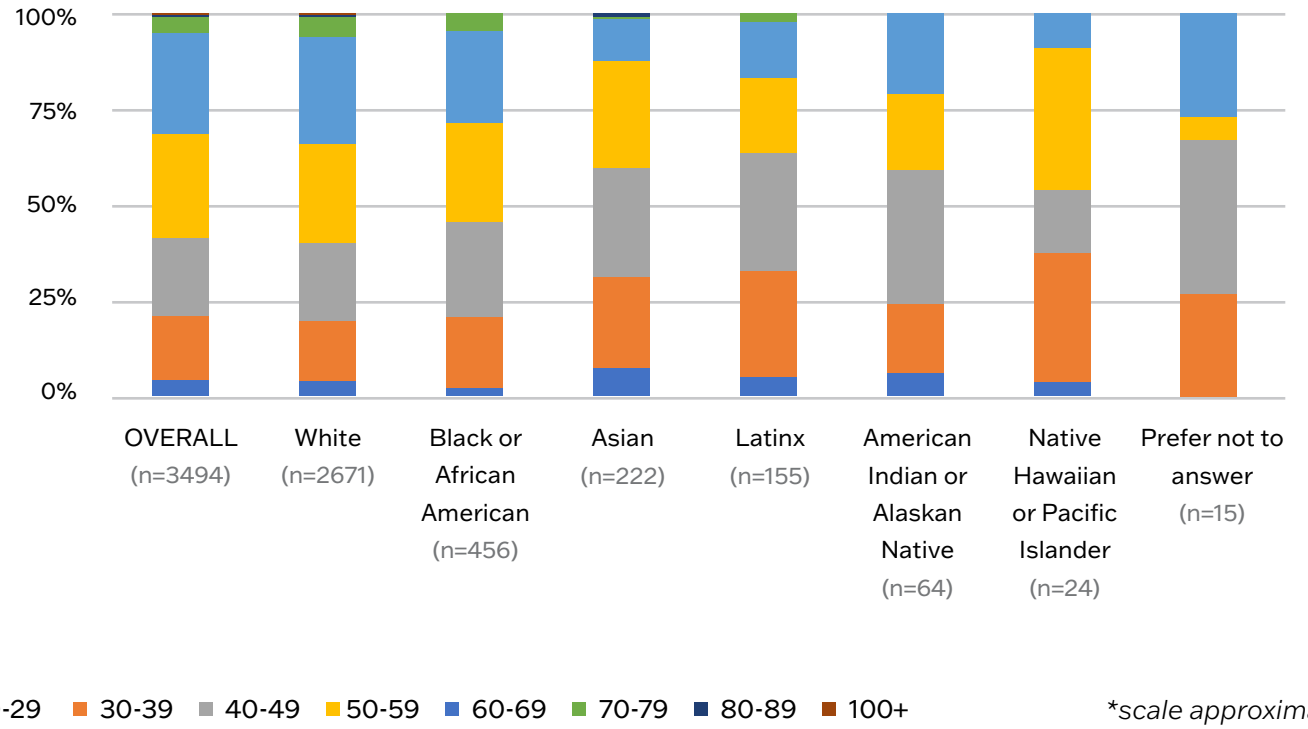
Figure 3 shows the race/ethnicity distribution across age groups. Race/ethnicity categories are not mutually exclusive.

Table 2

Ethnicity	n	Age M (SD)	Min	Max
White	77.2%	52.17 (12.59)	22	101
Black or African American	13.2%	50.72 (11.68)	25	79
Asian	6.4%	45.75 (11.38)	24	81
Latinx	4.5%	46.31 (11.89)	25	75
American Indian or Alaska Native	1.8%	47.31 (10.85)	25	65
Native Hawaiian or Pacific Islander	0.7%	44.63 (10.31)	27	63

Race/Ethnicity by Age*

Figure 3



**scale approximate*

Race/Ethnicity by Gender

Race/ethnicity does not significantly vary by gender among responding PMH-RNs. (Table 3 shows the number of respondents that comprise each racial category by reported gender.)

Table 3

Gender	Overall		Race					
	n	%	American Indian or Alaska Native	Asian	Black or African American	Native Hawaiian or Pacific Islander	White	Latinx
Female	3,009	87.2%	55	177	392	21	2,334	126
Male	426	12.4%	8	41	56	3	304	27
Non-Binary	13	0.3%	0	0	1	0	12	0
Transgender	2	0.1%	0	0	0	0	2	0
Total	**3,449**	**100%**	**63**	**222**	**451**	**24**	**2,668**	**155**

Active Duty Service

Of 3,476 PMH-RNs, 6% are veterans, 0.5% are on active duty, and 2% are in the reserves or National Guard. PMH-RNs in their 70s have the highest (9%) proportion of veterans, and those in their 20s have the lowest proportion of veterans (2%).

HUMAN CAPITAL

Education

Forty-five percent of respondents qualified for their initial RN license by obtaining an Associate Degree in Nursing, while 42% earned a Bachelor of Science in Nursing (BSN) as their first nursing degree. Eighty-two percent of PMH-RNs in their 20s and 57% of PMH-RNs in their 30s first qualified for their initial RN license by earning a BSN. This trend holds across gender. Similarly, 42% of RNs in a national sample qualified for their first RN license by earning a BSN degree, a trend that has increased over the past several years (NCSBN, 2020). Respondents who identified as Asian (66%) and Native Hawaiian and Pacific Islanders (50%) were the only racial groups where a majority obtained a BSN degree to qualify for their first RN license.

Percentage of Coursework Online for Initial RN Education

3,948 PMH-RNs reported that on average, 8% of their didactic coursework for their initial RN education was completed online (SD=18.1). Two-thirds of PMH-RN respondents reported that none of their coursework was online.

Highest Degree Earned

Half of responding PMH-RNs reported their highest degree as a Bachelor of Science in Nursing (BSN) which is consistent with the NCSBN (2020) survey that showing that 48% of RNs reported their highest degree as a Bachelor of Science in Nursing. There are no differences in highest degree earned by race or certification. Black or African American PMH-RNs have the highest proportion (38%) of MSN training. The proportion of PMH-RNs who hold a BSN tends to decrease with age, with PMH-RNs more likely to have either an Associate's or Master's degree with each successive decade.

New Graduate Residency or Fellowship Program

Of 3,987 PMH-RN respondents, 15% reported that they completed a new graduate residency or fellowship program. These PMH-RNs reported that their new graduate residency or fellowship program lasted an average of 8.4 months (SD=5.8) ranging from 0 to 36 months. More than half of PMH-RN respondents to this question reported their residency or fellowship program was less than one year. About three quarters of PMH-RN respondents who completed a new graduate residency or fellowship program reported that they were either satisfied or very satisfied with the program. There were no differences in program satisfaction by age, gender, or Magnet hospital status.

Current Enrollment in Nursing Program

One quarter of PMH-RN respondents reported current enrollment in a formal education program. More than half of all Black or African American PMH-RN respondents reported current enrollment in a formal education program while White PMH-RN respondents were the least likely to be enrolled in an education program. Slightly more men (30%) were enrolled

than women (25%), and PMH-RNs in their 20s (48%) and 30s (42%) were the age groups most likely to report enrollment in a formal education program.

State Licensure and Certification

Respondents were licensed in all 50 states, as well as Washington, DC, with 76% of respondents licensed in one state, and 20% licensed in 2 to 4 states. Almost half of responding PMH-RNs reported holding an American Nurses Credentialing Center (ANCC) certification as a PMH-RN. Rates of certification by race include 47% of all White PMH-RNs being certified, 45% of Asian PMH-RNs, 43% of Latinx PMH-RNs, 42% of Black or African American PMH-RNs, 42% of Native Hawaiian or Pacific Islander PMH-RNs, and 28% of American Indian or Alaska Native PMH-RNs being certified. Although there is no substantive difference between the proportion of certification among men and women, the proportion of PMH-RNs holding an ANCC certification increases with age. In addition, rates of ANCC certification vary by primary role in employment setting, ranging from 64% of utilization review nurses to 43% of nurse educators. The two most common reasons reported for not being certified by ANCC are cost and that certification is not valued by current employer.

Plans for Retirement

About half of PMH-RN respondents plan to retire more than 10 years from now with 13% undecided. Unsurprisingly, older PMH-RNs in more senior roles tend to anticipate retiring sooner than their younger or more junior counterparts. There were no differences in characteristics among respondents who were undecided about retirement.

EMPLOYMENT CHARACTERISTICS

Experience as a Psychiatric-Mental Health Nurse

The average number of years of experience among respondents is 6.6 (SD=8.7) with a median of three years of RN experience prior to becoming a PMH-RN. Twenty-nine percent of those respondents did not have any prior nursing experience, and 10% had only one year of experience prior to becoming a PMH-RN. Older nurses tend to have more nursing experience prior to becoming a PMH-RN. However, years of experience as an RN prior to becoming a PMH-RN does not vary by type of role. While more than half of respondents did not experience barriers to becoming a PMH-RN, the most common barriers reported by those who reported barriers are, 'I felt I needed general/medical nursing experience before entering PMH nursing', and 'faculty advised me that I needed medical-surgical experience before going into psychiatric-mental health.' Females and younger RN respondents were more likely to feel that they needed more nursing experience before becoming a PMH-RN.

PMH-RN Roles

Of 3,787 responding PMH-RNs, 52% are staff nurses, 13% are nurse educators, 9% are nurse managers, 7% are nurse administrators, and 6% are nursing supervisors. The remainder of respondents selected 'other' noting roles such as care/case manager, utilization review nurse, consultant, and retired. The proportion of respondents working in staff nurse roles decreases with age and with years of experience.

Primary Employment Setting

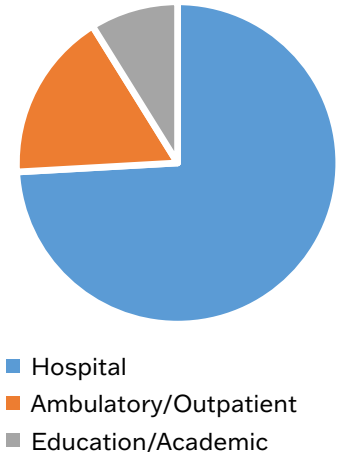
Of 2,069 responding PMH-RNs, only 12 work in rural counties. PMH-RN respondents overwhelmingly work in metropolitan counties. 2,214 PMH-RNs reported living an average of 14.56 miles (SD=11.76; median=11.2; range: 0.5-91) from their primary employment.

Of 3,756 responding PMH-RNs, 62% work in a hospital setting, 14% in an ambulatory care/outpatient setting and 7% in an education/academic setting. The percentage of PMH-RNs working in a hospital as their primary employment setting is higher than that reported by a national sample of RNs which is 55%. (NCSBN, 2020). The proportion of PMH-RNs working in hospital settings decreases with age. Other settings less frequently reported by PMH-RN respondents include: residential/long-term care, psychiatric home care, college/university counseling center, school-based clinic, correctional facility, private practice/consulting, health plan/insurance, and retired or unemployed.

Of PMH-RN respondents who reported working in a non-hospital setting, 22% reported working in a mental health clinic and 9% reported working for the Veterans Health Administration. Almost three-quarters of these respondents reported completing an orientation for their position, but only 10% completed a fellowship or residency, and only 11% work at a Magnet certified facility. The majority of respondents working in a non-hospital setting are female and White. More than two-thirds of PMH-RNs working in non-hospital settings are age 50 or older. However, primary or specialist medical care and community health center settings had more than 30% of PMH-RNs under age 40. A BSN in nursing degree is the most common maximum credential, with the exception of PMH-APRN offices, academic settings, and long-term care settings.

Top 3 PMH-RN Primary Employment Settings

Figure 4



Of 3,394 responding PMH-RNs, 88% reported having completed an orientation for their primary RN position. Of 2,995 responding PMH-RNs, 32% reported having an orientation that lasted 10-19 days, with PMH-RNs working at ANCC Magnet certified facilities representing the greatest proportion of PMH-RNs reporting an orientation of greater than one month. Orientation length was longest in hospitals, ambulatory or outpatient settings, and correctional facilities. As the length of orientation increased, the proportion of PMH-RNs either satisfied or very satisfied with orientation increased from less than 25% for no orientation to more than 75% for orientations lasting over one month. Orientations were least likely to be offered in private practice or consulting. Overall, 63% of PMH-RNs were either satisfied or very satisfied with their orientations, but of those working in Magnet certified facilities 71% were either satisfied or very satisfied with their orientations. PMH-RNs in private practice or consulting and hospital settings were most likely to be either satisfied or very satisfied with their orientations, and those in correctional facilities were the least satisfied. Satisfaction with orientation did not vary by age or gender.

Of 3,027 PMH-RNs, 64% reported that a preceptor was assigned to them during orientation. Approximately two-thirds of PMH-RNs working at Magnet certified facilities and hospital settings were assigned a preceptor during orientation. There is a relationship between the presence of an orientation preceptor and PMH-RN satisfaction with orientation: of those assigned a preceptor, 75% were satisfied or very satisfied, and only 8% were dissatisfied or very dissatisfied.

Of the 43% of PMH-RNs who responded that they precept nursing students, the average number of nursing students precepted is 10 per year ranging from 1-50. We speculate that some respondents reported the number of nursing students in each clinical group as opposed to one-to-one preceptorship, thereby inflating the mean. There are no differences in the number of students precepted by level of education or experience of the PMH-RN preceptor.

Perception of Safety

Less than two-thirds of respondents reported feeling either safe or very safe on the job. Perceptions of safety did not depend on whether respondents worked at a Magnet certified facility, completed a residency or fellowship, held an ANCC certification, completed an orientation program, or had a preceptor. Feelings of safety also did not vary by gender, population served, length of orientation, or hours worked per week. Feelings of safety increased with increased experience and levels of education. Feelings of safety also varied by work environment, with PMH-RNs in academic or university and school-based clinic settings feeling most safe, and PMH-RNs in correctional facilities and hospital settings feeling least safe.

3,363 PMH-RNs identified factors that influenced their feelings of safety at the workplace. Patient acuity (59%), level of administrative support (56%), staffing ratio (55%), and level of staff training (54%) were cited by a majority of respondents as factors that influenced their feelings of workplace safety. However, security was not identified as a factor in perceptions of safety, particularly among PMH-RNs in their 30s. Patient acuity was the most cited factor for PMH-RNs in their 20s, 30s, and 40s while level of administrative support the most cited factor for PMH-RNs in their 50s, 60s, and 70s.

Populations Served

Adults are the primary population served by PMH-RN respondents across employment settings, except for home psychiatric care and school-based clinic settings serving geriatric and child/adolescent populations, respectively. PMH-RNs in private practice/consulting settings are roughly evenly split between lifespan (45%) and geriatric (39%) populations. The 3,584 responding PMH-RNs reported that 46% (SD=25.0) of their patient population is, on average, from a racial or ethnic minority. About two-thirds of responding PMH-RNs report that up to 24% of their patient population has limited English proficiency.

Services Provided

Respondents described a range of services they provide in their primary employment setting by indicating if they provide a particular service to no patients, few, some, or most patients. Between 61 and 71% of respondents reported that they assess physical health status, assess mental health status, and educate patients and families for most patients. About 40% of

respondents reported that they provide care coordination, therapeutic relationship and counseling, crisis management, and milieu therapy to most patients. Approximately one-quarter of respondents noted that they provide consult liaison, groups, and make referrals for most patients.

Provision of Telehealth

Of 3,584 responding PMH-RNs, 41% reported that they provide telehealth services in any of their employment settings. Three quarters of respondents reported that they provide telehealth services in rural counties. About three-quarters (72%) of case or care managers and ambulatory or outpatient PMH-RNs reported providing telehealth services. Of PMH-RN respondents providing telehealth services, they reported providing telehealth to an average of 14.3 and a median of 10 patients per week (SD=15) [range: 0-50]. Few respondents provide telehealth services in more than one state.

Secondary Employment Setting

Of 3,654 responding PMH-RNs, 19% reported holding a second nursing position, which is greater than the percentage of RNs in a national sample who reported a second position (13.7%) (NCSBN, 2020). Fewer White PMH-RN respondents held a second nursing position compared with other racial minority groups. PMH-RN respondents with a second nursing position reported working an average of 14 hours per week (SD=8.9) at that second position. Eleven percent of those respondents reported working between 21 and 35 hours per week in that second position. This pattern held true across gender and age categories. A slightly larger proportion of male PMH-RNs (17%) and Black or African American PMH-RNs (15%) reported working between 21 and 35 hours per week, but these were not statistically significant differences.

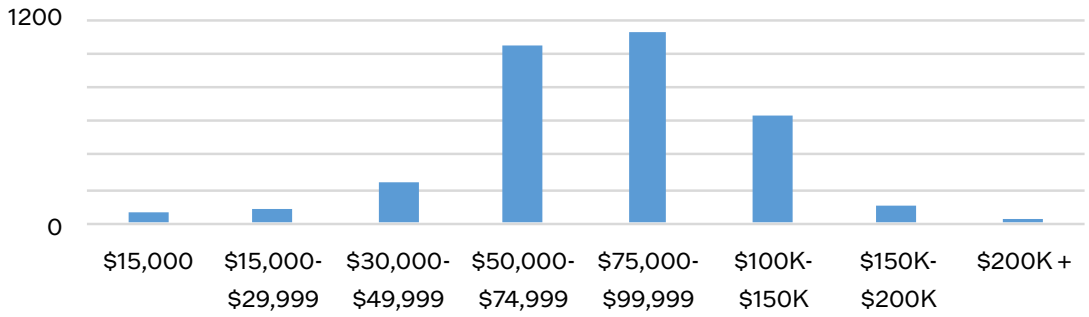
EARNINGS

Pre-tax annual income from primary employment was in the $50,000-99,000 range for about two-thirds of respondents. Income from primary employment tended to increase with age up to 70 years and then decreased. Nurse administrators most frequently reported earning greater than $100,000 annually, followed by nurse managers and those working in correctional facilities.

PMH-RN respondents who reported earning less than $75,000 annually included a disproportionate number of American Indian and Alaskan Native PMH-RNs and those employed in rural counties. PMH-RN respondents who reported earning less than $50,000 annually were more likely to report working in school-based clinics and in home psychiatric care. There were no differences in earnings by identified gender. This differs from the finding in a national sample of RNs that males have a higher median salary compared with females across all nursing specialties (NCSBN, 2020). Figure 4 shows the distribution of annual salary across the PMH-RN respondents.

PMH-RN Annual Salary

Figure 5



DISCUSSION

This report describes the demographic, education, employment characteristics, and earnings reported by PMH-RNs surveyed by the American Psychiatric Nurses Association (APNA) in 2020-2021. Key findings from this survey have significant implications for practice, education, policy, and research.

Aging of Psychiatric-Mental Health RNs

Our findings suggest that the PMH-RN workforce is aging, similar to the national registered nursing workforce sample (Smiley et al., 2021). However, there are fewer PMH-RNs in the 20-29 age range compared with the national RN sample suggesting that younger nurses are not entering the psychiatric-mental health nursing field.

This finding should be considered in light of the fact that younger nurses may not have ANCC certification or are not in the APNA database as they have not been socialized to the role of the professional PMH-RN.

The top two reasons respondents reported as barriers to becoming a PMH-RN are that individuals felt they needed medical-surgical experience and that a faculty member told them they needed medical-surgical experience prior to becoming a PMH-RN. These findings are consistent with research that suggests there is a stigma associated with specializing in PMH nursing and that the negative view of PMH nursing is perpetuated by nursing faculty (Ben Natan, Drori, & Hochman, 2015; Halter, 2008).

Recent research has identified that PMH nurses have difficulty articulating their value and expertise (Lakeman & Hurley, 2021). The small number of younger nurses entering PMH nursing and nursing faculty promulgating the belief that nurses need medical surgical experience prior to practicing in PMH nursing have far reaching implications for education. Pre-licensure nursing programs should re-envision the delivery of PMH nursing education by providing students with opportunities outside of the hospital that capitalize on the broad knowledge and skills of PMH-RNs (Delaney, 2016; Kaas, 2020). This could be accomplished, in

part, by nursing programs developing academic-practice partnerships and exposing students to diverse roles of PMH-RNs (Kaas, 2020; Phoenix, 2019).

Diversity

PMH-RNs have a different racial and gender composition than a national sample of RNs. While the majority of both groups of nurses are White, the second most frequently reported race among PMH-RNs is Black or African American, while the second most frequently reported race among the 2020 national registered nurse sample is Asian. In addition, the proportion of respondents that identified as Black or African American in the PMH-RN sample is double that of the national RN sample. Only 4% of respondents identified as Latinx suggesting a significant underrepresentation of this ethnic subgroup compared with the general population which has far reaching implications for the diversity of the nursing workforce. Further, a greater proportion of PMH-RNs identified as multiracial compared with the national RN sample. Finally, males comprise a greater proportion of the PMH-RN population compared with their male counterparts in the national sample. The greater proportion of males in the PMH-RN workforce compared with the general RN population and the disparity between the percentage of Hispanics in the general population compared with the PMH-RN workforce has been documented previously (Phoenix, 2019).

Employment Setting

Compared with a national sample of RNs, more PMH-RNs reported a hospital as their primary employment setting. Future research should examine trends in PMH-RN employment. Consistent with previous reports, very few PMH-RNs are working in rural locations, which contributes to the service gap in these areas (Phoenix, 2019).

Services Provided

Findings about services provided could shed light on the role of PMH-RNs in mental health settings. The majority of respondents reported that they assess physical health status, assess mental health status, and educate patients and families for most patients. Less than half of respondents reported that they provide care coordination, therapeutic relationship and counseling, crisis management, and milieu therapy for most patients. Recent literature suggests a lack of role clarity and shared vision among PMH-RNs and the need for discourse that articulates the value and expertise of PMH nurses (Hurley & Lakeman, 2021; Salberg, Bäckström, Röing, & Öster, 2019). It should be noted that the majority of the literature on the role of PMH-RNs has been conducted outside of the United States.

Perceptions of Safety

Less than two-thirds of respondents reported feeling ‘safe’ or ‘very safe’ at work. Patient acuity, level of administrative support, staffing ratio, and level of staff were reported as factors that influenced safety. Patient acuity was the most cited factor influencing perceptions of safety for PMH-RNs ages 20 through 50, while level of administrative support was the most cited factor influencing perceptions of safety for PMH-RNs greater than age 50.

Feelings of safety increased with increased experience and education. Research has identified high rates of violence in psychiatric treatment settings and risk factors for that violence such as gender, job function, years of experience, and patient diagnosis (Odes, Chapman, Harrison,

Ackerman, & Hong, 2021). Research shows that perceived risk of assault, lack of leadership, inadequate staffing, and demanding work schedules negatively impact retention (Adams, Ryan, & Wood, 2021). Increased acuity in inpatient psychiatric settings has been attributed to decreased length of stay and increased throughput of admissions, transfers, and discharges. It is not known if the facilities in which the PMH-RNs are employed use an acuity tool to stratify patients for assignments and to determine staffing. Future research should examine the use of tools to measure patient acuity and the reliability of these tools to predict perceived levels of safety. Research should also examine the types of training PMH-RNs receive by their employers related to management of high acuity patients.

Summary

In summary, PMH-RNs stand ready to provide integrated care interventions to vulnerable populations, but there is little data available to describe these specialized RNs (Merwin, 2020). Further, PMH-RNs contribute to the health and recovery of persons with mental health disorders and have the potential to transform care delivery (Gabrielsson, Tuvesson, Wiklund Gustin, & Jormfeldt, 2020). This report is an initial attempt to fill the gap in data related to the PMH nursing workforce. Ongoing collection of the demographic, education, and employment data on PMH-RNs will inform behavioral health workforce planning and program and policy development.

Psychiatric-Mental Health Advanced Practice Registered Nurse Survey Findings

EXECUTIVE SUMMARY

Overview

This section of this report contains data on the demographics of the current Psychiatric-Mental Health Advanced Practice Registered Nurse (PMH-APRN) workforce and their demographics, educational preparation, practice settings, clinical activities, and earnings.

Demographics

The average age of PMH-APRNs is 54 years, with more than half of the respondents in their 50s or 60s. Twenty seven percent of respondents plan on retiring in the next six years, with a greater percent of intended retirements among Clinical Nurse Specialists (CNS). Although the majority of PMH-APRNs are White (86%), the proportion of respondents that identified as Black or African American in the PMH-APRN sample is slightly larger than the broader Nurse Practitioner (NP) population, but less diverse in terms of PMH-APRNs who identify as Hispanic/Latino. The sample largely is female and the proportion of males (10%) reflects the gender distribution of the broader NP population.

Education and Certification

A majority of the sample reported a Master of Science (MSN) as their highest degree, and their initial PMH-APRN preparation. A significant percentage of respondents were prepared at the Doctor of Nursing Practice (DNP) level (12%) and a smaller number of PMH-APRNs hold a Doctor of Philosophy as their highest degree. The number of respondents completing their graduate degree since 2010 almost doubled, which mirrors the reported increase in ANCC certifications over the last 10 years. A small number of respondents (11%) reported completing a Post-Masters Residency and they were generally satisfied with the program. A PMH-NP (lifespan) was the most common certification with noted differences by age; older PMH-APRNs were more likely to hold a CNS certification.

Employment Characteristics

A majority of respondents (70%) practice in a range of outpatient settings, including mental health clinics, private practice, federally qualified health centers, and community health centers. Approximately 88% of respondents prescribe as well as provide diagnosis and management services to most patients. A significant portion combine prescribing with psychotherapy (69%) but a much smaller percentage of respondents provide any type of stand-alone psychotherapy. Approximately 42% of respondents completed Medication for Addiction Treatment (MAT) training and, of these, 72% subsequently applied for a Drug

Enforcement Administration (DEA) X-waiver to prescribe Buprenorphine for opioid use disorders. A majority of respondents treat patients who hold commercial insurance or Medicaid/Medicare, with 44% stating most of their clients were covered by federal insurance. These findings indicate that PMH-APRNs play an important role in providing care to underserved populations.

Earnings

Pre-tax annual income from primary employment was in the $100,000-150,000 range for 47% of respondents. Males reported higher income ranges. There was no mean income difference based on race. The majority of respondents indicated they have a 40-hour work week. The only group that works significantly fewer hours is PMH-APRNs whose primary employment setting is educational, who reported 19-26 hours per week.

FULL DATA FROM THE APNA PMH-APRN SURVEY

In some instances, data from the PMH-APRN survey are compared with data from the American Association of Nurse Practitioner (AANP) 2020 National Practitioner Sample Survey, which includes a nationally representative sample of all NPs.

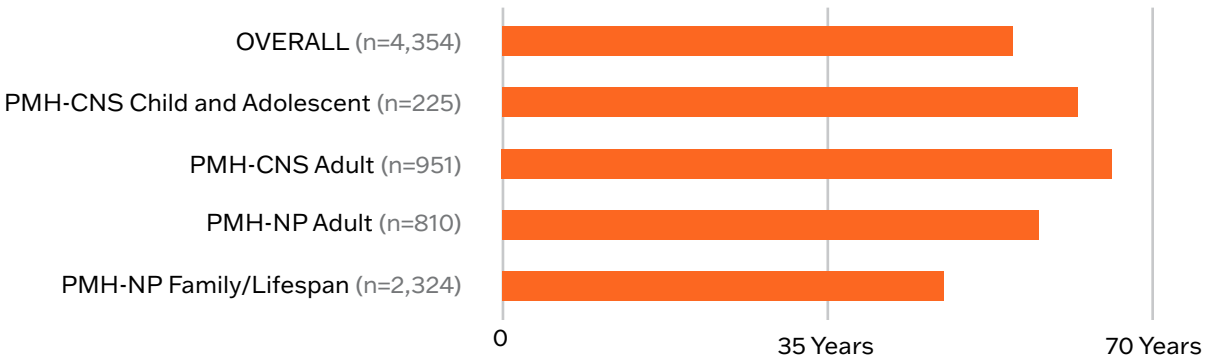
DEMOGRAPHICS

Age

The average age of the 4,354 PMH-APRNs who responded to the survey is 54.1 years ranging from 25 to 88 years old. Age is calculated by participant responses to date of birth. The average age of these respondents is older than the average age of NPs reported nationally which is 49 years (AANP, 2021). More than half of the respondents (53%) are in their 50s or 60s. In the AANP (2021) sample 37% of NPs were over 55 years old. The age of PMH-APRNs varies by certification: PMH-NP-lifespan certification holders' median age is 48 years versus 66 years for PMH-CNSs. (See Figure 6.) The large number of PMH-APRNs in their 50s and 60s represents a significant context for many other observations in this report.

Type of PMH-APRN Certification by Median Age of Respondents

*Figure 6**



**scale approximate*

Gender, Sex, and Sexual Orientation

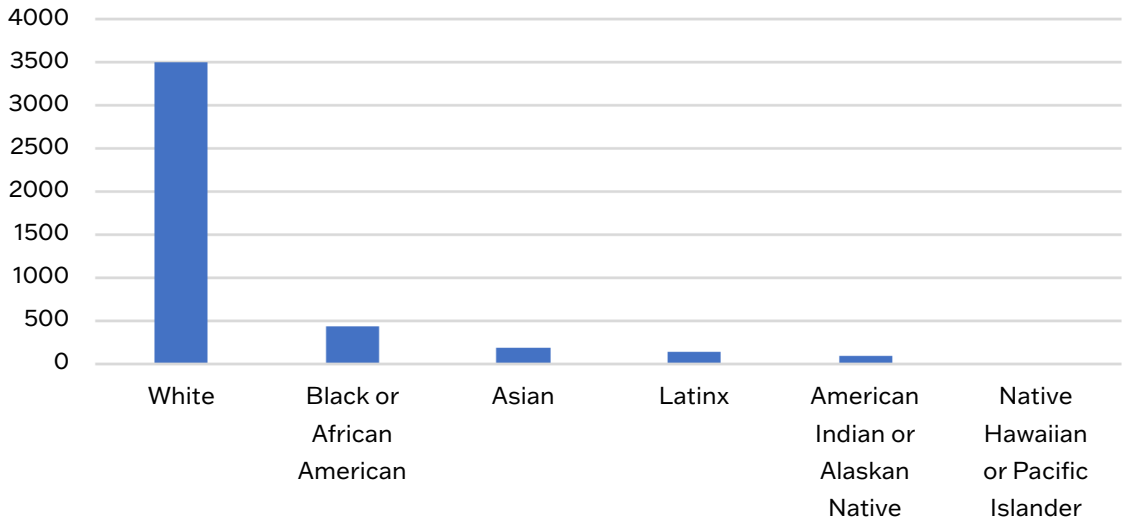
Of 4,364 PMH-APRNs who responded, 88% reported their gender as female, 10% reported male gender, and 0.44% reported either non-binary or transgender. Similarly, 89% were assigned female on their original birth certificate while 10% were assigned male; a percentage close to the reported national gender distribution for all NPs (10% male) (Kaiser Family Foundation, 2021).

Race/Ethnicity

Of 4,364 PMH-APRNs responding, 80% identified as White and approximately 20% of respondents identified as racial or ethnic minorities. The second most frequently identified race in our sample was Black or African American (10%) which is slightly higher than the national sample of NPs who identified as Black (8%) (AANP, 2021). However, compared with the NP national sample, only 2% of the PMH-APRN respondents identified at Latinx compared to 5% of NPs in the national sample (AANP, 2021). In addition, 2% of the sample identified as American Indian or Alaskan Native and 0.5% as Native Hawaiian or Pacific Islander. (See Figure 7 for racial distribution among the sample of PMH-APRNs.) Given the growing Hispanic/Latinx US population (18%) (US Census Bureau, 2020), the low percentage of PMH-APRNs of similar ethnic identity is concerning. It should be noted that 0.4% of respondents said they spoke Spanish.

Race as Identified by Survey Respondents

Figure 7



Active Duty Service

Fewer than 10% of responding PMH-APRNs have any relationship to the military: 6% have been on active duty in past, 3% currently serve in the National Guard or Reserves, and 0.9% are currently on active duty.

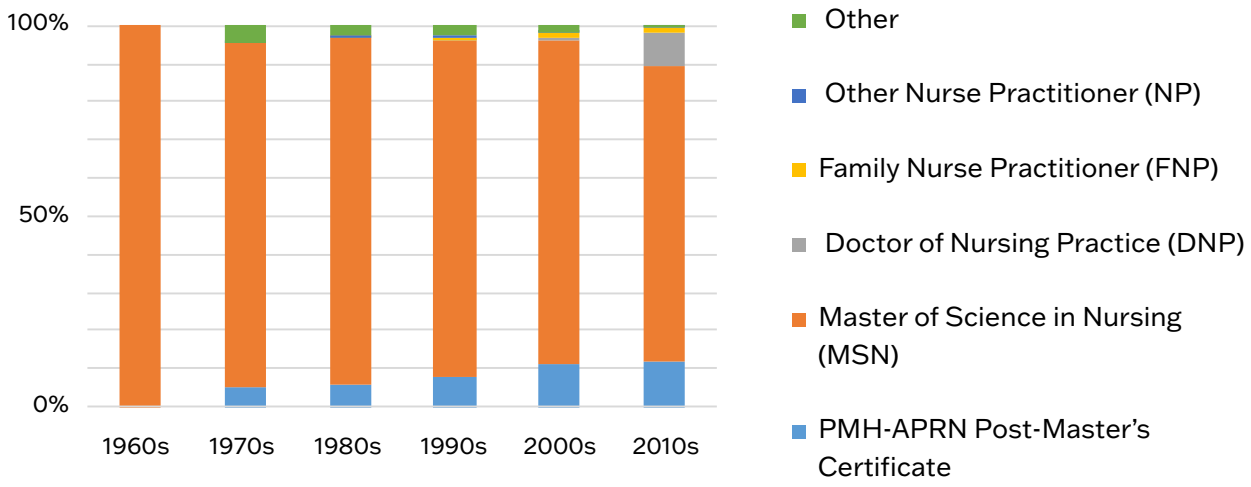
HUMAN CAPITAL

Education

Of 4,938 respondents, the overwhelming majority (82%) reported that their initial PMH-APRN preparation was via completion of an MSN degree. This does not vary meaningfully by age or race. In the past 10 years about 12% of respondents have received a DNP as their initial preparation, with similar proportions of respondents in their 30s or 40s being prepared initially as DNPs. (See Figure 8.) These data mirror national NP trends showing 95% of NPs reporting their initial preparation was a Master's degree, with 17.9% holding a DNP (AANP, 2021). Interestingly, approximately 36% of respondents completed their initial PMH-APRN preparation in the 2010 decade, almost double the number completing their initial degree in the 2000s. These data reflect the rapid growth of the PMH-APRN workforce. Indeed, ANCC certification data indicate from 2013 to 2020 the total number of certified PMH-APRNs nearly doubled; from 13,393 PMH-APRN in 2013 to 26,690 in 2020 (ANCC, 2013; 2020). Of note, 10% of respondents completed a PMH Post-Master's Certificate as their initial role preparation. This number also doubled for those earning Post Master's Certificates in 2000s to those completing this preparation in the 2010s.

Initial Type of PMH-APRN Preparation by Year of Degree Completion

Figure 8



Percentage of Coursework Online for Initial PMH-APRN Education

For respondents under 50, more than 40%, on average, of the didactic coursework was online. For those in their 20s, more than a quarter reported that 100% of the didactic coursework was online, and for those in their 30s, a quarter reported 85% of coursework was online.

New Graduate Residency or Fellowship Program Education

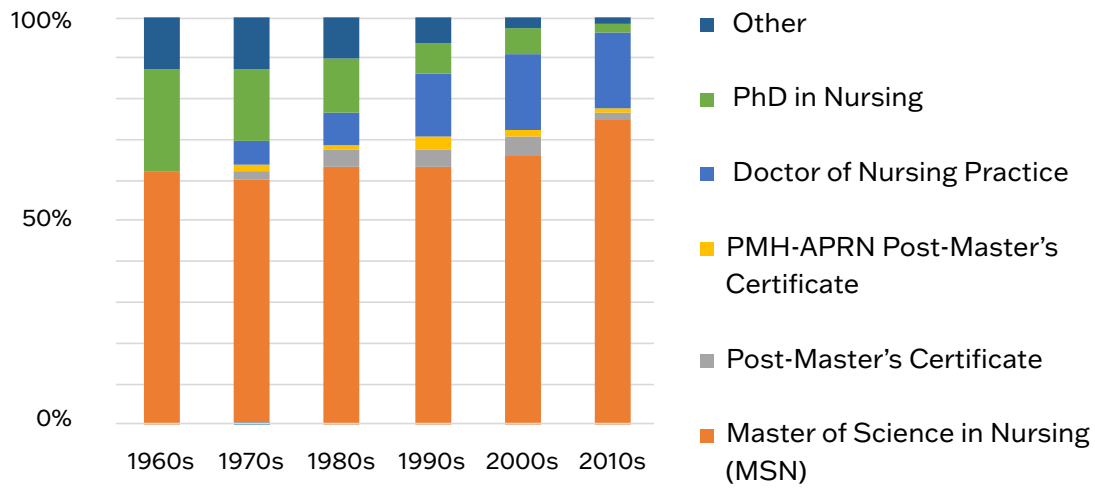
Of 5,012 respondents, 11% completed a post-graduate residency or fellowship program. This did not meaningfully vary by age, gender, or race. The proportion of respondents with a post-graduate residency or fellowship increased slightly with age, but the sample sizes were too small to establish statistical significance. For 516 respondents who completed a residency, the typical program was either 12, 18, or 24 months. About 86% of the PMH-APRN respondents who completed a residency or fellowship program reported that they were either satisfied or very satisfied with the program.

Highest Degree Earned

Approximately 17% of PMH-APRN respondents hold a DNP, which is slightly higher than the national NP cohort who earned a DNP (15%) (AANP, 2021). In addition, the number of PMH-APRNs holding a DNP doubled from the 2000 to the 2010 decade. The majority (69%) of the PMH-APRN respondents reported their highest degree as a Master of Science in Nursing (MSN), which is slightly lower than the AANP (2021) survey which found that 81% of NPs reported an MSN as their highest degree earned. (See Figure 9.) There are no differences in highest degree earned by race or certification. An interesting aspect of the educational trajectory of respondents is that close to 41% completed a diploma or Associate degree program for their initial RN license; this speaks to career mobility within PMH nursing.

Highest Level of Nursing Education by Year of Completion

Figure 9



State Licensure and Certification

Respondents included those licensed in all 50 states, as well as Washington, DC. About three quarters of respondents were licensed in one state, and 23% licensed in 2 to 4 states. Eighty-seven percent of respondents are currently certified by ANCC. Four states do not require NPs to have a national certification to practice (California, New York, Kansas, and Indiana). PMH-NP Family/Lifespan is the most common certification of the respondents, but there are significant differences in certification types by age. Generally speaking, PMH-APRNs in their 60s and above are more likely to be certified as a CNS than as an NP and more focused on the adult population. Younger PMH-APRNs increasingly hold PMH-NP Family/Lifespan certifications.

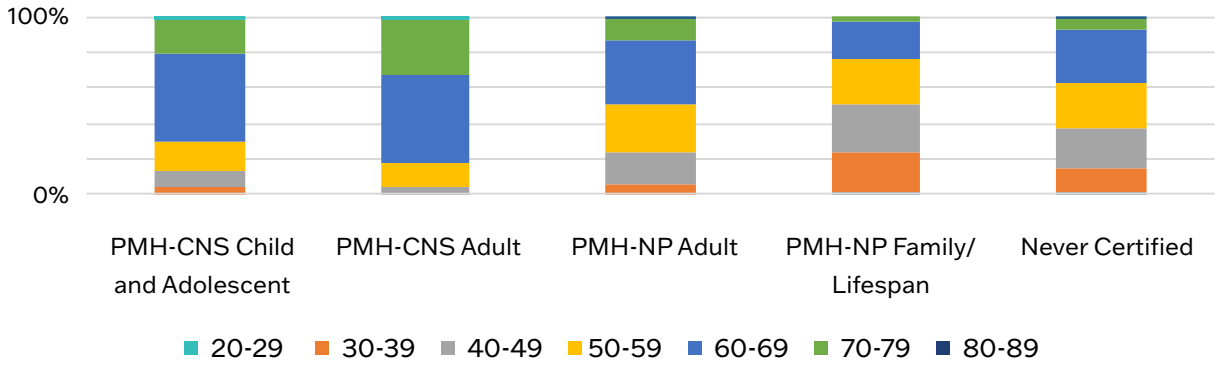
Figure 10 shows that the distribution of certification types is influenced by ANCC certification exams currently available.

Generally, the number of PMH-APRN survey respondents was greatest in large, highly populated states, such as New York, California, Florida, and Texas, that have generally low state density of PMH-APRNs. Two exceptions are Massachusetts and Washington, which ranked third and fourth among state respondents to the survey and also have higher state densities of PMH-APRNs.

Understanding PMH-APRN distribution requires calculating PMH-APRN providers per state per 100,000 population. In this regard our respondent distribution no longer mirrors national data. For instance, while a large number of survey respondents were from California, that state has one of the lowest ratios of PMH-APRNs per 100,000 population (2.15) in the US (Beck et al., 2018). While PMH-APRN state density is important, no inferences can be drawn from our data on this point. However, the report from Beck and colleagues (2018) contains the most recent data on state level PMH-APRN density, indicating the highest ratios of PMH-APRNs per 100,000 in the Northeast states (Maine (22.0), Massachusetts (17.6); Rhode Island (16.6) Connecticut (16.2) and Vermont (14.9) and the lowest ratio of PMH-APRNs per 100,000 in Illinois (2.8), Nevada (2.8), West Virginia (2.5), California (2.1), and Oklahoma (1.5).

Current Certification Held by Respondents by Age

Figure 10

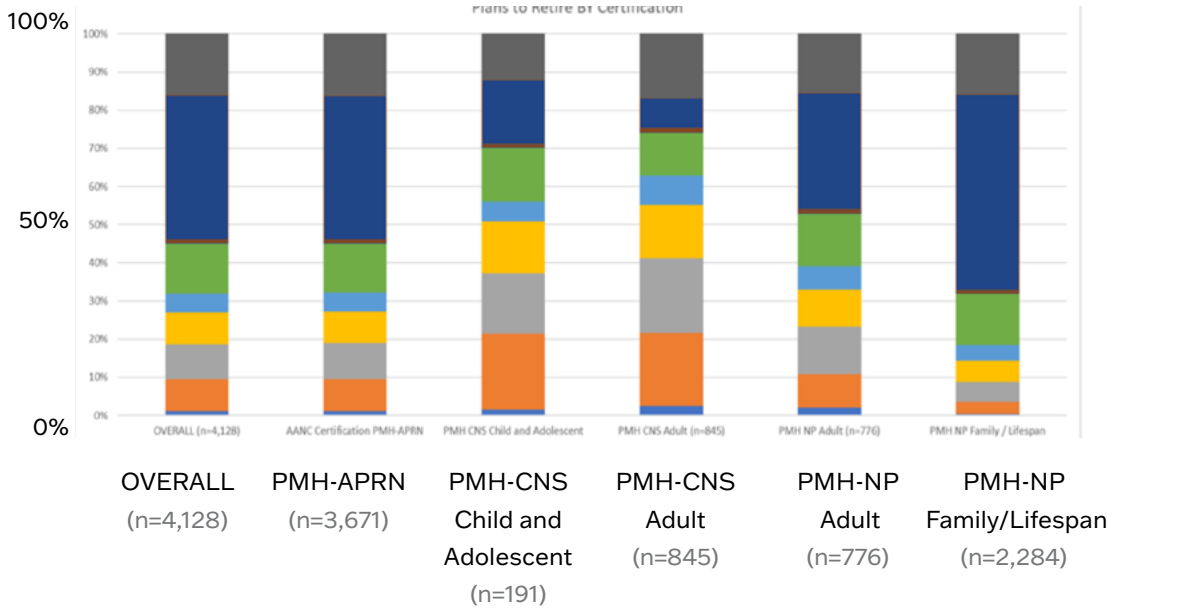


Plans for Retirement

Approximately 27% of respondents plan to retire in the next six years, 7% in the next one to two years. This is not surprising given that 40% of PMH-APRN respondents are over 60 years old. Retirement plans vary by certification, with a greater percent of PMH-CNSs indicating plans to retire in the next 6 years, 55% of Adult PMH-CNSs and 51% of Child and Adolescent PMH-CNSs. The CNS group has a higher mean age and thus this retirement rate is anticipated. (See Figure 11.)

Retirement Plans by Certification Type

Figure 11



EMPLOYMENT CHARACTERISTICS

Primary Employment Setting

Of the 4,703 PMH-APRNs who responded, 70% practice in outpatient settings. The next largest employment site is hospitals (16%). Respondents also work in correctional facilities (2%) and as educators with a practice component (4%). (See Figure 12.) Employment in an outpatient setting is not statistically impacted by age, race, or gender. Primary employment setting is influenced by year of graduation, with more recent graduates less likely to be employed in a college/university or hospital setting and more likely to practice in an outpatient setting.

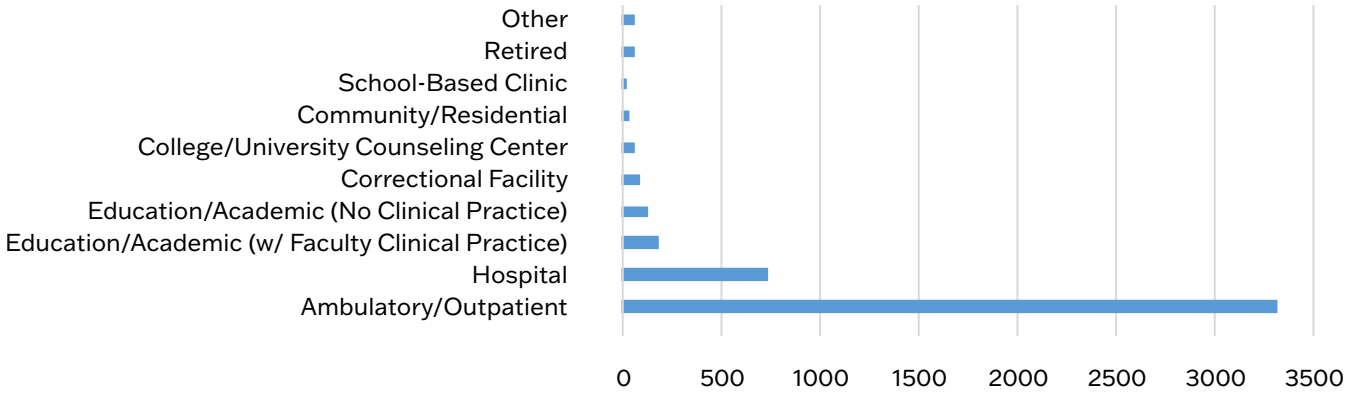
Those respondents who practice in an outpatient setting specified the type. A significant number of PMH-APRNs now practice in FQHCs and mental health clinics and fewer PMH-APRNs practice in private practice, either in a PMH-APRN or MD office. A significant segment of PMH-APRNs practice in integrated care and substance use treatment. (See Figure 13.) Of the PMH-APRNs practicing in hospitals (n = 646), the largest percentage of respondents practice in public general hospitals (28%) and city, county, or state psychiatric hospitals (16%) with more recent graduates (since 2010) making up half of the PMH-APRNs practicing in these sites. Of the 4,215 PMH-APRNs who responded to the question on hospital admitting privileges, 82% indicated they do not have hospital admitting privileges.

Eighty-eight percent of respondents reported their employment setting is in a metropolitan county. Only 1% are in a rural county (defined as both rural AND not adjacent to a metropolitan area). Alaska has the highest proportion of rural PMH-APRNs (10%). Of interest is if state

requirements restricting practice have an impact on PMH-APRN distribution, particularly in rural areas, since it may be more difficult to secure a collaborating physician in regions which are traditionally health professional shortage areas. This relationship has been difficult to demonstrate (Ortiz et al., 2018). One recent labor analysis of PMH-APRN practice, however, concluded that if more states granted Nurse Practitioners professional independence it could encourage an increase in available working time and encourage practice with populations and in regions that are underserved (Luo, Escalante & Taylor, 2021). As the PMH-APRN workforce grows, state distribution and the provision of rural mental health services will be an important area of workforce research.

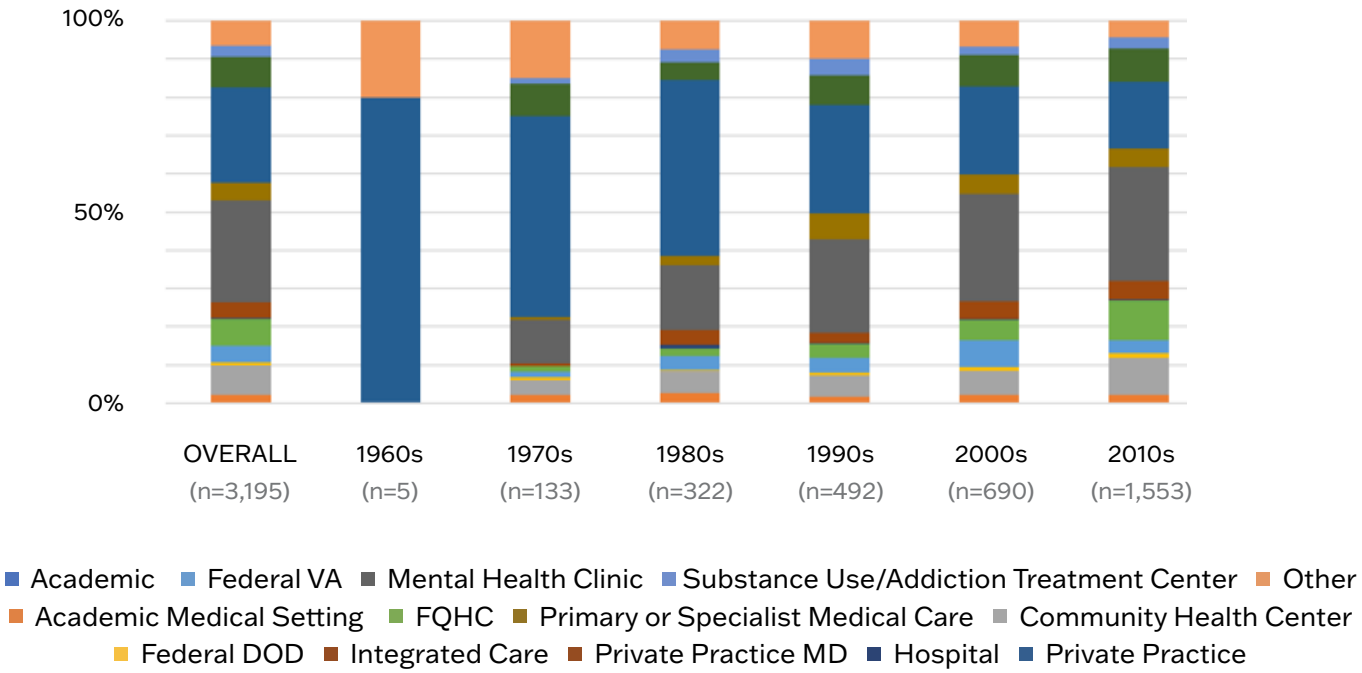
Primary Employment Setting of Respondents

Figure 12



Type of Outpatient Employment Setting by Year of PMH-APRN Degree Completion

Figure 13



Telehealth Services

Of the 4,329 respondents, 86% indicated they provide telehealth services in their employment settings. On average, they provide these services in two states, to an average of 25 patients per week. Since the survey was conducted at the start of the COVID-19 pandemic, these numbers may represent only a fraction of telehealth services provided in the last two years.

Precepting Students

Of 4,305 respondents, approximately 44% indicated that they are precepting students in a clinical setting. On average, these respondents precept four students per year.

Billing for Services

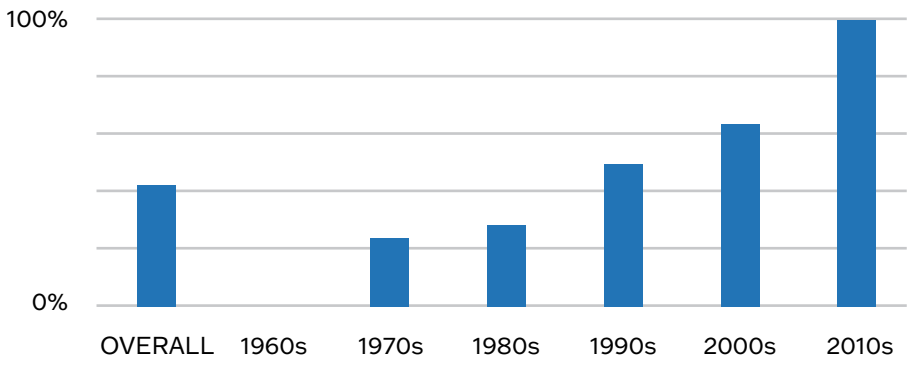
Over half (55%) of the 4,342 respondents to this question indicated they billed under their National Provider Indicator (NPI) number, the majority of whom practice in an ambulatory or outpatient setting. Of this group, one-quarter indicated they did not know if the billing occurred under their own NPI number. When asked about payment, 38% of respondents indicated that some of their patients used commercial insurance, while 44% of respondents reported that most of their patients use Medicare/Medicaid.

Provision of Substance Use Services

There were three survey questions on provision of Medication for Addiction Treatment (MAT) for opioid use disorders. Approximately 42% of respondents (1,767) had completed MAT training, 60% of whom graduated since 2000. (See Figure 14.) Of the 1,273 respondents who indicated they completed MAT training, 72% subsequently applied for the DEA X-waiver. Of these respondents, 32% reported that they had a 30-patient waiver limit and 40% had a 100-patient limit, with half of respondents indicating they would increase their waiver limit when eligible. At the state level, 75% of states have approximately two-thirds of respondents applying for the waiver; however, some states have as few as 30% applying for the waiver. This finding may be related to limitations on PMH-APRN scope of practice in specific states, since PMH-APRNs are less likely to be waivered in states that require physician supervision (Spetz et al., 2021).

Respondents who Completed MAT Training by Year of Graduation

*Figure 14**



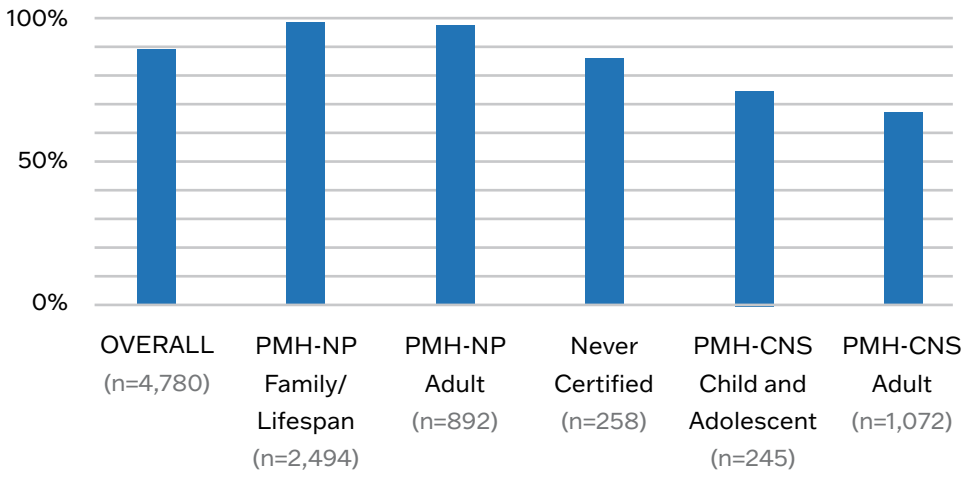
**scale approximate*

Prescriptive Authority

Of 4,780 respondents, 88% reported having prescriptive authority. Those holding PMH-NP certifications had much higher rates of prescriptive authority (98%), and those with PMH-CNS certifications significantly lower; however, a substantial number of PMH-CNSs do prescribe (66%). (See Figure 15). Prescriptive authority decreases with years since graduation and increases with those graduating since 2010; 97% of these more recent graduates have prescriptive authority. This is likely because most PMH-APRN graduates during this period completed PMH-NP programs.

Prescriptive Authority by Certification

*Figure 15**



**scale approximate*

Practice Hours

The majority of respondents indicated they work 40 hours per week. The only group that works significantly fewer hours is PMH-APRNs whose primary employment setting is educational, who work 19-26 hours per week. This group is likely the approximately 4% of respondents who indicated they held an academic position and maintain a practice; thus, the number of practice hours may reflect their dual position.

Services Provided

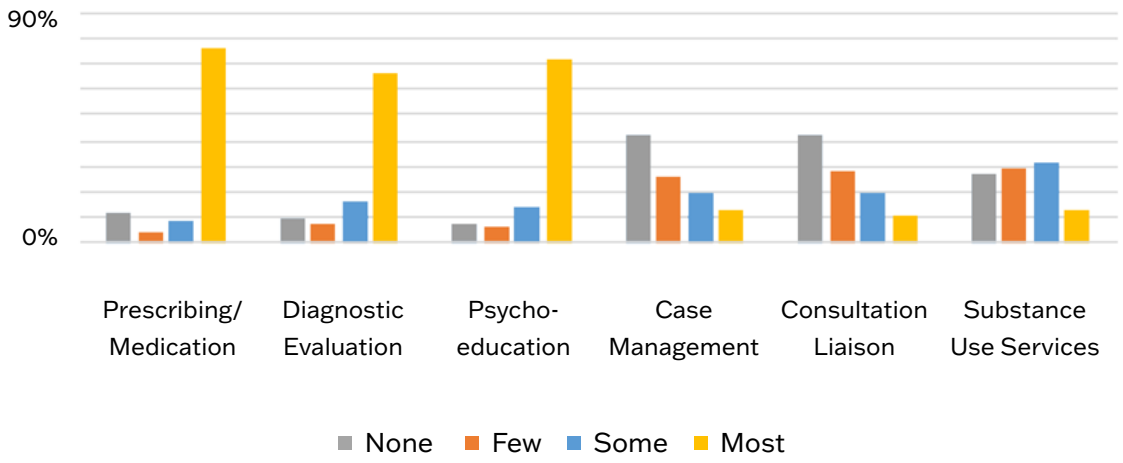
Respondents were asked to indicate services they provided to none, few, some, or most patients. In these queries, respondents indicated that for most patients they prescribed medications (76%), conducted diagnostic evaluations (66%), ordered lab tests and diagnostic studies (41%), provided education (81%), and provided care coordination (43%). Services not provided to a majority of patients included conducting physical exams (14%), providing preventive services such as immunizations (17%), and making referrals (29%). While a small percentage of PMH-APRNs indicated they provide substance use services to most patients (13%), more than one quarter of PMH-APRNs (31%) provide these services to some patients. (See Figure 16.)

In terms of therapy, a significant portion of respondents provided crisis intervention services to some patients (41%), and fewer PMH-APRNs provided crisis services to most patients (17%). Close to half of respondents (48%) provide psychotherapy combined with medication management to most patients. Fewer respondents provided individual psychotherapy to

most patients (10%), or provided group therapy (3%), family therapy (2%), or child/adolescent psychotherapy (4%) to most patients. (See Figure 17.)

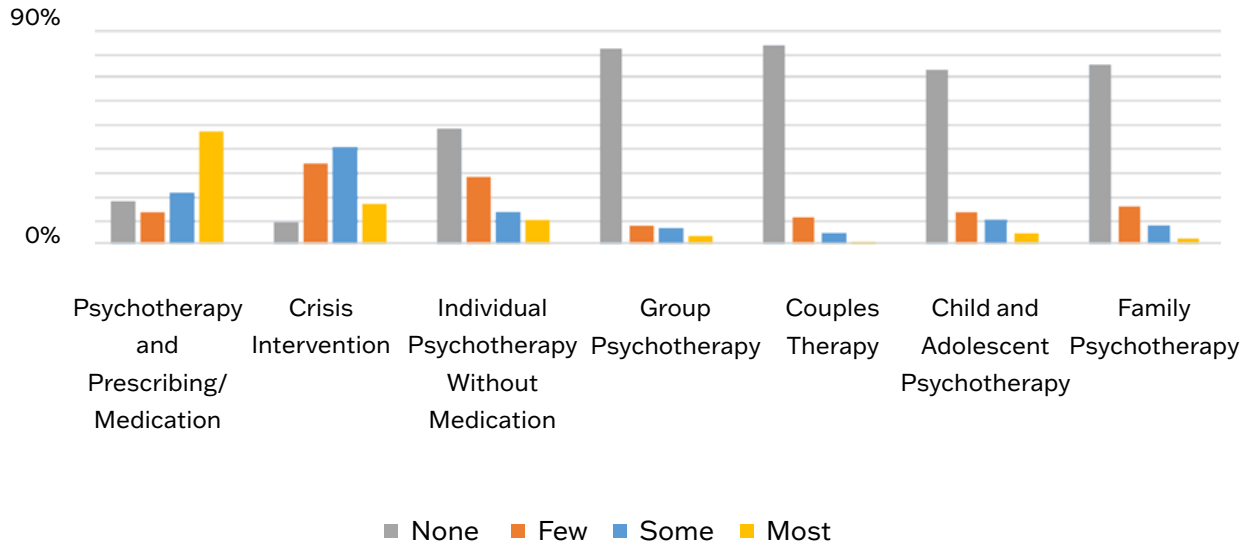
Services Provided in Primary Work Setting

Figure 16



Therapy Services Provided in Primary Work Setting

Figure 17

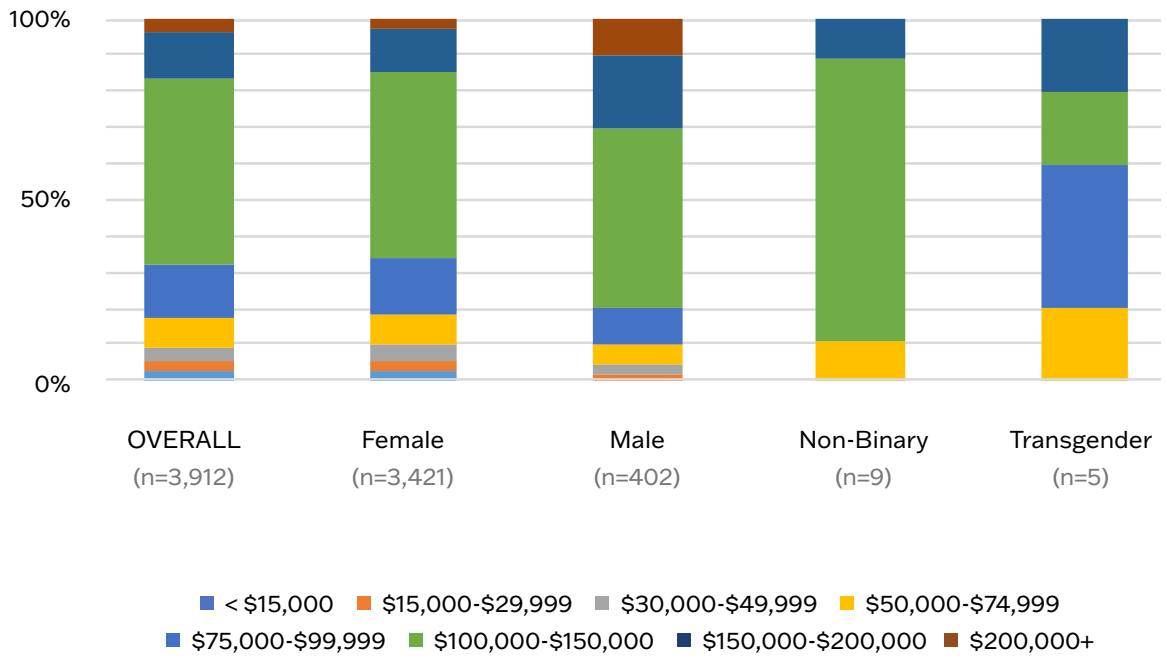


EARNINGS

Nearly half of the 4,288 PMH-APRN respondents (47%) indicated they earned between $100,000-150,000 per year; 13% indicated earning less ($75,000-99,000), and 11% reported earning more ($150,000-200,000). A higher percentage of males are in the upper income bracket. (See Figure 18.) These data are in line with the AANP (2021) survey that place PMH-NPs as the highest paid group of NPs by certification (average $136,000 total income).

Reported Income by Gender

Figure 18



DISCUSSION

This report describes the demographic, education, employment characteristics, and earnings reported by PMH Advanced Practice Nurses who were surveyed by the American Psychiatric Nurses Association in 2020-2021. Key findings from this survey have significant implications for practice, education, policy, and research.

Demographics

The demographics of PMH-APRN respondents are similar to those reported in national NP workforce surveys except for the percentage who identified as Latinx. Compared with the NP national sample where 5% of respondents identified as Hispanic (AANP, 2021), only 2% of the PMH-APRN respondents identified as Latinx. Given the growing Hispanic/Latinx US population (18%) (US Census Bureau, 2020), the low percentage of PMH-APRNs of similar ethnic identity is an opportunity for improvement. It is well documented that the racial/ethnic composition of the behavioral health care workforce does not mirror the populations needing and seeking mental health services, and the challenges in addressing this disparity are significant (Buche, Beck, & Singer, 2017). With growing emphasis on increasing diversity in the RN workforce, there is an opportunity to strategize how to improve diversity beginning at the level of PMH-NP educational programs (Gates, 2018). Younger cohorts of RNs are generally more racially diverse than those who are older than 55 and the percentage of RNs who identify as Hispanic/Latinx is slowly increasing (Smiley, et al., 2021), which will create opportunities to recruit more diverse cohorts of PMH-NP students.

Retirements

The PMH-APRN workforce mirrors the national NP workforce in many respects, save average age. Owing to the longevity of the PMH-APRN certification, the profession built a substantial PMH-CNS workforce throughout the 1970's (Drew, 2014). As these valued PMH-APRNs begin retirement, it is critical to monitor the growth of PMH-NP workforce. It appears PMH-NP workforce growth is accelerating, with 2020 PMH-NP lifespan certifications demonstrating a 30% increase over 2019 (ANCC, 2021). Given that PMH-APRNs are one of four professions licensed to provide the full range of mental health services, sustaining this workforce is vital to the provision of mental health care, particularly given the small numbers of Psychiatric Pharmacists (996), Physician Assistants specializing in psychiatry (1,164), and the diminishing number of practicing psychiatrists (Beck et al., 2018). Demand for psychiatric services is projected to exceed the supply by 15,600 workers (25%) in 2025 (National Council, 2017), a demand that will undoubtedly be even higher given the impact of the COVID-19 pandemic on mental health (Pfefferbaum & North, 2020). Thus, maintaining the size and capabilities of the PMH-APRN workforce is vital.

Clinical Focus

PMH-APRNs focus on the critical tasks of primary mental health care: diagnosis, management, prescribing, and treatment monitoring. The vast majority of PMH-APRNs provide these services to most patients they treat. As PMH-APRNs move into providing comprehensive outpatient mental health care, our respondents' lack of hospital admitting privileges may become a significant barrier to accessing services needed by clients in acute distress.

While providing psychotherapy alone is rare, close to 70% of respondents said they provide psychotherapy and medication management to some or most patients. As the role of the PMH-APRN vis-a-vis psychotherapy continues to be debated (Scheydt, & Hegedüs, 2021), in line with our data, prescribing combined with psychotherapy is the dominant practice and its outcomes should be examined.

Practice Settings

The data indicate that PMH-APRNs are increasingly likely to practice in outpatient settings, particularly mental health clinics and FQHCs. These data mirror national trends of increasing NP roles in the delivery of care at these sites (Yang et al., 2017) and their importance in reaching the underserved (Xue et al., 2019). Data indicate a large percentage of recent graduates have completed MAT training, demonstrating that this group can be a vital resource for closing disparities in opioid treatment (Andrilla et al., 2020). Over three quarters of NP educational programs report implementing curricular modifications to address treatment of opioid use disorders, which in some programs includes MAT training to provide medication for addictions treatment (Kameg, et al., 2021). Recommended competencies and content are in place for increasing the inclusion of substance use competencies into PMH-NP educational programs (Finnell, Tierney, & Mitchell, 2019) and reports are emerging of how these competencies/content have been integrated into select PMH-NP programs (Abram, White, & Jacobowitz, 2020). Thus, these outpatient roles and the capacity of PMH-APRNs to address gaps in mental health/substance use care should be highlighted to behavioral health care planning groups, policymakers, and insurers who are now beginning to recognize their potential contribution in these settings (Pietras & Wishon, 2021).

Caring for Insured and Underserved Individuals

Almost half of the respondents indicated that most of their patients used Medicare/Medicaid insurance. Providing services to this population is critical as a significant number of individuals dealing with serious mental illness are enrolled in these insurances (McGinty, 2020; Ward et al., 2017) and psychiatrists have low acceptance rates of individuals on these plans, indeed lower than those for other types of physicians (Bishop et al., 2014). These are some of the most complex patients and, similarly to the broader universe of NPs, PMH-APRNs are well suited to provide care and address the significant unmet mental health care needs of this population (Beeber, 2019; Han et al., 2017). Bishop et al. (2014) also reported that only 55% of psychiatrists accept fee for service insurance of any type, compared with 89% of physicians in other specialties. One quarter of our respondents indicated that most patients used commercial insurance. Emerging data on mental health services with youth indicate the care delivered by PMH-NPs is of high quality (Yang et al., 2018; 2021). Thus, PMH-APRNs are an important provider group for increasing access to mental health services for individuals seeking services since they accept payment via either commercial or federal insurance.

Shifting Patterns of Education

Two noteworthy trends in PMH-APRN education preparation emerged in our data. One is the number of PMH-APRN programs with increased percentage of content online: more than a quarter of participants in their 20s reported that 100% of their didactic coursework was online, and for those in their 30s, a quarter reported 85% was online. While the shift to online didactic

education is acknowledged, there is scant direct study of the effectiveness of this delivery method. There is ongoing interest in the development of clinical competencies, including the move to adapt the American Association of Colleges of Nursing's (AACN) competency-based education model (AACN, 2012).

The second trend is the increased number of recent PMH-NP graduates with DNP preparation. This mirrors national trends toward adopting the DNP for entry to advanced practice and which identified PMH-NP as a top population focus in moving from MSN-to-DNP (46%) (Baldyga & DePaepe, 2021). The PMH-NP BSN-to-DNP program growth has also been substantial (74% change) (Baldyga & DePaepe, 2021). DNP preparation will produce graduates with considerable skills in outcome evaluation and quality improvement. This shift in educational preparation provides an opportunity to focus on how to use DNP project research in a way that builds our knowledge and evidence base around the nursing approach to service issues and builds the scholarly output of psychiatric-mental health nurses (Redman et al., 2015). At the same time the profession should be concerned about the slow growth in numbers of PMH-APRNs with PhD preparation (Vance et al., 2020). This is mirrored in our data indicating the PhD degree is held by only 6% of our respondents, with a decreasing percentage of PMH-APRNs holding a PhD in the cohort graduating since 2010. Nursing research is vital to the improvement of mental health services and policy development and our profession needs to maintain focus on ensuring adequate capacity of PhD-prepared psychiatric-mental health nurses.

Report Summary

The final section of this report synthesizes and highlights overall key findings about the Psychiatric-Mental Health (PMH) nursing workforce, that is—registered nurses (RNs) and advanced practice registered nurses (APRNs), and their educational preparation, employment characteristics, and earnings.

The PMH nursing workforce is aging with more than half of the PMH-RN and PMH-APRN respondents in their 50s or 60s. Only a small percentage of PMH-RNs are in the 20-29 age range and more than one-quarter of PMH-APRN respondents plan on retiring in the next six years, with a greater percent of intended retirements among clinical nurse specialists (CNSs). While the number of students graduating from PMH Nurse Practitioner (NP) programs is significantly increasing, the profession should monitor the balance between retirements and PMH-NPs entering practice.

Although the majority of the PMH nursing workforce is White, the proportion of respondents that identified as Black or African American in our sample is greater than national samples of RNs and NPs. However, the PMH nursing workforce is less diverse in terms of those who identify as Hispanic/Latinx. Psychiatric-Mental Health Nurse leaders should focus on recruiting early-career nurses as well as racial and ethnic minority populations into the field.

About half of the PMH-RN sample reported a Bachelor of Science in Nursing (BSN) as their highest degree, while the majority of the PMH-APRN sample reported a Master of Science in Nursing (MSN) as their highest degree and their initial PMH-APRN preparation. Rates of certification among PMH-RNs vary by race and age with the highest proportion of respondents certified by the American Nurses Credentialing Center identifying as older and White. Nurses noted that the top reason for not obtaining certification is because it is not valued by their employer. For PMH-APRNs, the PMH-NP (Lifespan) was the most common certification with differences by age; older PMH-APRNs were more likely to hold a CNS certification. These findings are due, in part, to the types of certifications available through ANCC.

PMH-RNs and PMH-APRNs are employed in a variety of settings. The majority of PMH-RNs reported a hospital as their primary employment setting while the majority of PMH-APRNs reported the outpatient setting as their primary employment setting. Services provided by PMH-RNs and PMH-APRNs are consistent with the scope of practice for these roles. Specifically, the majority of PMH-RN respondents reported that they assess physical health status, assess mental health status, and educate patients and families for most patients. The majority of PMH-APRN respondents prescribe as well as provide diagnosis and management services to most patients. A significant portion of PMH-APRNs also combine prescribing with psychotherapy (69%) but a much smaller percentage of respondents provide any type of

stand-alone psychotherapy. Less than half of PMH-APRN respondents completed Medication for Addiction Treatment (MAT) training and, of these, 72% subsequently applied for a DEA X-waiver to prescribe Buprenorphine. Finally, a majority of PMH-APRN respondents treat patients who hold commercial insurance or Medicaid/Medicare, with 44% stating most of their clients were covered by federal insurance. Few PMH-RNs and PMH-APRNs reported working in a rural setting.

Pre-tax annual income from primary employment for PMH-RNs was in the $50,000-99,000 range for about two-thirds of respondents. Income from primary employment tended to increase with age up to 70 years and then decreased. Nurse administrators most frequently reported earning greater than $100,000, followed by nurse managers and those working in correctional facilities. PMH-APRN pre-tax annual income from primary employment was greater than that reported by PMH-RNs with almost half of PMH-APRN respondents reported earnings in the $100,000-150,000 range. While there was no mean income difference among PMH-APRNs based on race, males reported higher income ranges.

This report is an initial attempt to fill the gap in data related to the PMH nursing workforce. Ongoing collection of the demographic, education, and employment data on the PMH Nursing Workforce will inform behavioral health workforce planning, program, and policy development.

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