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PRIMARY MENTAL HEALTH AND ADVANCED PRACTICE PSYCHIATRIC NURSING

Society for Education
and Research
in Psychiatric/Mental
Health Nursing

PRIMARY MENTAL HEALTH AND ADVANCED PRACTICE PSYCHIATRIC NURSING

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Dedicated with Gratitude

to

Jeanette Chamberlain, EdD, RN, FAAN

whose vision, persistence, and leadership have resulted in the education of hundreds of advanced practice psychiatric nurses.

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EXECUTIVE SUMMARY

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Change is a constant in today's world. This statement, of course, has been true throughout history. What is different today is the rapidity with which change occurs. Technology has made it possible to access and analyze vast quantities of data about a seemingly infinite number of phenomena. In fact, if data are not available about a given phenomenon, that phenomenon may be overlooked and left behind in the inexorable march to the future.

This survey of certified advanced practice psychiatric nurses (APPNs) is one effort to provide data about an important group of mental health practitioners. The survey was designed to:

1. Update the data base about APPNs, and
2. Identify and describe select characteristics of APPNs and their practice in order to paint a picture of "what is."

It is also hoped that another outcome of this project will be to reaffirm the presence of the discipline and its position in relation to the other mental health disciplines.

The healthcare environment is in turmoil precipitated by unprecedented changes in the way in which the system is financed. The inroad of managed care with its emphasis on cost-containment has induced a myriad of responses along a continuum from total rejection (Wooley, 1993) to espousal of and advocacy for its precepts (Feldman, 1992). One of the precepts of managed health care that has created considerable anxiety among mental health clinicians is the emphasis by managed care entities on the use of primary care as the gateway through which mental health consumers must access both physical and mental health care.

Some of this anxiety stems from an awareness that people with serious mental disabilities and those with mental health problems are currently receiving inadequate care within the primary care system. It is estimated that 20% to 30% of persons in primary care clinics have diagnosable mental disorders (Costello et al. 1988). However, studies indicate that 50% to 80% of these disorders are not detected in primary care settings for a variety of reasons, including clinical variables. Even when psychiatric illnesses or mental health problems are diagnosed and treated, medications are frequently the only treatment prescribed, and, more likely than not, in sub-clinical doses (Kelleher, Holmes, & Williams, 1994).

Where and by whom gatekeeping should occur needs to be thought through carefully. The overuse of the healthcare system by undiagnosed or undertreated persons with mental illnesses who are treated inappropriately for physical illnesses has the potential to continue to escalate costs. The primary care system as it currently exists needs to be redesigned and expanded to meet the challenges presented by persons with mental illnesses and mental health problems if the managed care goal of cost-containment is to be achieved.

In order to redesign a system, it is necessary to understand its current design, how it is defined, and who are the players. What is primary care? A 1960's definition identifies primary care as ". . . the essential, continuous care necessary for general well-being and common problems provided in a community setting" (Kelleher, Holmes, & Williams, p. 149). More recently, Starfield (cited in Kelleher, Holmes, & Williams, p. 149) identified primary care as ". . . the point of entry into the health care system and the locus of responsibility for organizing care for patients and populations over time." The Institute of Medicine (IOM) lists five main characteristics of primary care that fit with both of the above definitions. These characteristics include:

1. first contact medicine,
2. comprehensive services,
3. assumption of longitudinal or continuous responsibility for the patient,
4. care coordination, and
5. accountability.

Additionally, "primary care clinicians are more likely to provide preventative and administrative services for patients [and] continuity is also a differentiating factor" (Kelleher, Holmes, & Williams, p. 150). Most commonly, primary care clinicians are found in office-based physical medicine practices.

Some believe "Primary care clinicians are uniquely suited to initiate and coordinate mental health services for persons with mental disorders because of their longitudinal relationships with patients and families, their knowledge of the patient's situation factors and social supports, and their management and awareness of other relevant medical conditions, and their position as contact and referral point for the health care system" (Kelleher, Holmes, & Williams, p. 149). However, when one considers the statistics concerning detection of psychiatric disorders in primary care settings, this belief is difficult to maintain. For example, "The low rates of mental health diagnosis and management in primary care settings are related to a number of factors including a lack of familiarity with the patient and amount of time available for assessment and treatment" (Kelleher, Holmes, & Williams, p. 155). Further, in contrast to the belief that primary care clinicians know patients and their problems better than specialists, psychiatrists are "much more likely to have a previous knowledge of the patient and their [sic] problem than are office based primary care clinicians" (Kelleher, Holmes, & Williams, p. 155).

The plight of persons with serious mental disabilities who are treated within the public mental health system is similar to those treated by primary care clinicians,

except that in the former instance, medical illnesses are likely to be underdiagnosed and undertreated. These observations reveal a need to expand concepts of primary care in both medical and psychiatric settings.

One suggestion for such an expansion, particularly appropriate in the public mental health sector, is the development of primary mental health care (Haber & Billings, 1995). Haber and Billings noted that "primary mental health care transcends specialty practice to become a holistic, integral component of the community-based primary care system [in which] primary mental health care is the care that is provided to those at risk or already in need of mental health services" (p.155). Primary mental health care includes "the continuous and comprehensive services necessary for the promotion of optimal mental health, prevention of mental illness, and health maintenance, and includes the management of and/or referral for mental and general health problems" (p.155). Primary mental health clinicians diagnose and treat a whole array of psychiatric illnesses and mental health problems. Additionally, the potential exists for them to diagnose common physical illnesses and refer more complex medical and psychiatric problems to specialists. APPNs, with their specialty knowledge in psychobiological and behavioral care and their general health knowledge from basic nursing preparation, are uniquely positioned to develop, provide, and supervise the provision of services in primary care settings.

This monograph reports the findings of a survey of adult and child/adolescent psychiatric clinical nurse specialists certified by the American Nurses Credentialing Center. The survey was conducted from Spring 1994 through Spring 1995. Three mailings were conducted. The 20% probability sample was drawn from a population of 6,090 certified nurse specialists. The survey response rate was 55% (675 respondents). The survey instrument included the core Human Resources Minimum Data Set items from the Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration and additional questions developed by the task force designed specifically to address psychiatric nursing practice and the contexts of that practice.

The survey sample was those advanced practice nurses who have chosen to seek certification as a psychiatric nurse specialist, the credential recognized by the profession as designating those nurses with specialized skills. Those nurses with master's degrees with a specialty in psychiatric nursing and without certification were not included in the study. The nine months during which data were collected was a time of rapid change in the healthcare environment. Thus, the survey describes the perceptions of psychiatric clinical nurse specialists poised at the crest of a changing context of practice. The survey findings identify the respondents' skills, the context in which they practice, the populations they serve, the characteristics of their practice, and their perceptions of the aspects of the healthcare environment that enhance or impede enactment of the advanced practice role.

Selected findings of the survey are as follows:

- APPNs are typically white, female, middle aged, and currently working in psychiatric nursing.
- APPNs primarily work full time.
- Most of the work hours of the APPNs are spent providing direct patient care.
- APPNs provide on-call services for direct care.
- APPNs identify more than one place of employment and work most frequently in hospitals, clinics and outpatient settings.
- APPNs treat both males and females of varying ages from Caucasian, African-American, Hispanic, and other ethnic backgrounds, and middle and lower socioeconomic groups.
- APPNs care for persons with a range of mental illness and mental health problems.
- Most APPNs are salaried in their primary care setting and receive fee for service in their secondary settings.
- APPNs report independent practice in both their primary and secondary work settings.
- Many APPNs provide clinical care through self employment models in addition to a full time position in another context.
- As a group, APPNs have sought advanced degrees and credentials beyond that required for certification and also plan for additional advanced degree preparation.
- APPNs as a group tend to seek additional certification in role specialization or specialty clinical skills.
- APPNs identify a desire for non-degree education in psychopharmacology, population specific psychotherapy, the biological basis of mental illness, and the administrative role.
- APPNs have extensive experience in practicing psychiatric nursing at both the basic and advanced practice levels.
- APPNs provide care in public and private organizations.
- APPNs are unevenly distributed throughout the country.
- Clinical nurse specialist is the employment position most frequently held by APPNs.
- Primary therapist is the APPNs most frequently cited clinical responsibility.
- Individual psychotherapy is the most frequent service offered by APPNs, followed by psychiatric assessment.

The findings of the survey suggest that APPNs are indeed involved in autonomous and community-oriented clinical care. They provide direct care to clients who are diverse in regard to ethnicity, age, socio-cultural backgrounds, gender, and diagnosis. Many APPNs are educated beyond basic Master's degree preparation and, as a group, are motivated to continue their education through both degree and non-degree options. As a group, they are experienced in the care of persons with mental illnesses and have remained involved in the workforce. These findings support the belief that APPNs are, and can continue to be, effective providers in a managed care environment that mandates primary care.

This monograph presents initial findings from the data to provide information about who APPNs are, the care they provide, and where and with whom they work. The data will be further analyzed in regard to the following topics: barriers to practice; outcome evaluation measures and the advanced practice psychiatric nurse; advanced practice nurses in the managed care environment; education and training needs of the advanced practice psychiatric nurse; and legislative and regulatory influences on the scope of practice of APPNs. These findings will be published as articles in *Archives of Psychiatric Nursing.*

On behalf of the Society for Education and Research in Psychiatric-Mental Health Nursing, we wish to extend appreciation to Ronald Manderscheid, PhD, without whose intellectual and financial support this survey would not have occurred; the members of the Task Force who were motivated, creative, and hard working; to colleagues from the Coalition of Psychiatric Nursing Organizations (see Appendix E) who encouraged the work and shared their time and talents in the initial phases of development of the project; to the staff of the American Nurses Credentialing Center who graciously provided the names and mailing labels of all certified psychiatric clinical nurse specialists in the country; and to the following graduate student assistants:

Mary Cheever-McKenzie, MS, RN, Northeastern University
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Anne Mauck, MS, RN, Virginia Commonwealth University
Christina Yim, MS, Virginia Commonwealth University

SERPN would like to acknowledge the following psychiatric-mental health nurse exemplars for sharing their psychiatric nursing practice for discussion at the initial workshop:

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Lana Chase, MS, RN, Atlanta, GA
Susan Brill, MS, RN, CS, Boston, MA
Suzanne Sayle-Jimerson, MS, RN, CS, Boston, MA
Maureen Streff, MS, RN, CS, Acton, MA

Two people who deserve special recognition are Elizabeth I. Merwin, PhD, RN, CNAA, FAAN, who oversaw the implementation of the data collection and its analysis and Cecelia M. Taylor, PhD, RN, the editor of the final copy, who has always provided consistent support to the work of the organization, and is a friend and colleague.

Margery M. Chisholm, EdD, RN, CS, ABPP
President, Society for Education and Research in Psychiatric-Mental Health Nursing
Co-Chair, Advanced Practice Project Task Force

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Letters of Endorsement

UNITED STATES CENTER FOR MENTAL HEALTH SERVICES

The demise of the President's efforts to reform health delivery and the subsequent rapid expansion of managed care are greatly altering the mental health landscape. In this environment, it is essential for mental health providers to take stock of their current capacities as they prepare for a new future.

The recent Survey of Certified Psychiatric Clinical Nurse Specialists conducted by SERPN will serve as a landmark for the psychiatric nursing community as it charts the new waters of managed care. It provides excellent baseline information on the characteristics of providers and practices, and the current status of the field.

The Center for Mental Health Services is pleased to have participated in the development and implementation of this survey, and dissemination of the final results. We congratulate SERPN on this important accomplishment.

Ron Manderscheid, PhD
U.S. Center for Mental Health Services

ASSOCIATION OF CHILD AND ADOLESCENT PSYCHIATRIC NURSES, INC.

I first want to commend the Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN) for the organization's commitment and vision in undertaking the survey on Advanced Practice Psychiatric Nurses (APPNs) in relation to healthcare reform. I am impressed with the collaboration modeling SERPN has demonstrated in working with the Substance Abuse and Mental Health Services Administration (SAMHSA) and in particular with Ronald Manderscheid, PhD. And, I deeply appreciate SERPN's spirit of demonstrated collegiality in asking me to respond to the Survey results and sharing my thoughts.

My initial reaction to the information is an ominous one in relation to the future of psychiatric nursing. With decreased funding for graduate education (Nay, higher education!), and registered nurses working well into "thirty-something" before obtaining advanced practice education, the specialty could rapidly be deleted. Survey results show the majority of respondents are between the ages of 40 and 49 years old. What implication will the graying of APPNs have on America's psychiatric population? Because of reimbursement and credibility issues, many psychiatric nurses sought advanced degrees in counseling, social work, and psychology and identify themselves with those fields. They are regarded as professionals in those fields rather than in nursing. This practice dilutes psychiatric nursing as a specialty. Most of the respondents worked in hospital settings. This is only *one* of a variety of settings where psychiatric care occurs. Psychiatric mental health nurses need to find a collective voice to educate not only the consumer regarding the scope of practice of APPNs but also their choice in providers.

The Association of Child and Adolescent Psychiatric Nurses, Inc. (ACAPN) is an organization committed to promoting mental health of infants, children, adolescents and their families. I want to speak to three of ACAPN's goals in relation to the survey's findings. One goal is to "Promote public policy, legislation and funding mechanisms in support of mental health services for children, adolescents and families." Clearly, the survey tells us we need to continue and increase our advocacy efforts and political activity. A second goal is to "Ensure access to mental health services for children with serious mental illnesses and their families." Few of the survey respondents worked with children and adolescents. Most nurses were working in hospital settings. That's where sick people are! We need to go to the community—schools, homes, alternative settings—and educate and practice. We need to provide role models for student nurses so they know the specialty. Exposure to the child and adolescent psychiatric specialty needs to occur at the undergraduate level, both in the classroom and the *clinical* setting.

A third goal is to "Promote advanced practice in child and adolescent psychiatric nursing." Survey data showed a Clinical Nurse Specialist (CNS) distribution throughout the United States in concentrated areas where thriving graduate nursing programs once were and now are closed. The Education Committee of ACAPN, ably chaired by Linda Finke, PhD, RN, is collecting data regarding locations of graduate child and adolescent psychiatric nursing programs. The care of the developmentally disabled population is an untapped field for this specialty. Graduate curricula need to be developed and implemented as modern medical technology has increased survival of so many who, a decade earlier, would have succumbed. The child and adolescent psychiatric practitioner is in a natural role of case manager. The role needs to be delineated and operationalized.

There has been much done before us and many nurses who shared their visions. We have an unprecedented challenge that I view as a wonderful opportunity. Now—to restate the members of the Advanced Practice Project Task Force—"We have a lot of work ahead!"

Elizabeth Bonham, MSN, RN, CS
ACAPN President

AMERICAN PSYCHIATRIC NURSES ASSOCIATION

It gives me great pleasure to endorse the Advanced Practice Nursing Survey monograph on behalf of the American Psychiatric Nurses Association. We are pleased to be involved in the conceptualization and design of this survey and believe the final product provides much needed information in the field. Given the current healthcare environment, it is clear that the role of advanced practice psychiatric nurses is expanding and that they have much to offer consumers of mental health care. It is important, therefore, that the profession understand the characteristics of these providers, the services they render, and factors that have an impact on their ability to provide primary mental health care. This monograph will be very useful in both directing the specialty and advocating for the services these nurses can provide in current and future healthcare delivery. Equally important, the survey identifies the ongoing educational needs of these nurses and suggests way in which the specialty can address important curricular and research issues.

The mission of the American Psychiatric Nurse Association is "To provide leadership to advance psychiatric-mental health nursing practice, improve mental health care for individuals, families, groups and communities, and shape healthcare policy for the delivery of mental health services." I believe the findings from this survey will be helpful to us in furthering our goals and maximizing the contribution that psychiatric nurses can make in meeting the needs of individuals, families, groups, and communities.

Gail W. Stuart, PhD, RN, CS, FAAN
President, American Psychiatric Nurses Association

INTERNATIONAL SOCIETY OF PSYCHIATRIC CONSULTATION LIAISON NURSES

The International Society of Psychiatric Consultation Liaison Nurses was pleased to be involved with SERPN and the others in COPNO in the Advanced Practice Psychiatric Nursing workshop and survey. The rate of response to the survey was quite impressive and lends much credibility to the results. We of ISPCLN agree with the conclusions that the SERPN task force reached (i.e., that this survey provides the "Loom upon which the fabric of mental health services can be woven"). We also believe this survey provides crucial information with which to educate the insurers, legislators, as well as the public about the services provided by APPNs. As we are all too well aware, the role and services of APPNs are woefully unclear to too many. We are appreciative of the time and commitment SERPN and others in COPNO devoted to this project and look forward to continued collaboration which will further develop the fabric design of the mental health services we offer.

Ann Robinette, MS, RN, CS, ARNP
ISPCLN, President

Advanced Practice Psychiatric Nursing

"Upon this gifted age, in its dark hour
Rains from the sky a meteoric shower of facts.
They lie unquestioned, uncombined,
Wisdom enough to teach us of our ill is daily spun, but
There exists no loom to weave it into fabric."

— Edna St. Vincent Millay

Advanced Practice Psychiatric Nursing

In 1994, a survey of 1211 Advanced Practice Psychiatric Nurses (APPNs) was conducted. In 1993, there was an air of excitement and a feeling of anticipation that a new order was in process. Many diverse groups believed there would be some kind of universal healthcare reform. The Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN) was wholly committed to working toward that reform. That commitment placed particular emphasis on both the inclusion of mental health and substance abuse care, with parity, in whatever plan was passed, and the recognition of APPNs as appropriate providers of that care. Part of the excitement that pervaded the membership of SERPN in 1993 was the hope that a dream would become reality. We dreamed that the inequities of the 1980s that had brought the growth of the community mental health movement to a screeching halt were over and that an increased concern for human dignity would set the stage for legislation that would bring needed services to persons with severe mental disabilities and to their family members.

Healthcare reform and the proposed redistribution of Graduate Medical Education Funds, supported by organized nursing, promised to curtail some of the erosion of training funds ($2.5 million in 1994 as opposed to $12 million in 1974 [Mandersheid, 1995]) that threatened the viability of APPNs as well as other mental health providers. The decline in persons entering the mental health professions, particularly psychiatrists and APPNs (the Society for Education and Research in Psychiatric-Mental Health Nursing, 1994), has the potential to contribute to a decline in the quality of care for persons with serious mental illnesses. While the population of the United States has a 28% one year prevalence rate of psychiatric diagnoses, only 14.7% of the population receives mental health services annually. Only six percent receive mental health services from the mental health specialty sector (Bourdon et al., 1994). The lack of treatment by the specialty sector is compounded by the lack of focus on the diagnosis and treatment of mental illness within the primary care sector where persons with psychiatric problems are often underdiagnosed and/or undertreated (Kelleher, Holmes, & Williams, 1994). An entire infrastructure needs to be rebuilt in order to provide care necessary to reduce costs, while increasing access and improving the quality of care. SERPN hoped that the development of the mental health workforce needed to provide those services, in partnership with

consumers and family members, would become a priority in a reformed healthcare system. The survey data are a means to an end in that they provide information about APPNs and their services available in 1994, a factual baseline for workforce planning.

This report of the survey's findings has been written in an environment characterized by change and turmoil. Efforts to change the healthcare system through universal reform failed. The focus of national reform efforts has shifted from attempting to change the entire healthcare system to changing selected aspects of the system. Currently, major changes in Medicare and Medicaid are being debated on the national level. Most states are adopting a wide variety of healthcare reform strategies. The sense of optimism has changed to one of resolute commitment to fight for the inclusion of access and quality, along with cost effectiveness, in the variety of changes that are occurring at the local, state, and national levels. As R.W. Manderscheid has noted, "With or without any health care reform being passed [on the national level], many trains have left the station" (1994). These environmental differences enhance rather than mitigate the importance of the findings contained in this report. The data reflect the importance of APPNs in the provision of mental health care to vulnerable populations and will be helpful in positioning APPNs as key providers in mental healthcare delivery systems.

OVERVIEW OF PROJECT

The theme of the SERPN annual conference in 1993 was "Changing Contexts: Psychiatric Mental Health Nursing in the Next Decade." In keeping with this theme and to set the stage for the involvement of the SERPN membership in the healthcare debate, Ronald Manderscheid, PhD, was invited to be the keynote speaker. His address was titled "Adapting Psychiatric Nursing to Health Care Reform." Dr. Manderscheid had received a draft copy of SERPN's position statement on psychiatric nursing education and, because of the interest of the Center for Mental Health Services (CMHS) in training issues and manpower needs, he expressed interest in developing a data set on psychiatric nurses. It was intended that the new information would be similar to that already available about the other core mental health disciplines (i.e., psychiatry, psychology, and social work).

Following the annual conference, discussions began which led to the development of the survey as well as compilation of anecdotal data about advanced psychiatric nursing practices. The Chair of the SERPN Research Committee, Patricia M. Hurley, PhD, RN, FAAN, contacted Dr. Manderscheid who indicated that technical assistance could be offered by the Substance Abuse and Mental Health Services Administration (SAMSA) to facilitate the development of a survey. With this information, Jeanne A. Clement, EdD, RN, CS, FAAN, SERPN President, Margery Chisholm, EdD, RN, CS, ABPP, SERPN President-Elect, and Dr. Manderscheid met to discuss the focus of the suggested survey and a process for proceeding with the project. The need to involve other psychiatric nursing organizations in this effort became apparent during these discussions.

A primary care approach in a revised healthcare system was a paramount concern from the start of this project. Therefore, it was decided that the survey would address issues related to manpower and training regarding the role of APPNs as primary mental healthcare providers. An Executive Board telephone conference was held in December 1993 regarding the proposed project. The Board voted to support the project and actively participate in the development of the survey instrument. Work proceeded by conference call to draft the initial objectives for the project. Survey questions were developed that were specific to the concerns of psychiatric nursing; in addition, questions from the draft CMHS Human Resource Minimum Data Set were used to facilitate comparison of data from other studies.

Dr. Clement sketched a proposal for a workshop that would involve representatives of the other psychiatric nursing organizations which, along with SERPN, comprised the Coalition of Psychiatric Nursing Organizations (COPNO). Involving COPNO was a means to further focus the survey and to ensure its relevance. The workshop was planned for March 1994. Its objectives were to:

1. use anecdotal data to develop descriptions of both current models of practice and the settings in which they are employed,
2. use anecdotal data to categorize the scope of practice of advanced practice psychiatric nurses in primary care settings,
3. identify the past, current, and future training needs of these nurses to enable them to maintain and enhance practice efficacy, and
4. provide qualitative data from advanced practice psychiatric nurses and the clients and families they serve concerning the outcomes of interventions employed by these nurses.

The Executive Board continued work on the project through telephone conferences. In February 1994, the Board met in Boston to complete the survey, draft the agenda for the upcoming March workshop, and prepare materials for the involvement of the COPNO representatives. During this meeting, fact sheets on healthcare reform regarding the position of psychiatric nursing (see Appendix A) and a diagram depicting the skills of APPNs were developed (see Figure 1). Participants at the workshop were encouraged to use the fact sheets to approach key Congressional representatives working on healthcare reform to inform them about the need for inclusion of APPNs in any healthcare reform models and proposals.

It was decided to ask workshop participants to identify nurse exemplars in order to develop anecdotal data regarding practice. The exemplars would be described in a videotaped interview using the "Advanced Psychiatric Nursing Practice Examples Conversation Guide" developed by Kathleen R. Delaney, DNSc, RN, and Doris Greiner, PhD, RN, CS, (see Appendix B). Dr. Clement invited the leadership of the COPNO organizations to prepare the videotaped interviews prior to the workshop

and to participate in the review of the survey instruments.

In March, the members of the Executive Board of SERPN and designated representatives chosen by each COPNO organization met to review the developed materials and to view videotapes of nurse exemplars. Sarah Stanley, MS, RN, CS, Senior Policy Analyst with the American Nurses Association also participated. Useful dialogue regarding the advanced practice of psychiatric nurses and the importance of the survey ensued. Participants at the workshop formally endorsed the survey process with the SERPN Executive Board assuming the responsibility for the implementation of the project including the mailing, input and analysis of data, and the dissemination of results. The methodology and implementation of the survey continued to be under the direction of Elizabeth I. Merwin, PhD, RN, CNAA, FAAN, in consultation with the Executive Board of SERPN. The members who participated in the original work group and developed the instruments and survey were reconstituted as a task force to facilitate continuation and completion of the survey project.

ADVANCED PRACTICE PSYCHIATRIC NURSING

The National Council of State Boards of Nursing (1993) stated that the advanced practice of nursing "is based on the following:

> (a) knowledge and skills acquired in basic nursing education;
>
> (b) demonstration of minimal competency in basic nursing as evidenced by license as a registered nurse;
>
> (c) graduate degree with a major in nursing or a graduate degree with a concentration in advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psychosocial assessment, appropriate interventions, and management of health care." (p. 2)

This definition of advanced practice includes the practice of all clinical nurse specialists regardless of their specialty areas, as well as nurse practitioners, nurse anesthetists, and nurse-midwives (p. 2). The American Nurses Association (ANA, 1994b) defined the Psychiatric-Mental Health Advanced Practice Registered Nurse (APRN) [referred to in this monograph as an APPN] as a "licensed RN who is educationally prepared at the master's level, at a minimum, and is nationally certified as a clinical specialist in psychiatric and mental health nursing. This preparation is distinguished by a depth of knowledge of theory and practice, supervised clinical practice, and competence in advanced clinical nursing skills" (p. 11).

APPNs possess knowledge and skill regarding the prevention, assessment, and treatment of mental illness. Figure 1 presents a diagram of the major components of the practice of these nurses. These nurses provide preventive care through their case-

management responsibilities for clients suffering from a mental illness; they also provide consumer and family education to promote mental health as well as clinical interventions to reduce suicides, violent behavior, and substance abuse. A large part of the APPN's role consists of conducting thorough assessments of the physiological, psychological, neurological, developmental, psychopharmacological, immunological, family, community, and spiritual aspects of clients in order to determine interventions appropriate to promote mental health. APPNs provide comprehensive treatment services within all types of settings that provide psychotherapy with individuals, groups, and families, as well as psychobiological interventions (ANA, 1994b).

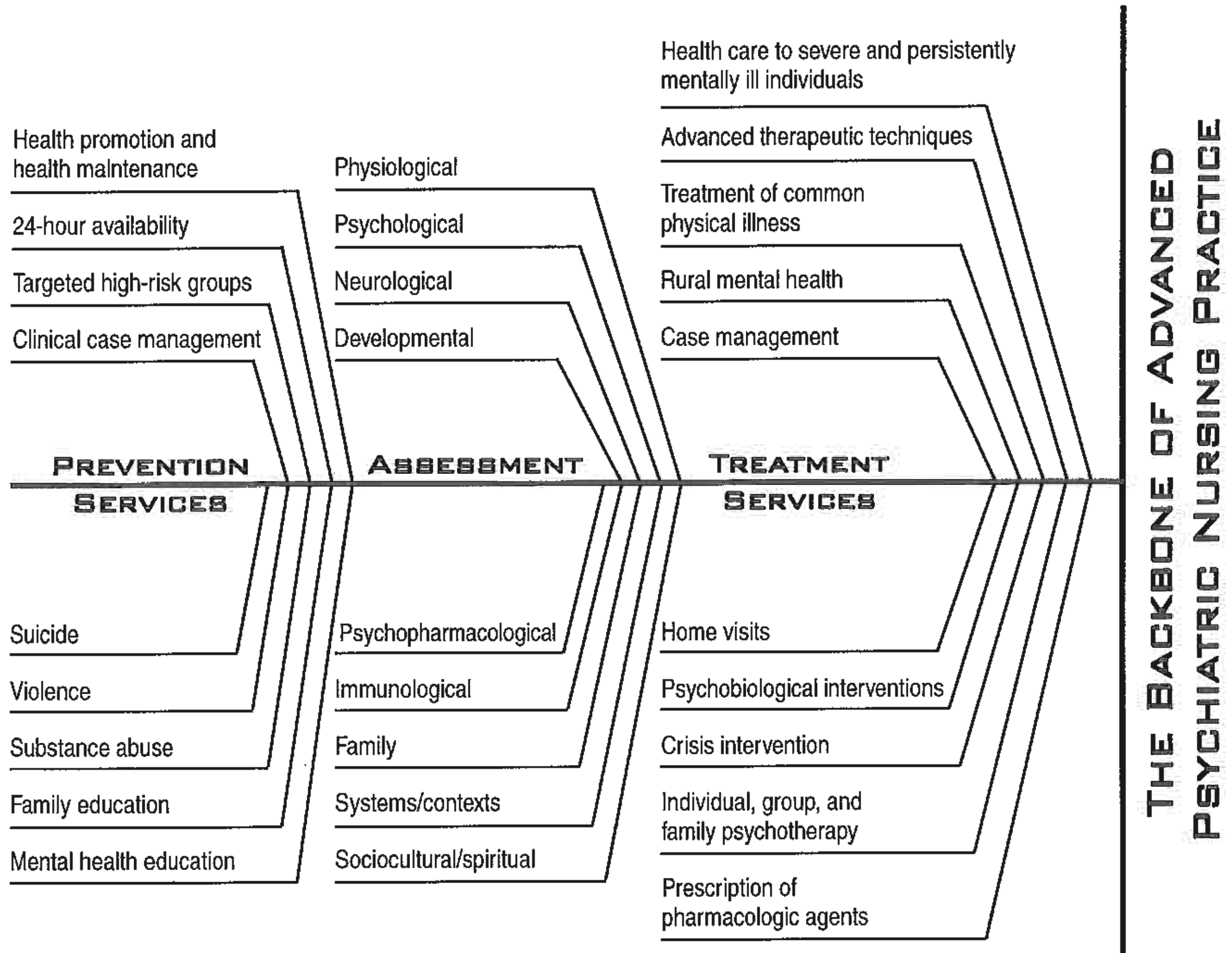


Figure 1

Certified psychiatric clinical nurse specialists are master's prepared APPNs who have passed a national certification examination, and whose post-master's clinical experiences have been evaluated and documented by consultants and supervisors. Specific certification requirements are found in Appendix C. APPN practice is governed by state regulation. A state by state comparison (see Appendix D) reveals there is wide variation in the extent to which states regulate the advanced practice of psychiatric nursing. Some states are silent on the regulation of these nurses; others have licensure, registration and/or certification requirements. Several states provide for independent prescriptive authority for these nurses. Regulation often influences the access to third party reimbursement which in turn affects patients' ability to use APPNs as primary mental health providers.

RESEARCH DESIGN

This study was developed to provide factual information about APPNs and their practices which is important to the reform of the mental healthcare delivery system. Making these practices more visible is crucial to ensuring their inclusion in mental health systems of the future. Specific research questions included:

1. What are the characteristics of APPNs and the clients they serve?
2. What factors affect their provision of services?
3. What factors have an impact on their ability to provide primary mental health care within a reformed delivery system?

A survey was designed based on the draft CMHS Human Resource Minimum Data Set, an adaptation of questions from prior surveys, and original questions. The resultant sixteen page survey tool included fifty questions; both open and closed ended questions were posed. The survey was designed to allow for the use of multiple methods of analysis, and incorporated both quantitative and qualitative approaches. The validity of the survey was established through a review of the questions by content experts representing the COPNO organizations. These experts attended the March 1994 worshop (see Appendix E).

The American Nurses Credentialing Center provided a mailing list of the population of certified adult and child/adolescent psychiatric clinical nurse specialists. A 20% probability sample of the 6,090 psychiatric clinical nurse specialists certified by the American Nurses Credentialing Center as of Spring 1994 was selected as the study sample. A response rate of 55% (N=675) resulted from a mail survey. A complete survey instrument was sent out in the first two mailings. The final mailing was a shortened form which included only the most important questions. The initial mailing took place in the Summer of 1994; the first follow-up took place in Fall of 1994. The final mailing took place in March of 1995. Confidentiality of responses was ensured through the use of a survey identification number instead of a name on the questionnaire. A master mailing list which included the identification number assigned

to each sample member was maintained to facilitate contacting non-respondents. The survey requested respondents to include their telephone numbers if they were willing to be contacted to provide additional information; it would be possible to obtain the names of those who included their telephone number from a master mailing list in order to contact them for follow-up information. For more information about the survey design, see Appendix F.

Section I. Characteristics of APPNs

APPNs are typically white, female, and middle aged. Ninety-five percent (95%) of these nurses are female, with 77% between 40 and 59 years of age. The average age was 47 years with a range of ages from 29–73. Forty-seven percent (47%) of these nurses are between 40 and 49; only 15.6% of these nurses are 39 or under (see Figure 2).

Age Distribution

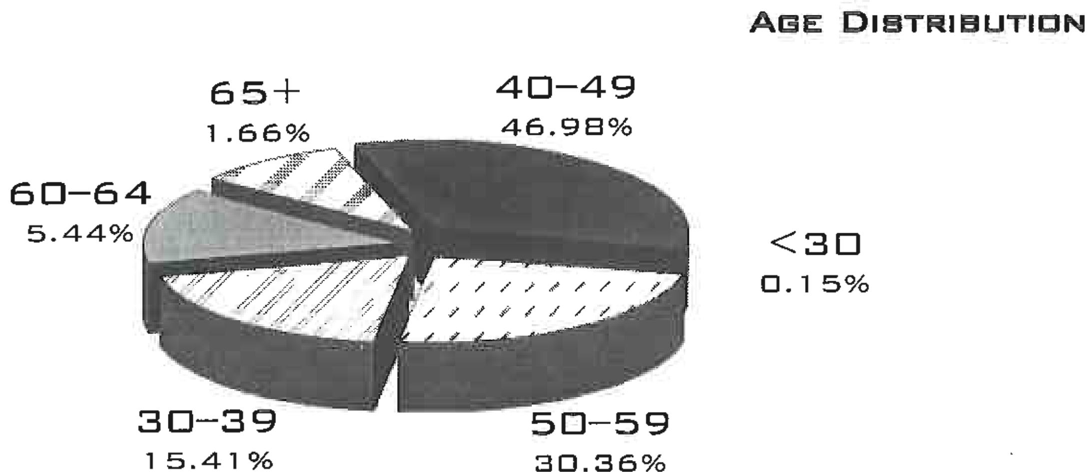


Figure 2

Beginning in the mid 1950s, NIMH funds were available for training in psychiatric nursing. The peak year for funding psychiatric-mental health nursing education was 1969; there has been a steep decline in federal funding for psychiatric nursing education beginning in 1976 (Chamberlain, 1986). The number of full-time graduate students in psychiatric nursing has dramatically declined since the 1970s; likewise the percentage of nursing graduate students specializing in psychiatric nursing has decreased. These trends have resulted in a declining number of psychiatric clinical nurse specialists graduating annually (Merwin & Fox, 1992). The length of time it takes to complete graduate programs on a part-time basis together with certification requirements for post-master's supervised clinical experience most likely account for the dearth of nurses below age 30.

Only 2% of APPNs are African-American; another 1% are Asian; and 1% are of other racial identities. Only 1% report being Hispanic. These demographic characteristics reveal that, despite consistent policy initiatives to diversify the profession and/or workforce, there are few men and few minorities in the population of advanced practice psychiatric nurses. Although this group of nurses is not particularly diverse in composition, between 7 and 10% do possess language skills other than English. These demographic characteristics raise issues related to the aging of the profession, the lack of diversity of its membership, and the implications this lack of diversity has for providing culturally sensitive care that is acceptable to minority populations.

APPNs tend to work full-time. Sixty-eight percent work full-time, defined as 35 or more hours per week. Twenty-three percent (23%) work part-time. Fewer than one percent (1%) are students or trainees. Few of these nurses are retired or are not employed. Only 1.5% are retired, while 3.4% are not employed. Remaining nurses classified their employment status as "other." The average number of hours these nurses work per week is 37.8 with a 11.7 standard deviation. On average, they hold 1.6 positions with a standard deviation of 0.7, indicating that many of these nurses are employed in more than one position.

APPNs have extensive experience in psychiatric nursing with an average of 17.1 total years of practicing psychiatric nursing (SD 7.1) and an average of 11.1 years for the advanced practice of psychiatric nursing (SD 6.6). It is probable that these nurses practiced psychiatric nursing as generalists before enrolling in graduate programs preparing for advanced practice and meeting the criteria for certification as certified specialists. Figure 3 shows additional credentialing reported by certified specialists in psychiatric mental health nursing. A variety of additional certifications were listed by respondents; these designate further role specialization (e.g., nurse practitioner, nurse midwife) and specialty skills such as biofeedback, hypnotherapy, and marriage and family counseling.

TYPES OF CERTIFICATIONS

EDUCATION
Nursing Education
Elementary Education
Staff Development

SPECIALTY PROVIDER
Nurse Practitioner
Nursing Administration
Nurse Midwife
Social Work
Public Health Nursing

CLINICAL AREAS
Genetics
Substance Abuse/Addictions Nursing
Women's Health

SPECIFIC THERAPIES
Hypnotherapist
Family Therapy
Graphoanalysis
Biofeedback
Counseling

Figure 3

Figure 4 shows the states of residence of the population of certified psychiatric clinical nurse specialists. Appendix G contains a table that shows the number of respondents to this survey from each state. The responses appear to accurately reflect the state by state distribution of these nurses. Figure 4 presents a map of the distribution of these specialists. The map shows that APPNs are not evenly distributed throughout the country. The number of specialists in different states range from four states having 10 or fewer specialists to seven states having more than 300 specialists.

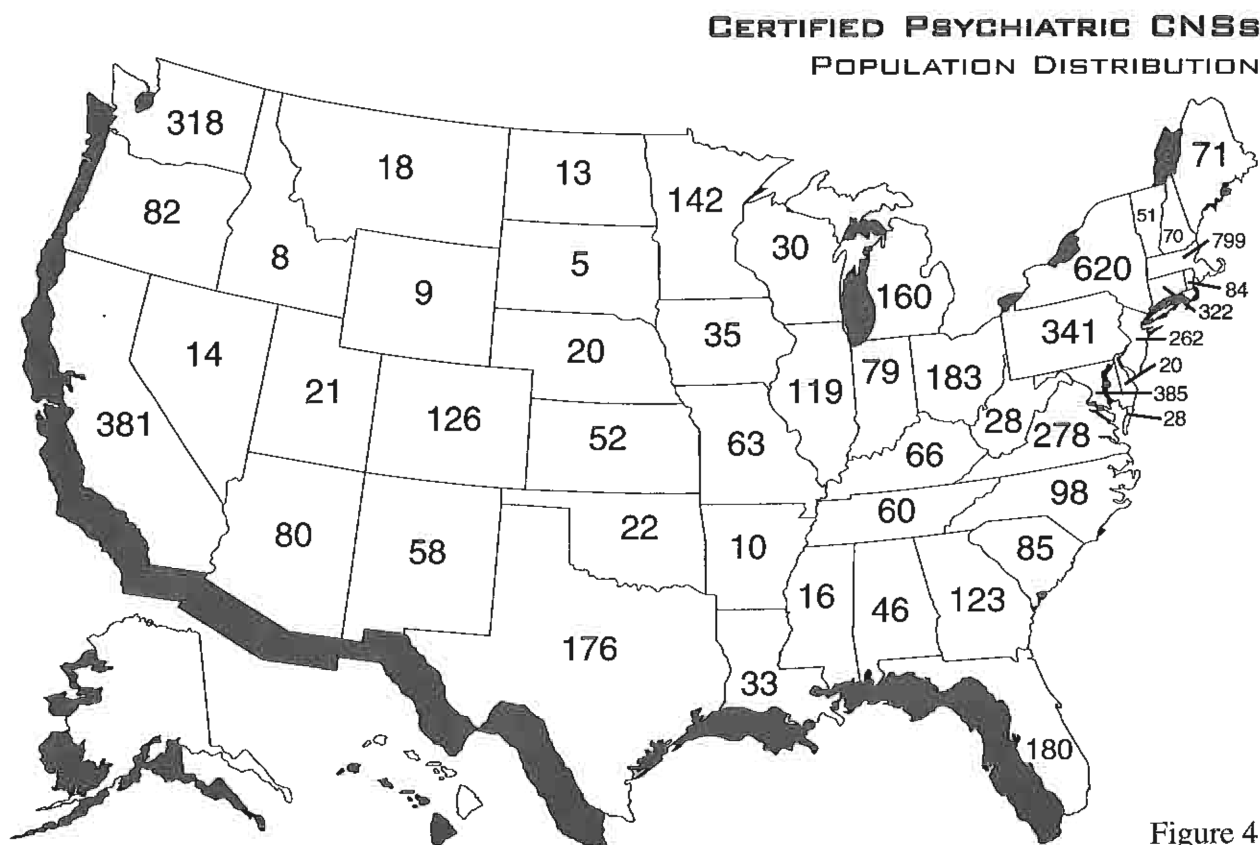


Figure 4

SOURCE: American Nurses Credentialing Center, 1995 Certification Catalog, American Nurses Association, p. 4.

SECTION II. EXPERTISE OF APPNs

Table 1 indicates the fields of highest degrees for certified psychiatric nurses prepared with master's and doctoral degrees. At the master's level the highest number of degrees were in psychiatric nursing (317 [51%]) and in other areas of nursing, (168 [27%]). Of the 87 individuals with earned doctorates, 31% held doctorates in nursing, 22% in education, and 20% in psychology. Twenty-two percent (22%) of employed APPNs plan to obtain additional education. Seventy-eight percent (78%) of those who plan to obtain an additional degree plan to seek a doctorate. Ten percent (10%) plan to obtain an additional master's degree, and 5% plan to seek nurse practitioner preparation. The expected fields of future study are presented in Table 1.

Table 1

FIELD OF HIGHEST DEGREE FOR APPN'S PREPARED AT DOCTORAL AND MASTER'S LEVEL

	Doctorate		Master's		Future Plans	
Education Field	**N**	**%**	**N**	**%**	**N**	**%**
Nursing	27	30.68	164	26.54	35	29.17
Adult health nursing	0	0	1	0.16	0	0
Community health nursing	0	0	1	0.16	1	0.83
Gerontological nursing	1	1.14	1	0.16	0	0
Medical/surgical nursing	0	0	1	0.16	0	0
Psychiatric/mental health nursing	5	5.68	317	51.30	11	9.17
Nursing administration	0	0	3	0.49	3	2.50
Nursing education	2	2.27	2	0.32	1	0.83
Total Nursing	**35**	**39.77**	**490**	**79.29**	**51**	**42.50**
Biological Sciences, General	0	0	1	0.16	0	0
Physiology	0	0	0	0	0	0
Education, General	19	21.59	13	2.10	5	4.17
Psychology	18	20.46	31	5.02	22	18.33
Public Health	1	1.14	9	1.46	1	0.83
Public Health Administration	0	0	2	0.32	1	0.83
Anthropology	3	3.41	0	0	0	0
Business Administration	0	0	3	0.49	0	0
Communications	2	2.27	2	0.32	3	2.50
Law	2	2.27	0	0	2	1.67
Social Work	0	0	10	1.62	2	1.67
Sociology	3	3.41	0	0	0	0
Other	0	0	7	1.13	22	18.33
Counseling	2	2.27	43	6.96	3	2.50
Marriage and Family	0	0	7	1.13	na	
Total Non-nursing	**50**	**56.82**	**128**	**20.71**	**61**	**50.83**
Unknown	3	3.41	0	0	8	6.67
Total	**88**	**100.00**	**618**	**100.00**	**120**	**100.00**

NOTE: There are 87 APPNs with doctorates; one of these APPNs holds two doctorates; the fields of these degrees are missing for three degrees. There are 587 APPNs whose highest degree is a Master's; 42 of these APPNs have two Master's degrees; the fields of these degrees are missing for eleven degrees.

Merely knowing the discipline of APPNs master's and/or doctoral education does not allow one to determine the professional discipline with which the APPN identifies. A prior study (Merwin, Fox, & Bell, 1992) found that psychiatric nursing was not the primary professional discipline for all APPNs. In this survey, respondents were asked to designate their primary professional discipline among choices of psychiatric nursing; other nursing fields; psychology; counselor; marriage and family therapist; psychosocial rehabilitation; social work; and other. Two factors help explain the rationale for inclusion of this question in a survey of nurses who are certified specialists in psychiatric nursing. The first is that the American Nurses Credentialing Center only recently has required that the academic preparation for certification is a master's degree in nursing with specific course work in psychiatric-mental health theory and clinical training; in the past, this requirement was a master's degree in psychiatric nursing *or a comparable field.* Therefore, some currently certified specialists in psychiatric nursing are prepared at the master's level in psychology, counseling, or social work and would designate one of those areas as their primary professional discipline. The second reason is a reimbursement issue in which some providers will reimburse at a higher level for services of a psychologist or social worker than for those of a psychiatric nurse. Sixty respondents reported having doctoral degrees as their highest degree in their chosen primary professional discipline (see Table 2).

Table 2

HIGHEST DEGREE IN PRIMARY PROFESSIONAL DISCIPLINE AND HIGHEST DEGREE OUTSIDE THAT DISCIPLINE

PRIMARY PROFESSIONAL DISCIPLINE (N)[3]	HIGHEST DEGREE IN DISCIPLINE			HIGHEST DEGREE OUTSIDE DISCIPLINE[2]		
	Doctorate N	Master's N	Bachelor N	Doctorate N	Master's N	Bachelor N
Nursing (16)	2	13	1	0	4	1
Psychiatric Nursing (417)[1]	36	368	10	21	44	42
Psychology (10)	6	4	0	0	4	2
Counselor (72)	5	65	2	3	7	12
Marriage & Family Therapist (32)	3	29	0	0	6	4
Psychosocial Rehabilitation (3)	0	3	0	1	0	0
Social Work (5)	0	5	0	0	1	2
Other (118)	8	109	1	1	3	19
TOTAL N	60	596	14	28	78	82

[1] There were two subjects with degrees other than doctorate, master's, or bachelors; an additional three were missing data.

[2] There were 10 subjects with degrees other than doctorate, master's, or bachelors; only 198 individuals report having a degree outside their primary professional discipline.

[3] Missing=1

Of those who consider psychiatric nursing as their primary professional discipline, 36 held doctorates in nursing, while 368 respondents reported having master's degrees in psychiatric nursing. Respondents were asked to designate their highest degree outside of their primary professional discipline. Psychiatric nursing at the doctoral, master's, and baccalaureate levels was identified by 107 of 188 total respondents even though they reported other professional orientations as the discipline of their practice (i.e., they consider their primary discipline to be social work, counseling). The choice of professional discipline may be influenced by reimbursement regulations. For example, if social workers are reimbursed at a higher rate than APPNs then an APPN with education in social work might choose the social worker designation to obtain the higher reimbursement.

SECTION III. COMPARISON OF APPNs PRIMARY AND SECONDARY WORK

CHARACTERISTICS

Sixty-eight percent (68%) of APPNs are employed at least 35 hours per week; 23% are employed, for less than 35 hours per week. Less than one percent (0.7%) are trainees; 1.5% are retired and not employed; and 3.4% are not currently employed. Fifteen percent (15%) are currently seeking additional employment. Forty-nine percent (49%) are on call for direct care. The 230 nurses who reported being on call reported a total average of 482 hours on call for a one month time period. Ninety percent (90%) of the sample report having a primary setting of employment (where they spend the most working time), while 43% of the sample identify a secondary setting of employment (next most working time). Table 3 presents the settings of employment. APPNs work most frequently in hospitals, followed by clinics and other outpatient settings. Fifteen percent (15%) work in academia, and 22% work in either solo or group independent practice. Although there has been a recent trend to provide more care in the home, only 5% provide care in either a home, the community, or a nursing home or other residential setting in their primary position. In contrast, the most frequent secondary setting of practice is that of independent practice. Forty-four percent (44%) report either a solo (32%) or group (12%) independent practice as their secondary setting. Academia is the next most frequent secondary setting (16%).

Self-employment is often cited as a primary and secondary setting of practice. Twenty-four percent (24%) of APPNs report self-employment in their primary setting, with 44% reporting self-employment in their secondary setting. Consistent with information presented in Table 2 which indicated that some APPNs identify with a primary professional discipline other than nursing, 8% of the nurses report working in a non-nursing position in their primary setting, while 14.5% report working in a non-nursing position in their secondary setting.

APPNs provide care in public and private organizations. Their primary setting is more likely than their secondary setting to be a public organization. Their participation in private for-profit settings is accentuated by their self-employment in private practice, which is for-profit by definition.

Table 3

CHARACTERISTICS OF PRIMARY AND SECONDARY WORK SETTING[1]

SETTING	PRIMARY	%	SECONDARY	%
Academic	92	15.2	47	16.2
Hospitals	196	32.3	39	13.4
Other Residential Settings	12	2.0	9	3.1
Clinics and Outpatient	136	22.4	36	12.4
Solo Independent Practice	87	14.3	94	32.4
Group Independent Practice	45	7.4	34	11.7
Home/Community/Nursing Home	16	2.6	10	3.4
Other	23	3.8	21	7.2
SELF-EMPLOYED				
	146	23.8	153	44.2
TYPE POSITION				
Nursing	553	91.9	253	85.5
Non-nursing	49	8.1	43	14.5
OWNERSHIP				
Public	233	37.8	53	17.7
Private — for profit	204	33.1	187	62.3
Private — not for profit	179	29.1	60	20.0

[1] The number of missing values differs for each of the variables reported in this chart; 607 individuals are included for setting, 602 for type of position, and 618 for ownership status for the primary work setting. There are 290 individuals included for setting, 296 for type of position, and 300 for ownership status for secondary setting.

Table 4 shows the types of positions filled by these nurses in their primary and secondary settings. Although some nurses indicated they assumed more than one role in their primary and secondary settings, the numbers in Table 4 are limited to one position. The most frequently held position in both settings is that of clinical nurse specialist. School of Nursing Instructor was the next most frequently identified position. Fourteen percent (14%) fill administrative/management positions in their primary setting. Seven percent (7%) assume nurse practitioner roles in their primary setting, while 10% do so in their secondary setting.

Table 4

COMPARISON OF POSITIONS, REPORTING RELATIONSHIPS, SCHEDULING AND HOURS WORKED IN PRIMARY AND SECONDARY SETTINGS

	PRIMARY		SECONDARY	
POSITION[1]	N	%	N	%
Administrator	29	4.7	2	0.7
Manager	35	5.6	5	1.6
CNS	330	53.1	132	43
Program Director	26	4.2	2	0.7
Staff Nurse	15	2.4	23	7.5
Staff Development	9	1.4	2	0.7
SON Instructor	63	10.1	35	11.4
Consultant	9	1.4	15	4.9
Nurse Practitioner	41	6.6	30	9.8
Researcher	3	0.5	3	1.0
Case Manager/Coordinator	8	1.3	4	1.3
Other	54	8.7	54	17.6
REPORT TO				
Nursing Administrator	116	24.6	27	12.0
Hospital Administrator	23	4.9	5	2.2
Clinical Director	77	16.3	30	13.3
Dean	53	11.3	24	10.7
Self (self-employed)	98	20.8	92	40.9
Physician	26	5.5	19	8.4
Other	78	16.6	28	12.4
TYPE OF FINANCIAL ARRANGEMENT				
Salaried	458	74.0	60	20.1
Contractual Arrangement	23	3.7	70	23.4
Fee-for-service	120	19.4	153	51.2
Other	18	2.9	16	5.4
SCHEDULE				
Days	439	93.8	127	57.0
Evenings	29	6.2	95	42.6
Nights	0	0.0	1	0.4

[1] 57 people listed two positions in their primary setting and 25 people listed 2 positions in their secondary setting. These observations were placed in the first position identified in the list (i.e., if administrator and manager were both checked the observation was classified as administration).

Few hold researcher or case manager positions. APPNs usually report to a nursing administrator or are self-employed, although about half report to a wide variety of supervisors ranging from deans, to physicians, directors, or hospital administrators. Most of these nurses are salaried in their primary setting and receive fee-for-service in their secondary settings. Generally, if the nurses are self-employed in independent practice, they are reimbursed by fee-for-service; employees of agencies are usually salaried or, particularly in secondary settings, may work under a contractual arrangement. The respondents typically work during the day; however, 43% report working evenings in their secondary setting of employment.

Forty-eight percent (48%) of full-time employed APPNs earn between $40,000 and $54,999; six percent (6%) earned over $75,000. Part-time earnings varied greatly (see Table 5). Figure 5 shows that 42% of nurses who are self employed in either primary or secondary settings earn between $25,000 and $49,000; 36% earn between $50,000 and $74,999; eight percent (8%) earned over $75,000.

Table 5

1993 Annual Earnings for Full-time and Part-time Workers

Salary Categories in $	Full-time (35 hours) N=457	76%	Part-time (<35 hours) N=142	24%
<10,000	1	0.2	12	8.6
10,000 – 14,999	1	0.2	8	5.8
15,000 – 19,999	1	0.2	16	11.5
20,000 – 24,999	6	1.3	17	12.2
25,000 – 29,999	7	1.6	18	12.9
30,000 – 34,999	24	5.3	18	12.9
35,000 – 39,999	41	9.1	12	8.6
40,000 – 44,999	85	18.9	14	10.1
45,000 – 49,999	70	15.6	5	3.6
50,000 – 54,999	64	14.2	6	4.3
55,000 – 59,999	44	9.8	4	2.8
60,000 – 64,999	35	7.8	3	2.2
65,000 – 69,999	27	6.0	1	0.7
70,000 – 74,999	18	4.0	3	2.2
75,000+	26	5.8	2	1.4

Figure 5

SELF EMPLOYMENT OF APPNS
SALARY OF SELF-EMPLOYED NURSES IN 1993

$	N	%
<24,999	29	13.7
25,000 – 49,999	88	41.7
50,000 – 74,999	76	36.0
75,000+	18	8.5

Table 6 presents the number of work hours these nurses work in all their positions during a two month time period. A two month time period was used to capture information about positions which require work on an irregular basis. These nurses spend the most time providing direct patient care, followed, in descending order, by providing educational activities, participating in management and administration, providing indirect care, providing clinical supervision of staff and trainees, participating in other activities, and research. It is important to note that most of their time is spent providing direct patient care.

Table 6

WORK HOURS IN PRIMARY, SECONDARY, AND OTHER POSITIONS FOR TWO MONTH TIME PERIOD

	Primary Position N=339		Secondary Position N=127		Other Position N=27		Total Work Hours N=341	
Activities	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Direct Care	110	93	43	40	7	11	126	93
Clinical Supervision of Staff & Trainees	26	45	6	16	2	10	28	45
Consultation Prevention	11	23	2	8	4	13	12	26
Educational Activities	39	71	5	22	6	17	41	73
Management & Administration	41	71	1	5	1	5	41	70
Research	9	32	1	3	3	8	9	32
Indirect Care	36	39	8	12	3	8	39	41
Other	9	23	2	7	9	23	10	24
TOTAL	284	89	70	48	34	23	313	93

NOTE: The hours were based on self-report. The hours should be considered approximations of hours spent on each type of activity. Seventy-seven observations were deleted from this analysis based on inconsistent responses.

Table 7 shows that the most frequent type of clinical responsibility APPNs have for clients is that of primary therapist in both primary and secondary settings. Although case manager is a popular term, only 17% of these nurses classify their patient responsibilities as that of case manager in their primary setting, and only 5% do so in their secondary setting. On average, there were 39 clients in the primary setting case load and 54 in the secondary setting case load.

Table 7

CLINICAL RESPONSIBILITY FOR DIRECT CARE IN PRIMARY AND SECONDARY WORK SETTINGS

CLINICAL RESPONSIBILITY	PRIMARY N=429	%	SECONDARY N=219	%
Case Manager	71	17	11	5
Primary Therapist	280	65	145	68
Therapist	95	22	30	14
Other	120	28	46	22

NOTE: Multiple responses were allowed.

The specific type of direct care given is influenced by regulations. As previously discussed, the role of advanced practice nurses is regulated on a state by state basis which results in different practice opportunities and/or barriers in each state. In this era of expanding nursing roles, only 98 respondents (16.5%) indicated they have prescriptive authority. Prescriptive authority is not sanctioned universally in all states which may account for this finding. A smaller number, 50 or 8.5% of respondents, reported having hospital admitting privileges. Table 8 shows the different levels of involvement of APPNs in diverse direct care activities. Individual psychotherapy is the most frequent service, followed by psychiatric assessment.

Table 8

LEVEL OF INVOLVEMENT IN DIFFERENT TYPES OF DIRECT AND INDIRECT CARE ACTIVITIES IN TWO MONTH TIME PERIOD

TYPE OF ACTIVITY	# HOURS SPENT ON ACTIVITY	TYPE OF ACTIVITY	# HOURS SPENT ON ACTIVITY
Psychotherapy:		Psychobiological Interventions (including medication related)	13
Individual	58		
Couple	8	Case Management	9
Family	6	Prevention/Mental Health Education	8
Group	11	Clinical Supervision	7
Type unknown	1	Consultation	7
Total	84	Other	4
Psychiatric Assessment	21		

NOTE: The question from which this information was obtained was confusing to respondents. 77 observations were deleted from the analysis based on inconsistent responses.

Table 9 shows the characteristics of clients receiving direct care by APPNs. Most APPNs treat both females and males; over ninety percent (90%) treat adults. In their primary work settings, the majority of clinical specialists provide care to Caucasian clients; however, a significant percentage care for African-American clients (69%) and Hispanic clients (51%).

Table 9

CHARACTERISTICS OF CLIENTS RECEIVING DIRECT CARE FROM APPNS IN PRIMARY AND SECONDARY WORK SETTINGS

	PRIMARY		SECONDARY	
GENDER	N	%	N	%
Females	344	98.9	161	98.2
Males	338	97.1	143	86.7
Age groups treated:				
Children	97	23.2	30	13.6
Adolescents	165	39.5	72	32.7
Adults	377	90.2	203	92.3
Older adults	227	54.3	83	37.7
Care provided to:				
Individuals	327	94.0	150	88.8
Couples	178	51.1	61	36.1
Groups	156	44.8	38	22.5
Family	200	57.5	67	39.6
Community Systems	63	18.1	15	8.9
Care for ethnic/racial groups:				
African-Americans	289	69.3	103	49.0
American Indian or Alaskan Native	64	15.3	15	7.2
Asian/Pacific Islanders	131	31.4	34	16.3
Hispanic	213	51.1	71	34.0
White	406	97.4	206	98.6
Other	28	6.7	5	2.4

NOTE: Percentages are based on the number of respondents to each set of questions.

Table 10 indicates the percent of time APPNs provide services to clients of specific socioeconomic groups. Although the single largest group served is the middle class, lower socioeconomic groups also receive a large percentage of APPN's time.

Table 10

Percent of APPNs' Time Spent Caring for Clients of Differing Economic Status

Economic Status of Clients	Primary Setting Mean	Primary Setting SD	Secondary Setting Mean	Secondary Setting SD
Eligible for public assistance	33.8	35.6	16.7	28.9
Lower income	21.1	20.9	19.3	23.5
Middle class	39.0	33.7	56.7	35.2
Upper class	5.6	10.4	5.6	12.4

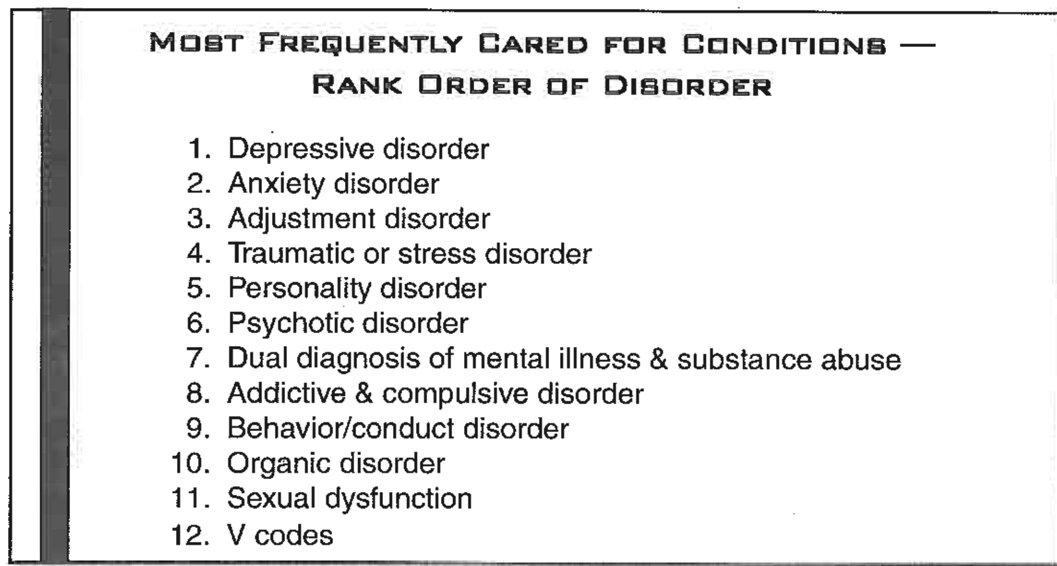
APPNs care for persons with a range of mental disorders. Table 11 reveals the percentage of nurses who treat clients with each type of diagnostic category.

Table 11

Treated Clients With the Following Diagnostic Characteristics in a Two Month Time Period

	N	%
Adjustment disorders	301	77
Affective disorders	372	95
Anxiety disorders	343	88
Disruptive disorders	146	37
Dually-diagnosed MH & SA	276	71
Dually-diagnosed MH/MR	112	29
Dually-diagnosed MR/SA	33	8
Eating disorder	198	51
Functional elimination disorders	46	12
Mental retardation & developmental disorders	68	17
Organic brain disorders & syndromes	153	39
Personality disorders	305	78
Schizophrenia & other major psychoses	216	55
Substance abuse	197	50
V code diagnoses	120	31
Other problems	86	22

Figure 6 provides details on clients' diagnostic characteristics. Clients suffering from affective and anxiety disorders are the most prevalent in APPN's case loads. When these nurses rank order the conditions of clients they treat, depression and anxiety disorder again emerge as the two most frequently treated conditions. The low frequency of APPNs treating adults with schizophrenia and other major psychoses is striking. This is a group of clients with a great need for services (Plum, 1987) and one which should be a priority for psychiatric nurses.



MOST FREQUENTLY CARED FOR CONDITIONS — RANK ORDER OF DISORDER

1. Depressive disorder
2. Anxiety disorder
3. Adjustment disorder
4. Traumatic or stress disorder
5. Personality disorder
6. Psychotic disorder
7. Dual diagnosis of mental illness & substance abuse
8. Addictive & compulsive disorder
9. Behavior/conduct disorder
10. Organic disorder
11. Sexual dysfunction
12. V codes

Figure 6

Section IV. Training Needs of APPNs

In addition to the high percentage of nurses who plan to seek additional degrees, APPNs are very interested in gaining additional non-degree education (see Figure 7).

Areas in Which APPNs Desire Additional Training — Rank Order of Items

Rank	N	%	Topic
1	310	58	Psychopharmacology
2	196	37	Population specific psychotherapy
3	193	36	Computer science
4	178	33	Population specific psychopharmacology
5	172	32	Assessment of neurobiological aspects of mental illness
6	164	31	Psychotherapeutic models
7	154	29	Neuro-physiology of mental illness
8	133	25	Neurological assessment
9	111	21	Management skills
10	103	19	Advanced physical assessment
11	90	17	Public policy knowledge
12	90	17	Other
13	89	17	Marketing
14	86	16	Basic physical assessment
15	70	13	Basic generic pharmacology
16	53	10	Public relations — media training
17	35	7	Advocacy training

Figure 7

Note: Percentages are based on 534 respondents.

Psychopharmacology is content they want. This desire is understandable given the national trend toward prescriptive authority for advanced practice nurses. Their second most salient interest is in population-specific psychotherapy which is understandable given the fact that psychotherapy is their most frequent direct care activity. Their interests also reflect the need for more information about the biological basis of mental illness, and more knowledge about administrative theory in light of the many roles they fulfill within the mental health care delivery system.

CONCLUSION

CONCLUSION

A multiplicity of separate but related factors provided both the context and the rationale for the study of advanced practice psychiatric nurses reported in this monograph. Not the least of these factors was a need to establish APPNs as part of the building material for a loom upon which the fabric of future mental health services can be woven. One step toward achieving that goal was the identification and description of the current practices of APPNs — to assemble a picture of "what is." A second step was to use methods to collect that information that would permit comparison with other disciplines in the field. This APPN survey contained questions that paralleled CMHS's draft core Human Resource Data Elements which will allow comparison of results with data about other mental health disciplines.

The results of this survey will aid in the development of a minimum data set. This set of items of information with common definitions will meet the essential needs of a variety of health data uses concerning advanced practice psychiatric nursing and will permit the comparison of APPNs with other providers. These data not only provide information about the presence and credibility of APPNs in a variety of primary care settings, they are a source of information that will help us to establish and define the breadth and depth of the current practice models. Additionally, and of great importance, the survey was developed by APPNs, asking questions defined as important by the discipline.

The data suggest areas of strength of APPNs. For example, these nurses are predominately engaged in direct care in multiple contexts with varying patient populations. The data additionally suggest that issues of education, reimbursement practices, and legislative constraints need to be addressed by the specialty. Taken together, the strengths of the currently certified APPNs as a provider group and the issues to be addressed for the advancement of the specialty role provide direction for the development of an action plan for the specialty in the current healthcare environment.

Components of the current healthcare environment include the burgeoning of managed care with an emphasis on cost-containment; access to and quality of service; consumer satisfaction; and primary care. In another sector of the environment, some consumers and family members expressed beliefs that current community approaches encourage dependency on the service system. These stakeholders are advocating for a vision of recovery (Ohio Department of Mental Health, 1995). The current definition of recovery grows out of the consumer self-help movement, and has a complex and future-oriented focus that involves risk taking. For mental health consumers to experience recovery, they must move from receiving prescriptive interventions to taking action, from faith to hope, from following routines to promoting change, from being protected to personal freedom, and from dependency to self reliance (Plum, 1987). This focus is congruent with the goals of managed care and, in the

mental health arena influenced by the recovery movement, has also prompted a rethinking about the healthcare workforce.

Rethinking the role and viability of healthcare providers has been stimulated by the Report of the Pew Health Professions Commission Task Force. Some of the principles inherent in the report of the Task Force of the Pew Health Professions Commission are congruent with the forces of reform generated by managed care and the recovery movement, and indirectly support the need for data about APPNs. The [Pew Professions Commission Task Force] envisions a system for health professions that is standardized, accountable, flexible, effective, and efficient. In keeping with the goals of managed care, the Task Force called for a revamping of the regulations governing the professions that will encourage "a flexible, rational, and cost-effective health system which allows effective working relationships among health care providers" and respects the "consumers' rights to choose their health care providers from a range of safe options." The report goes on to note that, "The public's perceptions of professionalism and its need for information about practitioners. . . call for improved accountability through increased public. . .disclosure of practitioner information so that consumers can make informed choices about their care." The report speaks to "The need for accessible health care [which] calls for flexible scopes of practice which recognize the demonstrated competence of different practitioners to provide the same health services" (Report of the Pew Health Professions Commission Task Force, 1995).

This survey of certified APPNs provides basic data which can serve to inform the public, managed care entities, other professionals, and the discipline about the current state of the specialty. This information becomes part of the crucial building material for the "loom." The findings help support decisions concerning what needs to occur to further position APPNs to be proactive players in the current healthcare environment. For example, these data will enable us to take "what is" and develop research questions that will enable APPNs to demonstrate the efficiency of their practices. Are the practice models we have adequate? What are the outcomes realized with the various models? What do we need to do to modify, shape, and adapt these models to meet the changing needs of people with mental illness, their family members, other providers of mental health care, and the persons who pay for that care?

Through collaborative efforts with consumers, policy makers, other professionals, and emerging healthcare entities, APPNs can be principle players in the re-engineering of services for recovery. They can continue to demonstrate and expand their competence as practitioners providing flexible, integrated primary mental health care. We have a lot of work ahead to meet these challenges and opportunities!

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Appendix A

Advanced Practice Psychiatric Nursing

Advanced Practice Psychiatric Nurses provide cost-effective, quality care to patients and their families. Please support their practice by:

- Supporting comprehensive mental health benefits parity with other health care
- Promoting access by ensuring consumer choice of providers to include Advanced Practice Psychiatric Nurses
- Eliminating unnecessary regulatory barriers to effective practice

  Support prescriptive privileges for Advanced Practice Nurses

  Facilitate independent admission privileges

  Support parity for nurses in third party reimbursement
- Including nurses on all task forces and decision-making bodies with citizen participation

Developed by the Society for Education & Research in Psychiatric-Mental Health Nursing (SERPN) Board of Directors, 1994.

HEALTHCARE REFORM

Advanced Practice Psychiatric Nurses Support:

- The inclusion of mental health and substance abuse benefits in healthcare reform at parity with all other illnesses.
- The creation of a system of care that ensures universal access, guaranteed coverage, and high quality services at an affordable cost.
- The use of multiple types of qualified care providers to provide needed services.
- The delivery of those services in a multiplicity of settings where people in need of primary and preventive care, acute, and long-term care services are most likely to be found.
- An emphasis on prevention, particularly with groups at high risk for the development of mental illness: children in inner cities and rural areas, persons who are homeless, ethnic minorities, and the elderly, to name a few.
- Emphasis on multi-disciplinary teams, case management, and managed care.
- Federally funded educational programs to support the development of advanced practice psychiatric nurses who can provide primary care and other treatment services.

Developed by the Society for Education & Research in Psychiatric-Mental Health Nursing (SERPN) Board of Directors, 1994.

THE ANSWER IS YES!

Do patients and their families benefit significantly from services provided by advanced practice psychiatric nurses in primary care?	YES!
Are services of advanced practice psychiatric nurses available 24 hours a day, seven days a week?	YES!
Do advanced practice psychiatric nurses provide treatment to children, adolescents, adults and older persons, and their families?	YES!
Do advanced practice psychiatric nurses provide services in home and community settings?	YES!
Do advanced practice psychiatric nurses admit patients to hospitals for acute care?	YES!
Do advanced practice psychiatric nurses prescribe medications?	YES!
Do advanced practice psychiatric nurses assess physical conditions in addition to psychiatric disorders?	YES!
Are underserved populations served by advanced practice psychiatric nurses?	YES!
Are advanced practice psychiatric nurses services cost effective?	YES!
Is third party reimbursement used for services provided by an advanced practice psychiatric nurse?	YES!

Developed by the Society for Education & Research in Psychiatric-Mental Health Nursing (SERPN) Board of Directors, 1994.

Appendix B

ADVANCED PSYCHIATRIC NURSING PRACTICE EXAMPLES CONVERSATION GUIDE

The purpose of this information is to educate the public and legislators. Many citizens have not had the occasion to receive care from a well-qualified psychiatric nurse and consequently don't have a clear idea of what we might be talking about when we talk about Advanced Practice Nursing. Also, many citizens have not had occasion to think about nurses as independent or autonomous professionals.

In a conversation with an Advanced Practice Nurse (CNS/psychiatric nurse practitioner), *discuss examples* of his/her practice that illustrate:

- Independence of practice
- Complexity of psychiatric problems/diagnosis
- How the practice is similar to/different from that of other mental health providers
- Details of specific interventions (in lay language)
- Outcome criteria used to evaluate the effectiveness of the practice
- Funding sources
- Current constraints to practice
- Additional training master's prepared psychiatric nurses need to function in the manner described

PLEASE ASK EACH PERSON INTERVIEWED IF HE/SHE WOULD BE WILLING TO BE RECONTACTED FOR MORE INFORMATION AND IF HE/SHE WOULD BE WILLING TO GIVE TESTIMONY BEFORE CONGRESS.

BE CREATIVE/PERSUASIVE/FORCEFUL IN COMMUNICATING THE QUALITY AND COMPETENCE OF THIS PRACTICE.

Appendix C

1994 Survey of Certified Psychiatric Clinical Nurse Specialists

Credentialing for Certified Specialists in Psychiatric Mental Health Nursing

Following are the certification requirements for Clinical Specialists in Adult Psychiatric Mental Health Nursing and Clinical Specialists in Child and Adolescent Psychiatric and Mental Health Nursing as published on pages 19 and 20 in the *1995 Certification Catalog* by the American Nurses Credentialing Center (ANCC). Catalogs are published annually by the American Nurses Credentialing Center and are subject to revision. Eligibility criteria are updated annually to reflect the current scope and standards of practice within the specialty.

Description of Practice

Clinical specialists in psychiatric and mental health nursing must possess a high degree of proficiency in therapeutic and interpersonal skills. These specialists not only influence and modify attitudes and behaviors of the patient, but also assume responsibility for the advancement of nursing theory and therapy. In addition to therapy, their role includes teaching, research, consultation, supervision, case management, and administration.

Eligibility Requirements

By the time of application, you must:

1. Currently hold an active RN license in the United States or its territories;

   and

2. Be currently involved in direct patient contact in psychiatric and mental health nursing an average of 4 hours per week. Administrators, educators, researchers, and consultants can meet this requirement if they are involved in direct patient contact;

   and

3. Be currently involved in clinical consultation or clinical supervision;

   and

4. Have experience in at least 2 different treatment modalities;

   and

5. Hold a master's or higher degree in psychiatric or mental health nursing.*

   *If you do not meet requirement #5, your application will be reviewed if your educational preparation meets the following criteria:

   a. A master's or higher degree in nursing outside the psychiatric and mental health nursing field with a minimum of 24 graduate or postgraduate level academic credits in courses which have a significant focus in psychiatric and mental health theory and supervised clinical training in 2 psychotherapeutic treatments

and

6. Have at least 800 hours of directed patient/client contact in advanced clinical practice of psychiatric and mental health nursing; up to 400 of these hours may be earned through the clinical practicum in a master's program of study; at least 400 of these hours must be earned following completion of the educational preparation listed in #5 or 5a above;

and

7. Document 100 hours of individual or group clinical consultation/supervision and submit endorsement(s) from the consultant/supervisor(s). Form A must be submitted for all supervision including practicum supervision and post education supervision. At least 50% of these hours must be earned following completion of the educational preparation listed in #5 or 5a above. These hours may be earned in the following manner:
   a. Up to 50% of the 100 hours may be earned within the master's degree program.*
   b. A minimum of 65% (up to 100%) of the consultation/supervision must be provided by a nurse who is ANCC certified or eligible for ANCC certification as a clinical specialist in psychiatric and mental health nursing.*
   c. Up to 35% of the consultation/supervision may be provided by a non-nurse who meets one of the criteria listed below. (For those nurses who expect to hold prescriptive privileges, these hours might be applied toward supervision of the prescription of medications.) The non-nurse(s) may be:
      - A master's prepared licensed/certified mental health social worker
      - A psychiatrist
      - A psychologist prepared at the doctoral level and listed in the National Register of Health Service Providers in Psychology
      - A psychologist prepared at the doctoral level in an APA accredited program in one of the following clinical areas: clinical psychology, counseling psychology, or school psychology.

* If the nurse consultant/supervisor is not ANCC certified as a clinical specialist in psychiatric and mental health nursing, documentation must be provided that he/she meets all ANCC eligibility requirements in education, practice, and supervision as outlined in the catalog.

PLEASE NOTE: Persons interested in certification should call (800) 284–CERT for specific and current catalog information. A new catalog is available at the beginning of each calendar year. The data included in this Appendix were reviewed and approved by Carolyn Lewis, PhD, RN, Senior Administrator, American Nurses Credentialing Center, September 1995.

APPENDIX D

Information obtained from the National Council of State Boards of Nursing, Inc. (1994). *National Council's profiles of member boards.* Chicago: Author.

Table 1

INDIVIDUAL BOARDS OF NURSING BY ABBREVIATION

ABBREVIATION	BOARD NAME
AK	Alaska Board of Nursing
AL	Alabama Board of Nursing
AR	Arkansas State Board of Nursing
AS	American Samoa Health Service Regulatory Board
AZ	Arizona State Board of Nursing
CARN	California Board of Registered Nursing
CAVN	California Board of Vocational Nurse and Psychiatric Technician Examiners
CO	Colorado Board of Nursing
CT	Connecticut Board of Examiners for Nursing
DC	District of Columbia Board of Nursing
DE	Delaware Board of Nursing
FL	Florida Board of Nursing
GAPN	Georgia State Board of Licensed Practical Nursing
GARN	Georgia Board of Nursing
GU	Guam Board of Nurse Examiners
HI	Hawaii Board of Nursing
IA	Iowa Board of Nursing
ID	Idaho Board of Nursing
IL	Illinois Department of Professional Regulation
IN	Indiana State Board of Nursing
KS	Kansas Board of Nursing
KY	Kentucky Board of Nursing
LAPN	Louisiana State Board of Practical Nurse Examiners
LARN	Louisiana State Board of Nursing
MA	Massachusetts Board of Registration in Nursing
MD	Maryland Board of Nursing
ME	Maine State Board of Nursing
MI	Michigan Board of Nursing
MN	Minnesota Board of Nursing
MO	Missouri State Board of Nursing
MP	Northern Marianna Islands Commonwealth Board of Nurse Examiners

ABBREVIATION	BOARD NAME
MS	Mississippi Board of Nursing
MT	Montana State Board of Nursing
NC	North Carolina Board of Nursing
ND	North Dakota Board of Nursing
NE	Nebraska Bureau of Examining Boards
NH	New Hampshire Board of Nursing
NJ	New Jersey Board of Nursing
NM	New Mexico Board of Nursing
NV	Nevada State Board of Nursing
NY	New York State Board for Nursing
OH	Ohio Board of Nursing
OK	Oklahoma Board of Nursing
OR	Oregon State Board of Nursing
PA	Pennsylvania Board of Nursing
PR	Commonwealth of Puerto Rico Board of Nurse Examiners
RI	Rhode Island Board of Nurse Registration and Nursing Education
SC	South Carolina State Board of Nursing
SD	South Dakota Board of Nursing
TN	Tennessee State Board of Nursing
TXRN	Texas Board of Nurse Examiners
TXVN	Texas Board of Vocational Nurse Examiners
UT	Utah State Board of Nursing
VA	Virginia State Board of Nursing
VI	Virgin Islands Board of Nurse Licensure
VT	Vermont State Board of Nursing
WAPN	Washington State Board of Practical Nursing
WARN	Washington State Board of Nursing
WI	Wisconsin Bureau of Health Professions
WVPN	West Virginia State Board of Examiners for Practical Nurses
WVRN	West Virginia Board of Examiners for Registered Professional Nurses
WY	Wyoming State Board of Nursing

Table 2

DEFINITIONS OF ADVANCED PRACTICE NURSING

A. The advanced practice of nursing by nurse practitioners, nurse anesthetists, nurse-midwives, and clinical nurse specialists is based on the following:

(a) knowledge and skills acquired in basic nursing education;

(b) demonstration of minimal competency in basic nursing as evidenced by licensure as a registered nurse;

(c) graduate degree with a major in nursing or a graduate degree with a concentration in an advanced nursing practice category, which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psychosocial assessment, appropriate interventions, and management of health care (National Council of State Boards of Nursing, Inc., 1983, p.2)[a]

B. The Psychiatric-Mental Health Advanced Practice Registered Nurse (APRN) is a licensed RN who is educationally prepared at the master's level, at a minimum, and is nationally certified as a clinical specialist in psychiatric and mental health nursing. This preparation is distinguished by a depth of knowledge of theory and practice, supervised clinical practice, and competence in advanced clinical nursing skills (American Nurses Association, 1994, p. 11).[b]

[a]National Council of State Boards of Nursing, Inc. (1993). *Position paper on the regulation of advanced nursing practice*. Chicago: Author.

[b]American Nurses Association. (1994). *A statement on psychiatric-mental health clinical nursing practice and standards of psychiatric-mental health clinical nursing practice*. Washington, DC: Author.

Table 3

TYPES OF ADVANCED PRACTICE REGULATED BY MEMBER BOARDS

BOARD	BOARD	CRNA	CNM	CNS	CNS	NP	NP	NP	NP	NP	NP
	regulates			psych/mental health	no designation	neonatal	family	family planning	geriatric	emergency	school health
AK	Yes	X	X			X	X	X	X		X
AL	Yes	X	X								
AR	Yes	X	X								
AS	*	*	*	*	*	*	*	*	*	*	*
AZ	Yes	X	X			X	X				X
CARN	Yes	X	X	X							
CO	No										
CT	Yes	X	X		X						
DC	Yes	X	X								
DE	Yes	X		X		X	X	X	X	X	X
FL	Yes	X	X	X			X	X	X	X	
GARN	Yes	X	X	X							
GU	Yes	X	X								
HI	No										
IA	Yes	X	X		X	X	X		X		X
ID	Yes	X	X								
IL	No										
IN	Yes	X	X		X						
KS	Yes	X	X								
KY	Yes	X	X	X	X						
LARN	Yes	X	X		X						
MA	Yes	X	X	X							
MD	Yes	X	X	X		X	X	X	X	X	X
ME	Yes	X	X								
MI	Yes	X	X								
MN	Yes		X								
MO	Yes	X	X		X						
MP	Yes		X								
MS	Yes	X	X			X	X	X	X		X
MT	Yes	X	X		X						
NC	Yes	X	X			X	X	X	X	X	X
ND	Yes	X	X	X	X	X	X	X	X	X	X
NE	Yes	X	X								
NH	Yes	X	X	X		X	X		X	X	X
NJ	No										
NM	Yes	X			X						
NV	Yes	X			X						
NY	Yes		X								
OH	Yes	X	X								
OK	Yes	X	X		X						
OR	Yes		X				X		X		
PA	Yes					X	X				X
PR	Yes	X	X	X	X						
RI	Yes	X		X							
SC	Yes	X	X	X	X	X	X	X	X	X	X
SD	Yes	X	X								
TN	No										
TXRN	Yes	X	X			X	X		X		X
UT	Yes	X	X	X	X						
VA	Yes	X	X	X	X	X	X	X	X	X	X
VI	Yes	X	X	X	X						
VT	Yes	X	X	X		X	X	X	X	X	X
WARN	Yes	X	X	X		X	X		X		X
WI	Yes		X								
WVRN	Yes	X	X	X		X	X		X		X
WY	Yes	X	X	X	X	X	X	X	X	X	X

*no information available

BOARD	NP college	NP ob/gyn women's health	NP psych/mental health	NP adult health	NP child health	NP no designation	NP other by specialty
AK		X	X	X	X		
AL						X	
AR						X	
AZ		X		X	X		
CARN						X	
CT						X	
DC						X	
DE	X	X	X	X	X		
FL		X	X		X		Adult Primary Care Practitioner
GARN						X	
GU						X	
IA		X	X	X	X		
ID						X	
IN						X	
KS						X	
KY							All NP with any specialty designation evidenced by education & national certification in field are regulated/recognized.
LARN						X	
MA						X	
MD	X	X	X	X	X	X	
ME						X	
MI						X	
MN						X	
MO							Certified NP (Ob-Gyn, Neonatal, Family, Adult, Gerontological, Pediatric)
MP							
MS		X		X	X		
MT						X	
NC		X		X	X	X	
ND	X	X	X	X	X	X	
NE						X	
NH		X	X	X	X		
NM						X	
NV						X	
NY						X	
OH							
OK						X	
OR	X	X	X	X	X		
PA		X		X	X		
PR							
RI						X	
SC	X	X	X	X	X	X	
SD						X	Specialty area is defined by the practice agreement
TXRN		X		X	X		All by specialty designated in their Master's program
UT						X	
VA		X		X	X		
VI						X	
VT	X	X	X	X	X		Certification by national organization is current & meets RN licensure
WARN		X		X	X		
WI							
WVRM		X		X	X		
WY	X	X	X	X	X	X	

Table 4

Advanced Psychiatric/Mental Health Nursing Practice: CNS and NP by Member Board

Member Board	CNS	NP
AK		X
CARN	X	
DE	X	X
FL	X	X
GARN	X	
IA		X
KY	X	
MA	X	
MD	X	X
ND	X	X
NH	X	X
OR		X
PR	X	
RI	X	
SC	X	X
UT	X	
VA	X	
VI	X	X
VT	X	
WARN	X	
WVRN	X	
WY	X	X

Table 5

ADVANCED PRACTICE REGULATORY OVERSIGHT RESPONSIBILITY BY MEMBER BOARD

BOARD	CRNA	CNM	CNS	NP
AK	Bd. of Nursing	a	a	Bd. of Nursing
AL	a	Jointly – Bd. of Nursing & Bd. of Med. Examiners	DNA	a
AR	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
AZ	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
CARN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing Insurance code	Bd. of Nursing
CT	Bd. of Nursing	Dept. of Health & Addiction Services	Bd. of Nursing	Bd. of Nursing
DC	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
DE	Bd. of Nursing	Bd. of Health	Bd. of Nursing	Bd. of Nursing
FL	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
GARN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
GU	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
IA	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
ID	Bd. of Nursing	a	DNA	DNA
IN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
KS	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
KY	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
LARN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
MA	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
MD	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
ME	Bd. of Nursing	Bd. of Nursing Bd. of Medicine	Bd. of Nursing	Bd. of Nursing Bd. of Medicine
MI	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
MN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
MO	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
MP		Bd. of Nursing	DNA	DNA
MS	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
MT	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing

BOARD	CRNA	CHM	CNS	NP
NC	Bd. of Nursing	Midwifery Joint Committee	DNA	Bd. of Nursing
ND	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
NE	Bd. of Nursing Bd. of Medicine	Bd. of Nursing Bd. of Medicine	DNA	Bd. of Nursing
NH	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
NM	Bd. of Nursing	Dept. of Health	Bd. of Nursing	Bd. of Nursing
NV	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing Bd. of Medicine
NY	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
OH	DNA	Bd. of Nursing	DNA	DNA
OK	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
OR	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
PA	DNA	DNA	DNA	Bd. of Nursing Bd. of Medicine
PR	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	DNA
RI	Bd. of Nursing	Div. of Professional Regulation	Bd. of Nursing	Bd. of Nursing
SC	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
SD	Bd. of Nursing	Bd. of Nursing Bd. of Medicine	DNA	Bd. of Nursing Bd. of Medicine
TXRN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
UT	Bd. of Nursing	Certified Nurse Midwife Licensing Board	Bd. of Nursing	Bd. of Nursing
VA	Bd. of Nursing Bd. of Medicine	Bd. of Nursing Bd. of Medicine	Bd. of Nursing	Bd. of Nursing Bd. of Medicine
VI	Bd. of Nursing	Bd. of Nursing	DNA	Bd. of Nursing
WARN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
WI	DNA	Bd. of Nursing	DNA	DNA
WVRN	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing	Bd. of Nursing
WY	Bd. of Nursing Bd. of Pharmacy	Bd. of Nursing Bd. of Pharmacy	Bd. of Nursing Bd. of Pharmacy	Bd. of Nursing Bd. of Pharmacy

[a]No information available

Table 6

ADVANCED PRACTICE NATIONAL CERTIFICATION REQUIREMENTS BY MEMBER BOARD

BOARD	CRNA	CNM	CNS	NP
AK	Yes	DNA	DNA	Yes
AL	Yes	Yes	DNA	Yes
AR	Yes	Yes	DNA	No
AZ	No	Yes	a	No
CARN	Yes	No	No	No
CT	Yes	Yes	Yes	Yes
DC	Yes	Yes	DNA	Yes
DE	Yes	Yes	Yes	Yes
FL	Yes	Yes	DNA	No
GARN	Yes	Yes	No	Yes
GU	Yes	Yes	DNA	Yes
IA	Yes	Yes	Yes	Yes
ID	Yes	Yes	DNA	Yes
IN	Yes	Yes	a	a
KS	Yes	No	No	No
KY	Yes	Yes	Yes	Yes
LARN	Yes	Yes	No	No
MA	Yes	Yes	Yes	Yes
MD	Yes	Yes	DNA	Yes
ME	Yes	Yes	Yes	Yes
MI	Yes	Yes	DNA	Yes
MN	a	a	a	a
MO	Yes	Yes	Yes	Yes
MP	DNA	Yes	DNA	DNA
MS	Yes	Yes	DNA	Yes
MT	Yes	Yes	Yes	Yes
NC	Yes	Yes	DNA	No
ND	Yes	Yes	Yes	Yes
NE	Yes	Yes	DNA	Yes
NH	Yes	Yes	Yes	Yes
NM	Yes	DNA	Yes	Yes
NV	Yes	No	No	No
NY	No	No	No	No
OH	DNA	Yes	DNA	DNA
OK	Yes	Yes	Yes	Yes
OR	DNA	No	DNA	No
PA	DNA	DNA	DNA	No
PR	No	No	No	DNA
RI	Yes	Yes	Yes	Yes
SC	Yes	Yes	No	No
SD	Yes	Yes	DNA	Yes
TXRN	No	No	No	No
UT	Yes	Yes	Yes	Yes
VA	Yes	Yes	Yes	Yes
VI	Yes	Yes	a	Yes
VT	Yes	Yes	Yes	Yes
WARN	Yes	Yes	Yes	Yes
WI	DNA	Yes	DNA	DNA
WVRN	Yes	Yes	Yes	Yes
WY	Yes	Yes	No	Yes

[a]No information available

Table 7

ADVANCED PRACTICE: LEVELS OF PRESCRIPTIVE AUTHORITY FOR CNS AND NP BY MEMBER BOARD

BOARD	CNS	NP
AK	a	Independent/restricted to area of practice expertise
AL	DNA	DNA
AR	DNA	None
AZ	None	Independent/restricted to area of practice expertise
CARN	None	Restricted to protocol
CT	Restricted to protocol Restricted to practice agreement with MD	Restricted to protocol Restricted to practice agreement with MD
DC	DNA	Restricted to protocol
DE	None	None
FL	DNA	Restricted to protocol
GARN	Restricted to protocol	Restricted to protocol
GU	DNA	None
IA	Independent/restricted to area of practice expertise (no controlled substances)	Independent/restricted to area of practice expertise (no controlled substances)
ID	DNA	Restricted to formulary
IN	Restricted to practice agreement with MD	Restricted to practice agreement with MD
KS	Restricted to protocol	Restricted to protocol
KY	Restricted to protocol	Restricted to protocol
LARN	None	None
MA	Restricted to practice agreement with MD	Restricted to practice agreement with MD
MD	DNA	Restricted to practice agreement with MD
ME	None	Restricted to formulary
MI	DNA	None
MN	None	Restricted to practice agreement with MD
MO	Restricted to practice agreement with MD	Restricted to practice agreement with MD
MP	DNA	DNA
MS	DNA	Restricted to protocol
MT	Independent without restrictions	Independent without restrictions
NC	DNA	Restricted to practice agreement with MD
ND	Independent/restricted to area of practice expertise	Independent/restricted to area of practice expertise
NE	DNA	Restricted to practice agreement with MD
NH	Restricted to formulary	Restricted to formulary
NM	DNA	Independent/restricted to area of practice expertise

Board	CNS	NP
NV	None	Restricted to practice agreement with MD
NY	DNA	Independent without restrictions
OH	DNA	DNA
OK	None	None
OR	DNA	Restricted to formulary Independent/restricted to area of practice expertise
PA	DNA	None
PR	None	DNA
RI	None	Restricted to formulary
SC	Restricted to protocol	Restricted to protocol
SD	DNA	Restricted to practice agreement with MD
TXRN	Restricted to protocol	Restricted to protocol
UT	In accordance with consultation & referral plan	In accordance with consultation & referral plan
VA	None	Restricted to practice agreement with MD
VI	DNA	None
VT	Restricted to protocol	Restricted to protocol
WARN	Independent/restricted to area of practice expertise	Independent/restricted to area of practice expertise
WI	DNA	DNA
WVRN	Exclusionary formulary, prescribing guidelines, protocols	Exclusionary formulary, prescribing guidelines, protocols
WY	Independent/restricted to area of practice expertise	Independent/restricted to area of practice expertise

[a]No information available

Table 8

Advanced Practice: Levels of Physicial Involvement for CNS and NP by Member Board

Board	CNS	NP
AK	a	No MD involvement, practice independently
AL	DNA	Under protocol developed with a collaborating MD
AR	DNA	Under protocol developed with a collaborating MD
AZ	a	Other
CARN	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
CT	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
DC	DNA	Under protocol developed with a collaborating MD & by an organization
DE	No MD involvement, practice independently	No MD involvement, practice independently
FL	DNA	Under protocol developed with a collaborating MD
GARN	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
GU	DNA	Under protocol developed with a collaborating MD
IA	Other	DNA
ID	DNA	Under no supervision
IN	No MD involvement/independently if no prescriptive authority, under protocol w/collaborating MD for prescriptive authority only	No MD involvement/independently if no prescriptive authority, under protocol w/collaborating MD for prescriptive authority only
KS	No MD involvement, practice independently	No MD involvement, practice independently
KY	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
LARN	No MD involvement, practice independently	Under protocol developed with a collaborating MD
MA	Independent practice/must identify who is responsible for emergency coverage	Independent practice/must identify who is responsible for emergency coverage
MD	DNA	Under protocol developed with a collaborating MD
ME	No MD involvement, practice independently	Under no supervision
MI	DNA	No MD involvement, practice independently
MN	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
MO	Other	DNA
MP	DNA	DNA
MS	DNA	Under protocol developed with a collaborating MD
MT	No MD involvement, practice independently	No MD involvement, practice independently
NC	DNA	Under no supervision
ND	No MD involvement, practice independently	No MD involvement, practice independently
NE	DNA	Under protocol developed with a collaborating MD, under no supervision
NH	No MD involvement, practice independently	No MD involvement, practice independently
NM	DNA	No MD involvement, practice independently
NV	Other	Under protocol developed with a collaborating MD

BOARD	CNS	NP
NY	DNA	Under protocol developed with a collaborating MD
OH	a	a
OK	No MD involvement, practice independently	No MD involvement, practice independently
OR	DNA	No MD involvement, practice independently
PA	DNA	Under protocol developed with a collaborating MD, under no supervision
PR	Independent practice/must identify who is responsible for emergency coverage	DNA
RI	DNA	Under protocol developed with a collaborating MD
SC	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
SD	DNA	Under no supervision
TXRN	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
UT	In accordance with consultation & referral plan	In accordance with consultation & referral plan
VA	No MD involvement, practice independently	Under protocol developed with a collaborating MD
VI	DNA	Under protocol developed with a collaborating MD, under no supervision
VT	Under protocol developed with a collaborating MD	Under protocol developed with a collaborating MD
WARN	No MD involvement, practice independently	No MD involvement, practice independently
WI	DNA	DNA
WVRN	No MD involvement, practice independently, under protocol developed with a collaborating MD	No MD involvement, practice independently, under protocol developed with a collaborating MD
WY	Independent/identify who is responsible for emergency coverage	Independent/identify who is responsible for emergency coverage

[a]No information available

APPENDIX E

Coalition of Psychiatric Nursing Organizations (COPNO)

- American Psychiatric Nurses Association (APNA)
- Association of Child and Adolescent Psychiatric Nurses (ACAPN)
- International Society of Psychiatric Consultation Liaison Nurses (ISPCLN)
- Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN)

ADVANCED PRACTICE PSYCHIATRIC PROJECT
MARCH 24 – 26, 1994

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Appendix F

Technical Appendix

Survey design

All psychiatric clinical nurse specialists certified by the American Nurses Association in Spring of 1994 were included in the population for this survey. The Society for Education and Research in Psychiatric-Mental Health Nursing (SERPN) conducted the survey using a mailing list of clinical specialists in psychiatric and mental health nursing provided by the American Nurses Association. The purpose of the study was to provide an up-to-date database on the advanced practice of psychiatric mental health nursing to use as a reference for ongoing healthcare reform issues.

Sampling frame and sample size

The population of Certified Specialists in Psychiatric-Mental Health Nursing included 6,090 individuals certified in the Spring of 1994 as either adult and/or child specialists. The mailing list did not allow for separation of specialists into adult and child categories; the population as a whole was used as a basis for a 20% random sample. A sample of 1,211 served as the specialists included in this study.

Sample design

This study used a simple random sample. All certified psychiatric clinical nurse specialists were included in the universe of the study.

Data Collection and Instrument

SERPN's Advanced Practice Project Task Force was responsible for the development and implementation of this study. The survey was developed to include issues of importance to psychiatric nursing as well as to collect baseline data based on CMHS's Draft Core Human Resources Minimum Data Set. The survey instrument consisted of items from prior surveys, the minimum data set, and original questions developed for this survey. The 16 page survey tool included fifty questions plus several open-ended questions.

The validity of the survey was established through a review of the questions by content experts representing the four psychiatric nursing organization represented in the Coalition of Psychiatric Nursing Organizations (COPNO). Representatives from the four psychiatric nursing organizations met to review the instrument and made recommendations which improved the survey tool. The survey and procedures for data collection were formally endorsed by the COPNO representatives.

A response rate of 55% (675) was achieved following three mailings. A complete survey instrument was sent out in the first two mailings. The final mailing was a shortened form of the most important questions. The initial mailing took place in Summer, 1994; the first follow-up took place in Fall, 1994; the final mailing took place in March, 1995. The results reported in this paper include those of all respondents. The number of respondents varied by question depending on whether

the data element was included on the short form and whether or not certain conditions applied to the respondent. For example, questions regarding secondary setting of employment only related to those with a secondary setting of employment. Other questions only related to those providing direct patient care or to those working. An effort was made to provide results on the population as a whole. Sub-population analyses are possible and will be reported in other publications.

LIMITATIONS

A higher than 55% sample response rate would improve the population estimates generated. An assumption is made that the 45% percent of non-responders is similar to those who did respond. This assumption cannot be tested; therefore, this response rate remains a limitation.

There were few missing values for most variables contained in both the long and short form. Generally the respondents answered questions applicable to them. An exception to this were the variables used to estimate types of work activities of nurse specialists. The items including these variables were not included in the shorter version of the survey used in the final mailing and therefore are missing for responders to the last mailing. About 60% of the respondents have data available regarding types of work activities. The questions which sought information related to types of work activities were considered confusing to participants. Seventy-seven observations were not used in the analyses due to known inconsistencies. The data elements used to compute hours of work activities are believed to contain some error. The work activity questions asked respondents to provide the number of hours worked in the different types of activities (listed in Table 6) for a two month period of time. Likewise, respondents were asked to provide the number of hours worked in specific clinical activities for that same period (see Table 8). Some respondents replied using a week or one month period as a framework. When this became apparent to researchers, the data were modified to reflect a two month period. The extent to which the data error affects the results is not known. It is expected that the relationships among the amounts of time spent in the different activities is reasonably stable. The numbers of hours spent in a two month period for a particular activity should be considered as approximate in light of the large standard deviations and the expectation that there is some level of measurement error in these variables. It is expected that these data may be able to be improved for future smaller sub-population analyses.

Appendix G

State	State of Residence # Certified[1]	# in Responses
Maine	71	5
New Hampshire	70	1
Vermont	51	6
Massachusetts	799	74
Rhode Island	84	8
Connecticut	322	34
New York	620	61
New Jersey	262	25
Pennsylvania	341	31
Delaware	20	3
Maryland	385	43
District of Columbia	28	3
Virginia	278	32
West Virginia	28	1
North Carolina	98	8
South Carolina	85	11
Georgia	123	18
Florida	180	16
Ohio	183	23
Indiana	79	10
Illinois	119	20
Michigan	160	16
Wisconsin	30	8
Kentucky	66	6
Tennessee	60	5
Alabama	46	3
Mississippi	16	1
Minnesota	142	16
Iowa	35	3
Missouri	63	8
South Dakota	5	1
Nebraska	20	4
Kansas	52	5
Arkansas	10	1
Louisiana	33	5

STATE	STATE OF RESIDENCE # CERTIFIED[1]	# IN RESPONSES
Oklahoma	22	1
Texas	176	16
Montana	18	4
Idaho	8	2
Wyoming	9	2
Colorado	126	9
New Mexico	58	6
Arizona	80	11
Utah	21	4
Nevada	14	3
Washington	318	29
Oregon	82	13
California	381	44
Alaska	34	4
Hawaii	28	3

[1]American Nurses Credentialing Center, 1995 Certification Catalog, p. 4.