Title

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Journal

Nursing Outlook, 73(1)

ISSN

0029-6554

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Publication Date

2025

DOI

10.1016/j.outlook.2024.102342

Policy Priorities to Improve Access to Advanced Practice Nursing Care for Mental Health and Substance Use Problems: An AAN Manuscript

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Credit Statement: All authors share credit for: conceptualization; writing – original draft; writing – review and editing

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Declarations of Interest

Declarations of interest: none

Policy Priorities to Improve Access to Advanced Practice Nursing Care for Mental Health and Substance Use Problems: An AAN Manuscript

"This article is part of a continuing series of policy-oriented papers written by members of the AAN's Expert Panels, has been reviewed by the Academy's Board of Directors, and has also undergone peer review by the journal."

Abstract

Nearly 50% of the US population struggles with a mental health or substance use disorder in their lifetime, yet a substantial number are unable to receive treatment or are undertreated due to significant shortages and disparities in the mental health workforce. These shortages and disparities contribute to health inequities that leave already vulnerable populations at increased risk for detrimental consequences. Access to mental health and substance use treatment could be improved by better utilizing the Advanced Practice nursing workforce providing care in mental health and substance use treatment, and by better defining Advanced Practice nursing roles, including those with specialty certifications in mental health and substance-related care. This paper makes policy recommendations to better define, grow, and more fully utilize the Advanced Practice nursing workforce providing mental health and substance-related services.

Introduction

U.S. population needs for mental health and substance related services are significant and largely unmet. In 2022, 59.3 million U.S. adults experienced a mental illness, yet only about half (50.6%) received treatment (SAMHSA, 2023). Twenty percent of American children have a known mental health problem, and 40% of them will meet criteria for a psychiatric disorder by age 18; yet only 14% of white children, 9.8% of black children and 8.7% of Hispanic/Latino(a) children receive treatment (Bitsko et al., 2022; Shim et al., 2022). In 2022, 17.3% of the US population aged 12 or older had a substance use disorder, yet only 12% of those received treatment of any kind, with lower treatment rates among ethnic and racial minorities (SAMHSA, 2023). Informed by low treatment rates for substance use disorders, the Centers for Disease Control and Prevention (CDC) reports over 100,000 drug overdose deaths for the 12-month period ending August 2023, with higher recent overdose death rates among non-Hispanic Black and American Indian/Alaska Native persons (Ahmad et al., 2023; Kariisa et al., 2022; Kaiser Family Foundation, 2022). These morbidity and mortality statistics occur in the context of available treatments that are evidence-based but underutilized.

One of the major factors contributing to these treatment gaps is a critical shortage of appropriately trained and credentialed health care providers (Aggarwal et al., 2023; Health Resources and Services Administration (HRSA), 2022). Unclear or inconsistent credentialing processes also contribute to suboptimal utilization of the existing health workforce (National Conference of State Legislatures, 2024). Experts also maintain that current workforce shortage discussions are based on a numbers count estimating regional network adequacy rather than consideration of a lack of providers to address specific patient mental health needs (Glied & Aguilar, 2022).

This paper articulates the American Academy of Nursing's (AAN or Academy) work to advance policy changes that could broadly expand much needed mental health and substance use treatment services by enhanced activation of the Advanced Practice Registered Nursing (APRN) workforce that provides mental health and addiction treatment. The workforce includes APRNs delivering primary care in a variety of settings, as well as APRNs who deliver specialty mental health and substance use treatment, namely: Psychiatric Mental Health Nurse Practitioners (PMHNP), Psychiatric Mental Health Clinical Nurse Specialists (PMHCNS) and Certified Addictions Registered Nurses in Advanced Practice (CARN-AP). To broaden APRN delivery of much-needed care in the areas of mental health and substance use, this paper proposes policy changes in the following areas: 1) Better definition and description of the APRN workforce providing direct care for persons with mental health and substance-related disorders; 2) Expansion of the APRN workforce generally, and of the specialty APRN workforce delivering mental health and substance-related care; and 3) Expanded utilization of the current APRN workforce by granting it full practice authority nationwide (**Table** summarizes these recommendations). This paper also emphasizes the importance of broadly expanding APRN visibility and input in developing policies that address mental health and substance-related needs.

I. Better Define the APRN Workforce in Mental Health and Substance Use

As the demand for mental and substance-related health services increases, the Health Resources and Services Administration (HRSA) expects the supply of adult psychiatrists to decrease by 20% to 27,010 by 2030, while projecting a 62% increase in Nurse Practitioners (NPs) working in behavioral health (HRSA, 2020). These data indicate that NPs will comprise a significant and growing component of the psychiatric, mental health, and substance use service workforce (Beck et al., 2020). HRSA's new National Center for Health Workforce Analysis

dashboard does list out Psychiatric Nurse Practitioners, but numbers cited are low with a description of the specialty that fails to list the basic services PMHNPs provide (HRSA, 2023).

APRNs in numerous specialties, including Family Nurse Practitioners (FNP), Adult-Gerontology Primary Care Nurse Practitioners (AGPCNP), and others, can and do assess and treat mental health and substance use disorders. Authors of a recent systematic review of the effectiveness of NP care for patients with mental health and substance use disorders acknowledge that both primary care NPs and APRN specialists in mental health provide these services in primary care settings (Turi et al., 2023). Results of the review detail the preponderance of the evidence that APRN-provided mental health outcomes include improvements in depression, anxiety, and substance-related symptoms and that NP care was comparable to physician-provided care in the provision of evidence-based practices and prescribing (Weissinger et al., 2024).

Evidence of the positive impact of APRN-delivered mental health and substance-related care is detailed elsewhere. Muench and colleagues (2022) analyzed Medicare psychiatric medication prescription claims data as well as inpatient and outpatient diagnosis claims data and found that primary care APRNs provided up to 13% of psychiatric medications for older adults in rural areas, a rate 2 to 4 times greater than physicians practicing in behavioral health specialties (Muench et al., 2022). Another study that used national retail prescription claims data for psychotropics (antidepressants, anxiolytics, antipsychotics, and mood stabilizers) and medications for opioid use disorder (MOUD), analyzed trends in the number of prescriptions by provider type (Schenk et al., 2024). The authors found that between 2017 and 2021, there was an overall 2.7% increase in these prescription categories, with the largest growth among Psychiatric Nurse Practitioners (44.7% growth), followed by other nurse practitioners (25.5%

growth). In this study, primary care physicians and primary care advanced practice clinicians (non-physicians including APRNs) prescribed 3.5 times fewer prescriptions in these medication classes compared to grouped psychiatric and addiction specialists.

The above evidence details that APRNs generally, as well as APRN specialists working in mental health and substance use treatment, are essential behavioral health care providers, with variability according to populations studied and research methodologies. One study that compared county-specific Medicare Part D billing trends between MD psychiatrists and PMHNPs revealed about a 1/3 decrease in the number of counties where MD psychiatrists were billing Part D simultaneous to a near doubling in the number of counties where PMHNPs billed Part D. The study also notes substantial numbers of counties have neither an MD Psychiatrist nor a PMHNP prescribing medications (Oh et al., 2022). A recent Medicare Payment Advisory Commission (MedPAC) report noted that between 2016 and 2021 there was a 12% increase in NP provision of behavioral health- Medicare part B services while the volume of these services provided by psychiatrists declined (5 percent average annual decrease) (Fout et al., 2023). boards of nursing.

APRNs specializing in mental health and substance use treatment include PMHNPs, PMHCNSs and CARN-APs. Providers with these specialty certifications are qualified to fill mental health and substance use treatment gaps and provide accessible, affordable, quality care across the lifespan (Delaney, 2018). Currently, there are 1,120 CARN- APs, 3,987 PMHCNSs, and 43,530 certified PMHNPs in the United States. The number of certified PMHNPs has increased 27% over the previous year and 118% since 2020 certification data (ANCC, 2023; ANCB, n.d.). Their defined professional activities include the assessment, diagnosis and management of mental and substance use disorders, prescription and management of

psychotropic therapies, and provision of psychotherapeutic interventions (ANA, APNA, ISPN, 2022). Competencies in these practice areas qualify them for national certification and licensure as providers by their state A recent report on the behavioral health workforce commissioned by the Department of Health and Human Services concluded that PMHNPs are trained and educated to provide many of the same services as psychiatrists and recommended greater use of PMHNPs as a strategy to increase the reach of behavioral health care (Pietras &Wishon, 2021). Yet in select Federal workforce planning reports, PMHNPs are not listed among professionals included in staffing plans, nor are PMHCNSs or CARN-APs (SAMHSA, 2023b). A recent SAMHSA report (2023c) detailed staffing needs for behavioral health care models, including needs for prescribers; while several models identify "Advanced Practice Nurse" as one possibility for this function, it is unclear if this means any APRN, or APRNs in designated specialties. There is a clear need to standardize data collection and monitoring of nationwide trends that track the size and roles of all APRNs, and the contributions that each APRN designation provides in helping people access needed care for mental health and substance use disorders (Delaney, 2024).

In a related matter, existing national identifiers may under-estimate APRNs working in specialty practice due to the lack of specialty designations in billing (O'Rielly-Jacob, 2020). The ten-digit NPPES (National Plan and Provider Enumeration System) number, which an NP uses to apply for the NPI, has a specialty designation. However, the NPI number used in billing only has one general NP specialization code (Harrison et al., 2021). That means that all NP billing is categorized into one pooled designation. It should be noted that other provider groups, such as MDs, have 50 different NPI specialty specifiers (e.g., primary care, psychiatry, internal medicine). The lack of NP specialty designation in NPI billing matters. Recently, researchers aimed to determine to what extent NPs were delivering behavioral health care (Richard et al.,

2022). Because they could not determine which NP billing records were being submitted by PMHNPs, they developed and validated two complex and time-consuming methods for identifying PMHNP provision of care (Richard et al., 2022). The authors noted this might not be the optimal way to detail practice by specialists, but delving into NPPES taxonomy codes was too cumbersome. Other researchers acknowledge the need for methodologies that identify the specialization of NPs to determine which types of APRNs are providing mental health and substance related care, and of what quality (Turi et al., 2023; Yang et al., 2017).

The AAN supports the creation of a National Nursing Workforce Center Act to establish a grant program supporting public-private partnerships to analyze and develop growth of the nursing workforce (Nursing Community Coalition, 2023). The AAN acknowledges the importance of 40 existing nursing workforce centers that currently conduct and publish research on regional nursing supply and demand, and advocates for creating national data efforts that define the current nursing workforce and nursing needs for the future.

Recommendation: Better Define the APRN Workforce in Mental Health and Substance Use

<u>Action Items</u>:

- Standardize nationwide data collection and monitoring that tracks the size and specialties of the APRN workforce to better describe the contributions they provide in helping people access needed care for mental health and substance-related problems.
- Organizations that collect data on APRN education, certification and employment should make these data publicly accessible and create clear mechanisms for researchers to access the data.
- Government data on the national mental health and substance use workforce should specify all APRN specialties, including those in mental health and substance related care, which

could be used to identify nurse provider types as important components of the mental health and substance use workforce. Recategorization of the NPI and NPPES systems could be one component of this.

- Enact the National Nursing Workforce Center Act to produce and disseminate data describing the nursing workforce and help plan for health needs provided by nurses.

II. Grow the APRN Workforce Providing Mental Health and Substance-Related Care

Building the APRN nursing workforce that delivers mental health and substance related care includes cultivating clear educational and licensure pathways to specialization. Research on Psychiatric Mental Health (PMH) nursing has identified historical discouragement to enter this specialty, informed by concerns about violence/safety, lack of advancement, and ongoing stigma and bias towards persons with mental illness and substance use disorders (Stevens et al., 2013). Although numbers of APRNs working in specialty mental health roles have increased, ongoing professional support, education and retention strategies are insufficient (Merwin, 2020).

A lack of consistent practice parameters and the use of PMH-APRNs within health systems is part of the long and complicated history of APRN titles and roles in Advanced Practice nursing (Horowitz & Posmontier, 2020; Pappas et al., 2023). The Psychiatric Clinical Nurse Specialist (CNS) was one of the first APRN roles, followed by the creation of the Psychiatric-Mental Health Nurse Practitioner (PMHNP). There has long been debate over differences in the educational preparation and utilization of these roles, but the ANA-defined Scope and Standards of Practice for these two roles are now identical (2022) and have been for many years. Confoundingly, the use and local regulation of these roles are widely divergent: some states allow prescriptive authority for one role or another; some states allow independent practice for one role or another—or none; insurance providers offer widely variant coverage for

these roles; and health systems may choose to emphasize one role over another or limit the applications of the roles even though the national scope and standards of practice are the same, and include assessment, diagnosis, psychotherapy and prescribing practices. Health policies that recognize and promote the similarity of these roles could significantly expand access to mental health and substance use treatment.

A related consideration for the growth of this specialty nursing workforce via education is the aging of individuals in the specialty. A 2022 survey of certified PMH APRNs conducted by the American Psychiatric Nurses Association (APNA) revealed that over a quarter of survey respondents (most of whom were specialty certified in PMH nursing) planned to retire in the next six years. The survey additionally noted that 40% of PMH-APRN respondents were older than 60 (APNA, 2022).

COVID has also played a significant role in shrinking the national nursing workforce generally. A recent report by the National Council of State Boards of Nursing (NCSBN) found that around 100,000 RNs left the workforce as a result of pandemic-related stress and burnout, with over 6 times that number reporting an "intent to leave" by 2027 for the same reasons (Martin et al., 2023). In this context, the AAN supports federal legislation such as the Future Advancement of Academic Nursing (FAAN) Act, which seeks to create and expand nurse education infrastructure, including expanding clinical education opportunities and supporting the recruitment and retention of nurse faculty (Nursing Community Coalition, 2022). These efforts have the potential to meaningfully impact access to nurse-delivered care for mental health and substance-related problems.

The American Association of Colleges of Nursing (AACN) reports that shortages of nurse faculty, nurse clinical training sites and preceptors, and lack of funding have limited the

acceptance of all qualified nursing school applicants, thus affecting the pipeline to nursing careers as nursing retirements increase (American Association of Colleges of Nursing, n.d.). Focus on the recruitment and retention of APRN faculty and clinical preceptors are key in growing this component of the specialty workforce (Kaas, 2020; Kueakomoldej et al., 2022). Other successful recruitment and retention strategies for faculty and clinical preceptors have included subsidies for nurse faculty who train learners in specific areas, including mental health and substance use.

The AAN supports expanded funding for nurse education and faculty recently introduced in the Bipartisan Primary Care and Health Workforce Act that proposes to grow the nursing workforce by: 1) expansion grants for nurse education, practice, and retention; 2) the creation of nurse faculty loan programs; 3) support for nurse corps scholarships and loan repayment programs; and 4) grants for nurse residency training programs (Bipartisan Primary Care and Health Workforce Act, 2023). The legislation should earmark monies specifically for students and faculty who plan to work in care that focuses on addressing mental health and substance-related problems.

Recommendation: Grow the APRN Workforce Delivering Mental Health and Substance- related Care

Action Items:

- Policies must recognize the shared scope and standards of the PMHCNS and PMHNP roles to allow both roles to practice to the top of their certification in all states and to promote payor reimbursement for specialty services provided by these roles.
- Enact the FAAN Act to increase federal financial support to expand nursing

education both broadly and in the specialties of mental health and substance use disorders, support faculty recruitment and retention, and support nurse faculty loan programs.

- Enact the Primary Care and Health Workforce Act to expand federal funding to support nursing students broadly and specifically in pursuit of mental health and substance use specialties, including financial support for nurse corps scholarships, loan repayment programs and grants to fund nursing fellowship and residency training programs.

III. Utilizing APRNs to the full extent of their education and training

The strategies outlined above for enhancing the definition, description, and growth of the APRN workforce providing mental health and substance use treatment are long-term endeavors. They demand unwavering commitment to achieve the desired outcomes, and the necessary policy changes to support them may take time to materialize. In contrast, there exists a third area of policy focus with the potential to more quickly improve access to nurse-delivered mental health and substance use treatment. This area involves discontinuing policies and practices that hinder APRN practice.

The Institute of Medicine's *Future of Nursing* report recommended the removal of scope of practice barriers well over a decade ago (Institute of Medicine [IOM], 2011). More recently, *The Future of Nursing 2020-2030* again called for removing nursing scope of practice restrictions, backed by evidence throughout the 2010s detailing that these restrictions are broadly associated with decreased access to care. The report notes: "Eliminating these restrictions so APRNs can practice to the full extent of their education and training will increase the types and amount of high-quality health care services that can be provided to those with complex health and social needs." (National Academies of Sciences, Engineering and Medicine

[NASEM], 2021, p.7). To advance health equity in all areas, including the treatment of mental health and substance-related problems, APRNs everywhere must have independent practice authority commensurate with the full extent of their education and training; however, APRN practice scope is frequently reduced by restrictive state laws and institutional policies (NASEM, p. 363), most commonly via some form of practice dependence on physicians. The Federal Trade Commission (FTC) has written letters to state governors in support of independent APRN scope of practice despite specious oppositional arguments and antitrust activity (Gilman & Fairman, 2015). Currently, only 27 states plus the District of Columbia have independent or full practice authority for nurse practitioners (AANP, n.d.), while in the remaining states, APRN practice is partially or fully dependent on physician oversight or collaboration. Meanwhile, federally, all APRNs have had independent practice authority at the Veterans Health Administration since 2017 (Veterans Health Administration [VHA], 2017).

Evidence shows that allowing APRNs independent practice improves access to mental health and substance use treatment. Research describes a well-defined pattern of decreased mental-health related deaths after states allowed NPs to have independent prescriptive authority (one component of independent practice authority), and also found that self-reported mental health improved after NPs were allowed independent prescriptive authority (Alexander & Schnell, 2019). These findings were particularly robust in areas defined by HRSA as "underserved" in mental health services; that is, in areas with less than 1 psychiatrist (MD) per 30,000 population.

Other evidence focuses on mental health care provided by NPs in Federally Qualified Health Centers (FQHCs), where about 11% of all clinical visits were for mental health problems (Yang et al., 2017). While physicians provided about 90% of all mental health care in the study,

the proportion of NPs treating patients with mental health disorders was significantly greater (12%) in states with independent practice authority for APRNs compared to states without independent practice authority (4%). There was no significant difference in the proportion of non-mental health visits provided by NPs in states with and without independent practice authority. Additionally, "a greater number of NPs provided visits related to mental disorders in states with NP-IPA [Independent Practice Authority] than in states without NP-IPA (Yang et al., 2017, p. 1036)." The same study shows that a higher proportion of FQHC visits for substance use disorders were provided by NPs (29.6%) compared to physicians (11%), and that NPs provided more mental health visits than did physicians for racial and ethnic minorities and Medicaid enrollees (Yang et al., 2017).

While APRNs have significantly expanded access to treatment for opioid use disorder (OUD), the expansion has been greater in states where they have expanded or independent practice authority. The Drug Addiction Treatment Act of 2000 expanded access to OUD treatment via the medication buprenorphine. The law, however, originally restricted treatment providers to Physicians only, excluding all APRNs and Physician Assistants (PAs) with prescriptive authority for controlled substances. By 2012, only about 2% of the physician workforce was able to prescribe buprenorphine for OUD (Tierney et al., 2015). Subsequent federal laws expanded buprenorphine prescriptive authority, including CARA 2016 which allowed NPs and PAs to prescribe, and the SUPPORT 2018 Act allowing other APRNs to prescribe. As a result, access to buprenorphine treatment for OUD improved substantially.

Following CARA 2016, from 2017 to 2018, there was a 9.1% increase in buprenorphine prescribing, with NPs and PAs accounting for 79.6% of that increase (Rohler et al, 2020). And in early 2019, the percentage of APRNs who possessed the DEA waiver to prescribe buprenorphine

exceeded the percentage of waivered MDs (Spetz et al, 2022). During the pandemic, APRNs and PAs accounted for more than half of the growth in capacity to treat OUD using buprenorphine (Spetz et al, 2022b). Importantly, states with independent practice authority for APRNs were shown to have 75% more NPs who possessed the then-required federal DATA waiver to prescribe buprenorphine compared to states with restricted NP practice (Spetz et al., 2019). It follows that independent practice authority for all APRNs might have further improved access to life-saving treatment for OUD.

Advocating for Parity in Billing and Reimbursement

APRN practice data in the areas of mental health and substance use care are often unclear due to methods of categorizing specialties according to billing records and indirect billing standards, particularly in states with restricted APRN practice where APRN services are billed under a supervising physician, (Cai et al, 2022). Patel et al. (2022) reported 38-54% of Medicare billing in their research was indirect, substantially underestimating the role of APRNs and overestimating the role of physicians.

In the aforementioned systematic review of the effectiveness of NP care for patients with mental health problems, Turi and colleagues noted: "in studies where NP SOP [scope of practice] was reduced or restricted, it is difficult to attribute the outcomes solely to the NPs because NPs were required to collaborate or be supervised by physicians to deliver care (Turi et al., 2023, p.11)." They also note that "NP contributions are obscured in reduced or restricted SOP states, and these restrictions may both limit access to mental health care, as well as research focused on the efficacy of NP care (Turi et al., 2023, p.10)."

In September 2023, the AAN co-signed a letter with 9 members of the APRN Workgroup to the Administrator of the Centers of Medicare and Medicaid Services (CMS) expressing

concerns regarding “incident to” billing (APRN Workgroup, 2023). The AAN noted that APRNs can bill directly for CMS services, and that “incident to” billing should be limited. Rather than continuing “incident to” billing, and billing at lower reimbursement rates than physicians for similar codes and services, APRN service reimbursement should be brought to parity with physician billing rates. This would ensure that payment occurs based on the service provided rather than provider education or licensure.

APRNs play an essential role in providing care to populations broadly, including patients with mental health and substance use problems. An important finding of the recent APNA workforce survey is that nearly half of APRN respondents (44%) state most of their clients were covered by federal insurance (APNA, 2022b). The AAN recognizes that 40% of Medicare beneficiaries receive care by an APRN, and that approximately a quarter of a million APRNs treat Medicare patients (Centers for Medicare and Medicaid Services [CMS], 2022). In that context, the AAN supports the federal Improving Care and Access to Nurses (I CAN) Act (H.R.2713) (2023), noting the act “would remove outdated barriers in the Medicare and Medicaid programs that currently prevent APRNs from practicing to the full extent of their education and clinical training. Removing these barriers will increase patients’ timely access to care from the provider of their choice” (Nursing Community Coalition, October 2023).

Finally, regarding insurance inequities, the AAN recognizes that commercial insurance companies have discriminatory practices toward APRN providers, including lower reimbursement rates than physicians when the same services are provided; not covering APRN services at all, or not covering certain APRN specialty areas; and requiring APRNs to bill services under a physician’s NPI number rather than their own. As a policy countermeasure to these discriminatory practices, the AAN calls for government agencies to enforce section 2706 of

the Public Health Services Act (PHS), which "prohibits private health plans from discriminating against qualified licensed healthcare professionals based on their licensure." (APRN Workgroup, April 2023).

Nursing Presence and Access to Care

Physicians and Nurse Practitioners treat comparable patient populations with similar evidence-based practices, including psychiatric evaluation, psychotherapy and the prescribing of psychotropic medications, leading to decreases in mental health related mortality (Alexander & Schnell, 2019; Turi et al., 2023; Yang et al, 2021). The reach of nursing in mental health and substance use care often exceeds the reach of physician-based care. For instance, NPs are more involved than MDs in patient visits for substance use disorders (Yang et al., 2017), and PMHNPs are also more likely than psychiatrists to treat patients in rural counties (Cai, et al., 2022). Despite these and similar statistics detailing APRN-driven care access, nurses who specialize in the assessment and treatment of mental health and substance use disorders are often not recognized in federal and other initiatives to improve access to care. For instance, as detailed in federal legislation, physicians who were specialty certified in the care of substance use disorders were exempted from the 8-hour educational requirement to obtain the DATA waiver to prescribe buprenorphine in office-based settings; yet, in the federal CARA 2016 and SUPPORT 2018 acts, APRNs with specialty certifications in addictions care—namely PMHNPs, PMHCNSs, and CARN-APs—were not similarly exempted from the educational requirement. More recently, under The Medication Access and Training Expansion (MATE) Act of 2023, physicians with specialty certification in the assessment and treatment of substance use and addictive disorders are exempted from the 8 hours of addictions education now required to apply for or renew a DEA certificate. Meanwhile, APRNs with prescriptive authority who are specialty certified in

substance use and addiction care are not exempted from this educational requirement (Finnell et al., 2023). Neglecting to include the specialty APRN workforce in these and similar legislative actions and considerations disadvantages individuals and communities who benefit from their care, even as preventable drug-related overdose deaths climb year after year.

This lack of legislative recognition of APRNs working in mental health and substance use is mirrored by the failure to recognize the contributions of APRNs in a recent behavioral health workforce database funded by a grant from the SAMHSA (Ericson et al., 2022). Even as the SAMHSA seeks to better define the behavioral health workforce broadly, it lumps all Nurse Practitioners in a single category while simultaneously failing to count APRN specialists in behavioral health, yet counts physician specialists working in psychiatry, addiction psychiatry and addiction medicine. SAMHSA failed to name APRN specialties working in behavioral health in its recent workforce planning document (SAMHSA, 2023c). Published literature now calls for better understanding and messaging regarding APRN specialty practice in mental health and substance use, including how this component of the workforce meets critical treatment needs (Delaney, 2024).

Recommendation: Recognize the range of APRNs working in mental health and substance use and utilize these roles to the full extent of their education and training, including broader recognition of and contributions by APRN specialists in mental health and substance related care.

Action Items:

- Expand Scope of Practice Recognition: Encourage federal, state, local, and institutional bodies to fully acknowledge and utilize the independent scope of practice of all Advanced Practice Registered Nurses (APRNs), including Psychiatric-Mental Health

Clinical Nurse Specialists (PMHCNSs), Psychiatric-Mental Health Nurse Practitioners (PMHNPs), and Certified Addictions Registered Nurse-Advanced Practice (CARN-APs).

- Ensure Insurance Parity: Enforce federal parity laws in order to prevent insurance companies from denying coverage for services provided by APRNs and limiting coverage for mental health and substance-related disorders.
- Eliminate Outdated CMS Restrictions: Enact the I CAN Act to remove outdated CMS restrictions on services provided by APRNs, adhering to the Public Health Service (PHS) Act, which prohibits discrimination against healthcare professionals based on licensure.
- Replace "Incident to" Billing: Replace the "incident to" billing model with reimbursement parity for APRNs, ensuring they are reimbursed at the same rate as physicians when delivering equivalent healthcare services and using the same billing codes.
- Combat Misleading Arguments: Address and challenge misleading arguments against safe and effective APRN practice, particularly when presented during policy formation hearings and testimony. Education and testimony by leading specialty APRN organizations in this area can counter specious arguments against known safe and effective APRN care and can help advance treatment for mental health and substance related disorders.
- Recognize APRN Specialties: Recognize APRN specialties within federal law, especially when these specialties involve unique abilities or exemptions from legal requirements, mirroring the recognition of physician specialties.
- Include Specialty APRN Organizations: Advocate for the inclusion of Mental Health and Addiction-focused APRN specialty organizations in testimony and hearings related to

mental health and addiction policy to ensure specialty nurse input in these practice areas.

The Academy's Position

The Academy strives to ensure that everyone in the communities served by nurses has equitable access to care for mental health and substance use problems. The Academy supports the above policy solutions that improve these treatment capacities in the health care system including allowing APRNs working in mental health and substance-related care to practice at the top of their training. This includes removing outdated CMS billing practices; ending commercial insurance billing practices that discriminate against APRN-delivered services; and expanding nurse education infrastructure, including expanding clinical education opportunities and recruitment and retention of nurse faculty with expertise in mental health and substance use treatment.

Summary

The Academy recognizes and promotes the effectiveness of care provided by the APRN workforce in the treatment of patients and communities with mental health and substance-related problems and also recognizes the contributions of specialty APRNs, including PMHNPs, PMHCNSs and CARN-APs, working in these practice domains. APRN roles and their related successful treatment outcomes should be better promoted given the continuing insufficient treatment of mental health and substance use disorders in this country. Policies that promote APRN roles in the treatment of mental health and substance-related problems could result in rapidly improved access to care for all populations with these disorders. Utilizing APRNs to the full extent of their education and training is known to improve patient outcomes and access to care in our fragmented health care system. Attracting, training, and supporting the APRN workforce is an achievable yet underutilized approach to address the nation's mental health and substance use treatment deficiencies (APNA, 2022).

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Table: Academy Positions and Policy Recommendations

	AAN Position	Policy Recommendations
Better define the APRN workforce in mental health and substance use services	The academy supports the analysis and development of the APRN workforce providing care in mental health and substance related services.	• Create a National Nursing Workforce Center to collect and disseminate data describing the nursing workforce providing mental health and substance related services. • Create and utilize specialty specifiers for APRN NPI numbers to better define and describe the APRN workforce providing mental health and substance use services.
Grow the APRN workforce providing mental health and substance-related care	The academy supports federal legislative action to expand nurse education infrastructure, including expanding clinical education opportunities, and recruitment and retention of nurse faculty, particularly in the fields of mental health and substance use care.	• Expand federal and state grants for nurse education, practice, and retention, including grants to fund nurse fellowships in mental health and substance related services. • Create federal and state nurse faculty loan programs. • Expand support for federal nurse corps scholarships and loan repayment programs for nurses working in mental health and substance-related care. • Expand federal grants for nurse residency training programs in mental health and substance use care (Bipartisan Primary Care and Health Workforce Act).
Utilize APRNs working in mental health and substance related care to the full extent of their education and training.	• To increase patient access to mental health and substance use care provided by the APRN workforce, the Academy supports removing outdated CMS billing practices that prevent APRNs from practicing at the top of their licensure. • The academy supports ending commercial insurance billing practices that discriminate against APRN-delivered mental health and substance related services. • The academy supports improved recognition of APRN specialties with training and skills to treat mental health and substance related problems, including PMHCNS, PMHNP, and CARN-AP.	• Eliminate “incident to” billing practices and replace with APRN direct CMS billing for mental health and substance use services at parity with physician rates. • Incentivize recognition of APRN full practice authority by increasing mental health and substance use service reimbursement rates. • In the language of federal law, include role recognition for APRN specialties in mental health and substance related care, especially when identifying unique abilities or exemptions from legal requirements, mirroring the recognition of similar physician specialties.