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Psychiatric Nurse Workforce Survey: 2020

Contents

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BACKGROUND

Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) provide essential health care services throughout Nebraska. There is a growing recognition that psychiatric care is an integral component of essential health care services, contributing to improved physical as well as mental health (van der Sluijs, et al., 2018). As the demand for psychiatric services increases, it is important to determine the capacity of the Nebraska Nursing workforce to provide psychiatric and mental health care.

Psychiatric Nursing. Evolving models of health-care delivery (e.g., integration of mental health care into primary care, managed-care insurance plans, and team-based care) require a 21st Century Health-Care Workforce Agenda that integrates demand, capacity, and capabilities of psychiatric care providers (Delany, 2016). Nursing education prepares RNs to monitor patients' health status, provide interventions to promote or restore health, educate patients about self-care, and coordinate care in several clinical specialties, including psychiatric mental health nursing (APNA, 2019; Delaney, 2016). LPNs are educated to provide basic nursing care under the supervision of registered nurses or other licensed providers (Nebraska Department of Health and Human Services) in a variety of health-care settings. The biopsychosocial foundation of nursing education provides a strong and flexible framework for nurses to provide integrated, team-based mental and physical health care in both primary care and psychiatric care settings within their scope of nursing practice. Nonetheless, in response to burgeoning health-care knowledge and competition among nursing specialties for content inclusion in nursing curricula, psychiatric mental health nursing content and clinical experiences have decreased over time (Adams, 2015). These changes provide fewer psychiatric mental health nursing learning opportunities for nursing students. In addition, Phoenix (2019) posits that the psychiatric mental health nursing specialty is at a disadvantage for recruiting nurses into the specialty because the work, which is relationship-based, does not involve visual signifiers (e.g., scrubs, stethoscopes) typically used to represent nursing as a career.

Nebraska Nursing Statistics. The Nebraska 2018 RN (N=29,062) and 2017 LPN (N=5,671) License Renewal Surveys indicate that the majority of licensed nurses practice in urban areas.[1] Approximately two-thirds (63.6%) of RNs work in Douglas and Lancaster counties (Ramirez, 2019). Similarly, 77% of LPNs work in urban areas (Ramirez, 1918). The prevalence of nurses in urban areas of Nebraska mirrors the population distribution (USDA-ERS, 2018) as well as the distribution of mental health providers. Only three counties, located in eastern Nebraska, are considered mental health non-shortage (Sarpy and Cass) or partial shortage (Douglas) areas (Rural Health Information Hub, 2019). Approximately a third of Nebraska counties (33 of 93) do not have *any* mental health providers (Hoebelheinrick & Ramirez, 2019). The disproportionate distribution of nurses and mental health providers limits the ability of rural health hospitals and clinics to deliver psychiatric care.

Psychiatric mental health (PMH) nurses comprise the second largest group of behavioral health professionals in the United States (Phoenix, 2019). An estimated 4% of the U.S. RNs report psychiatric mental health and substance abuse as their primary nursing specialty (Smiley, et al., 2018). In comparison, 641 (2.7%) (RNs and Advanced Practice Registered Nurses [APRNs] combined) who responded to the 2018

[1] Completion of the surveys is voluntary and completed by most, but not all, nurses at the time of license renewal. Therefore, the number of RNs and LPNs responding to the survey is less than the number of licensed RNs and LPNs in Nebraska for the renewal period. In addition, the survey data cited here pertain to RNs and LPNs who work in Nebraska, which represents approximately 80 % of licensed NE nurses. (Personal communication J. Reznicek, K.Hoebelheinrich, & J-P. Ramirez, July 2-3, 2020).

Nebraska RN License Renewal Survey chose PMH nursing as their primary practice focus (Hoebelheinrick & Ramirez, 2019). Hoebelheinrick and Ramirez presented additional demographic and workforce characteristics of Nebraska PMH nurses. Approximately 96% (n=613) of Nebraska PMH nurses work in 12 urban counties. The majority of PMH nurses practice as RNs (n=510; 79.6%) in psychiatric facilities (n=267; 50.7%). Other practice settings selected by PMH RNs include hospitals (n=165; 31.3%) and clinics (n=17; 3.2%). With regard to age, which is an important factor with regard to future workforce projections, PMH nurses (RNs and APRNs) are four years older on average compared to all Nebraska RNs (48 years vs. 44 years, respectively). Although practice focus is not available from the 2017 LPN Renewal Survey, one-third (33.9%) work in long-term care, 23.2% in ambulatory care, and 10.7% in hospitals (Ramirez, 2018). The average age of Nebraska LPNs is 46 years**.**

To better determine the current employment of and need for psychiatric RNs and LPNs in Nebraska, the current survey gathered data from hospital and clinic administrators.

METHODS

The survey was executed by the University of Nebraska's Health Professional Tracking Service (HPTS). A paper-based survey with return envelope was mailed to facilities identified as potentially utilizing psychiatric nurses; Nebraska hospitals and clinics with health care professionals (MDs, DOs, APRNs, or PAs) identified as practicing psychiatry. The survey requested information from the facility perspective regarding the availability, employment, and utilization of employed and contracted psychiatric nurses. The completed survey could be returned via mail, email or fax. A total of 180 facilities received the survey (rural 57, urban 123).

RESULTS

The response rate was 42.3% for urban facilities (52 facilities) and 50.9% for rural facilities (29 facilities). Of the 52 urban facilities, 21 (40.4%) indicated that they employ or contract for RN or LPN psychiatric nurses whereas of the 29 rural facilities, 9 (31.0%) indicated that they employ or contract for RN or LPN psychiatric nurses (Table 1).

Table 1. Number and percentage of facilities that employ or contract RN or LPN psychiatric nurses

Employed or contracted RN or LPN psychiatric nurse	Urban (n=52)	Rural (n=29)
	Number (percentage)	Number (percentage)
Yes	21 (40.4)	9 (31.0)
No	31 (59.6)	19 (69.0)

Reasons for not employing or contracting for psychiatric nurses. Respondents provided the following reasons for not employing or contracting for psychiatric nurses:

Urban:

- Lack of availability of PMH nurses and funding (1 facility)
- No need for PMH nurse (solo practice, business just starting, not taking psychiatric referrals from APNRs) (6 facilities)

Rural:

- Limited or lack of funding or resources (2 facilities)
- Lack of candidate (1 facility)
- No need for PMH nurse (do not treat psychiatric patients, Psych NP provides care) (3 facilities)

Number of RN or LPN psychiatric nurses working at facilities. A total of 29 facilities (20 urban and 9 rural) reported the number of RN and LPN psychiatric nurses working at the facilities (Table 2). As shown in Figure 1, the largest number of nurses employed was full-time RNs for both urban and rural facilities.

Figure 1. Number of Full-time and part-time RNs and LPNs hired at urban and rural facilities

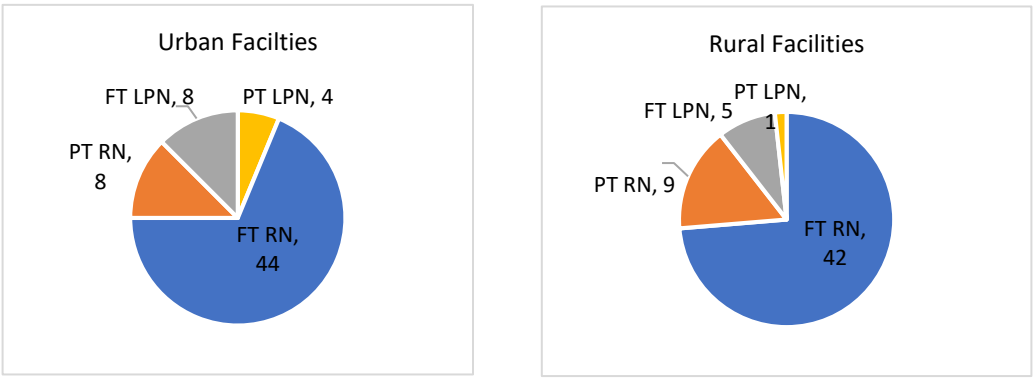


Table 2. Number of RN and LPN psychiatric nurses working at the facilities by full-time (36+ hours/week) and part-time (<36 hours/week) status: Urban and rural facilities

Facility	RN		LPN	
	Full time	Part time	Full time	Part time
	URBAN			
1	17	2	0	0
2	8	0	2	1
3	3	0	0	0
4	2	0	0	0
5	2	0	1	0
6	2	1	0	0
7	2	0	0	0
8	2	1	1	3
9	2	0	0	0
10	1	0	0	0
11	1	1	0	0
12	1	0	0	0
13	1	0	0	0
14	0	0	1	0
15	0	0	1	0
16	0	0	1	0
17	0	0	1	0
18	0	1	0	0
19	0	1	0	0
20	0	1	0	0
Total	44	8	8	4
	RURAL			
1	15	1	2	0

2	10	7	0	0
3	8	1	0	0
4	6	0	1	0
5	2	0	0	0
6	1	0	0	0
7	0	0	1	0
8	0	0	0	1
9	0	0	1	0
Total	42	9	5	1

Staffing models. Table 3 shows the combination of RNs and LPNs working at each facility: of the 29 facilities , 17 (59%) employed RNs (either full-time and/or part-time) and no LPNs. Seven facilities (24%) had only LPNs (full-time and/or part-time) and five facilities (17%) had a combination of RNs (full-time and/or part-time) and LPNs (full-time and/or part-time). The seven facilities employing only LPNs were outpatient clinics.

Table 3. Staffing models of RN and LPN psychiatric nurses

Staffing "Mix"	LPN FT & PT	LPN FT only	LPN PT only	No LPNs	Total
RN FT & PT	1	1		5	7
RN FT only	1	2		9	12
RN PT only				3	3
No RNs		6	1		7
Total	2	9	1	17	29

Type of duties psychiatric nurses perform. A total of 28 facilities reported type of work done by psychiatric nurses (Table 4). The most common types of duties include patient and family education, direct patient care, evaluation of patient's progress, collaboration with other health professions, and maintaining patient records. Rural facilities selected educating patients and families less frequently than urban facilities (4 out of 9 vs. 18 of 19 facilities, respectively). Relative to other duties selected, rural facilities also chose pre-admission screening/assessments less often. Similarly, urban facilities chose administrative and pre-admission screening/assessments less often relative to other duties.

Table 4. Urban and rural facilities' report of types of duties performed by psychiatric nurses

Type of duties	Urban n=19	Rural n=9
Educating patients and families	18	4
Patient medicine and treatment	17	9
Maintaining patient records	17	6
Direct patient care	15	9
Evaluating patient's progress	15	8
Work with social workers, counselors, therapists, medical professionals etc.	15	9
Maintaining a safe environment	12	9
Administrative	11	6
Pre-admission screening/ assessments	9	5

RN and LPN recruitment in the last 6 months. A total of 17 facilities reported that they hired an RN or LPN psychiatric nurses in the past 6 months. One facility did not provide a number. As Table 5 shows, 21 RNs were hired by 11 facilities. Another five facilities each reported hiring one LPN. Rural facilities hired more PMH nurses during this period than urban facilities.

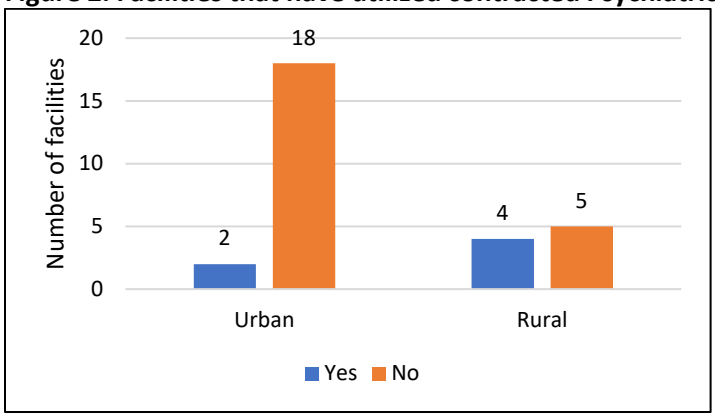
Table 5. Number of RN or LPN psychiatric nurses hired by the facilities in the last 6 months

URBAN		
Facility	**Past six months - RN**	**Past six months - LPN**
1	2	0
2	1	0
3	1	0
4	1	0
5	1	0
6	1	0
7	1	0
8	0	1
9	0	1
Total	8	2
RURAL		
1	6	0
2	4	0
3	2	0
4	1	0
5	0	1
6	0	1
7	0	1
Total	13	3

RN and LPN recruitment in the present and in the future. Nine facilities reported recruiting for RN psychiatric nurses currently (at the time of survey); two facilities reported recruiting for LPN psychiatric nurses currently (at the time of survey). Further, 12 out of 23 (52%) facilities reported planning to hire RN psychiatric nurses in the next 12 months and three facilities reported planning to hire LPN psychiatric nurses in the next 12 months.

Contracted nurses. Of those surveyed, rural facilities used more contracted psychiatric nurses than urban facilities. Figure 2 shows that only two urban facilities, while four rural facilities, utilized contracted psychiatric nurses in the past six months.

Figure 2. Facilities that have utilized contracted Psychiatric Nurses in the past six months



The facilities that used contracted nurses had a variety of reasons for doing so.
Urban:

- Coverage for absence of regular staff (1 facility)
- Lack of applicants (1 facility)
- Lack of qualified applicants (1 facility)
- Between regular hires (1 facility)

Rural:

- Coverage for absence of regular staff (3 facilities)
- Lack of applicants (3 facilities)
- Lack of qualified applicants (2 facilities)
- Between regular hires (2 facilities)

Difficulties maintaining staffing levels. Urban and rural facilities responded similarly when asked whether they have encountered difficulties maintaining desired staffing levels of employed psychiatric nurses. Nearly 50% of facilities in both settings reported they do have difficulties, and 50% reported that they do not. One urban facility did not respond. One urban facility needed to close beds or units in the past six months due to shortages of psychiatric nurses. Of the 9 rural facilities only 6 responded to this question and three (33%) indicated they closed beds or units in the past six months due to shortage of psychiatric nurses. Of the facilities that had closed beds during the past six months, the urban facility reported closing beds one to two times. One rural facility indicated closing beds one to two times, one indicated three to five times, and one did not provide a number.

Estimate of the time needed to fill psychiatric nurse positions. Table 6 shows the number of months it takes on average to fill psychiatric nurse positions. Of the facilities responding, over half (ten of 15) urban facilities and half (four of eight) rural facilities required four or more months to fill a vacant position.

Table 6. Number of months to fill psychiatric nurse positions

Psychiatric nurses to hire	Urban (n=15)	Rural (n=8)
1-3 months	5	4
4-6 months	7	2
7+ months	3	2

Barriers to hiring psychiatric nurses. Proportionally more rural than urban facilities encountered barriers during the hiring process to employ psychiatric nurses (seven of nine [77.8%] vs. ten of 20 [50.0%]).

Participants were asked to indicate perceived barriers to hiring psychiatric nurses into a permanent nursing position (Table 7). The most commonly cited barriers are lack of applicants (n=14), salary and benefit package (n=9), applicant's lack of appropriate experience (n=10) and applicant's lack of appropriate specialization (n=9). Five of the 9 rural facilities cited geographic location as a barrier. Compared to urban facilities, fewer rural facilities cited salary and benefits as barriers.

Table 7. Facilities'(N=30) perceived barriers to hiring permanent psychiatric nurses

	Urban n=20	Rural n=9
Lack of applicants	10	4
Salary, benefits package	7	2
Applicants' lack of appropriate experience	6	4
Applicants' lack of appropriate specialization	4	5
Local/ regional competition for new hires	3	2
Geographic location	1	5
National competition for new hires	1	1

DISCUSSION

This survey targeted health-care facilities in Nebraska likely to employ PMH nurses (N=180), with most surveys sent to urban facilities. Over half of the rural facilities (29 of 57; 51%) responded, while less than half (52 of 123; 42.3%) of urban facilities responded. Only 21 (40.4%) of the 52 responding urban facilities and 9 (31%) of the 29 responding rural facilities employed PMH nurses and provided data to address the use and need of PMH RNs and LPNs. Among facilities reporting reasons for not employing PMH nurses, the most frequent reason was a lack of need for these nurses (six urban and 3 rural facilities). One urban and two rural facilities cited lack of funds.

Employment. Figure 1 and Table 2 show that both urban and rural facilities reported employing a comparable number of RNs and LPNs. Urban facilities employed 52 RNs (44 full-time and 8 part-time) while rural facilities employed 51 RNs (42 full-time and 9 part-time). This finding is in contrast to findings of the 2018 RN License Renewal Survey, which showed that the majority of Nebraska nurses, including PMH nurses, work in urban areas (Ramirez, 2018; Hoebelheinrick & Ramirez, 2019). Slightly more LPNs were employed by urban than rural facilities (12 vs. 6, respectively). This finding is consistent with findings from the 2017 LPN License Renewal Survey, which found that most LPNs work in urban areas (Ramirez, 2018). The License Renewal Surveys obtained employment data from individual RNs and LPNs, whereas our survey targeted facilities likely to employ PMH nurses. It is possible urban facilities that did not participate in the survey employ more PMH RNs than rural facilities that participated. In addition, we classified facilities as located in urban or rural areas based on the list of rural counties from the federal Office of Rural Health Policy (HRSA, 2018). Thus, more of the facilities providing data for this survey were classified as rural when compared to geographic classifications by the U.S. Census Bureau used in Hoebelheinrick and Ramirez (2019) and Ramirez (2018).

Both urban and rural facilities report employing fewer LPNs than RNs. When the combination of RNs and LPNs employment was analyzed by facility (Table 3), the most common staffing model was RNs only (n= 17; 59%). An LPN model was reported by 7 (24%), whereas the least reported staffing model was a combination of RNs and LPNs (n=5; 17%). The LPN only model was reported by out-patient clinics where

basic patient care activities (e.g., vital signs, medication administration) can be performed by LPNs under the supervision of the physician or advanced practice provider. This finding is congruent with data from the 2017 LPN License Renewal survey, which found that ambulatory care settings was the most frequent LPN work setting after long-term care (Ramirez, 2018). The types of duties expected of PMH nurses (Table 4) require more conceptual knowledge than technical skills, which may explain the prevalence of an RN only staffing model.

Expected duties. To better understand PMH nursing responsibilities in urban and rural facilities, participants indicated the types of duties expected of PMH nurses. Most duties listed in the Survey (Table 4) were selected by over half of urban and rural facilities. . Nonetheless, there were both similarities and differences between urban and rural facilities that may be areas for future study, including how these duties are performed under different staffing models (i.e., Table 3). Rural facilities selected educating patients and families less frequently than urban facilities, although reasons for this difference is not apparent. Given the importance of patient and family education in health-care, this finding is somewhat surprising. Possibly, facilities that did not select this duty had dedicated staff (e.g., therapists) to provide patient and family education. Relative to other duties selected, rural facilities chose pre-admission screening/assessments less often. Similarly, duties chosen less by urban facilities were administrative and pre-admission screening/assessments. The finding that pre-admission screening by PMH nurses was chosen by less by facilities relative to other duties suggests that these assessments may be performed by other behavioral health professionals in specific psychiatric emergency/assessment services or by psychiatric providers in their own clinics. Possibly, less emphasis on administrative duties by PMH nurses in urban facilities reflects a more complex organizational structure with formal nursing administrative positions.

Nurse Hiring & Recruitment. Responses to questions about hiring PMH nurses in the past six months, current recruitment, and anticipated hiring suggest an on-going need for both RNs and, to a lesser extent, LPNs. Facilities also reported current recruitment and anticipated future hiring of PMH nurses. Challenges in recruitment are reflected in facilities hiring contracted PMH nurses on a temporary basis. Two reasons for employing contracted nurses, lack of applicants and lack of qualified applicants, indicate an on-going shortage or need, especially for rural facilities.

Recruitment and hiring challenges may also affect maintaining adequate nurse staffing levels. Both urban and rural facilities perceived difficulties in maintaining desired staffing levels for PMH nurses, with rural facilities reporting more challenges. While only one urban facility reported the need to close beds in the last six months due to low PMH nurse staffing, three rural facilities reported closing beds.

Time required to fill nurse positions also portrays recruitment and hiring challenges experienced by both urban and rural facilities. Less than half of urban and rural facilities were able to fill their PMH nursing positions in three months. Most facilities that answered this question reported that the recruitment/hiring process took four or more months, suggesting an on-going need for PMH nurses in both urban and rural settings.

With regard to barriers to hiring permanent PMH nurses, both urban and rural facilities cited lack of applicants overall. Proportionately more urban facilities than rural facilities reported salary and benefits as barriers, whereas proportionately more rural facilities cited lack of appropriate specialization and geographic location as barriers. Possibly, limited psychiatric nursing content and clinical experiences in nursing curricula contributed to the lack of applicants or applicants with appropriate specialization for

PMH nursing positions. These differences also suggest that different recruitment, training, or continuing education strategies may be needed to reduce hiring and staffing barriers in urban and rural facilities. Strategies for recruitment and employment of PMH nurses by geographic location and type of facility may also be an area for future study.

Limitations. The small and select target sample prohibits generalization of the findings. We identified the number of facilities likely to employ PMH nurses in Nebraska, but we may not have identified all facilities. In addition, the low response rate, especially among urban facilities, may have resulted in an under-representation of the number of PMH nurses, their use and need. The small number of facilities providing data about PMH nurse use and need limited the statistical analysis to frequencies and percentages.

Nursing Workforce Implications. The Behavioral Health Education Center of Nebraska's (BHECN's) mission to recruit, train, and retain the behavioral health workforce in Nebraska plays an important role in developing the psychiatric nursing RN workforce. BHECN provides support for nursing student training at psychiatric hospitals and outpatient facilities in Nebraska, which facilitates students' psychiatric mental health clinical education. Based on this report, support to psychiatric hospitals and clinics not currently partnered with BHECN as a nursing training site may increase nursing students' psychiatric clinical experiences as well as recruitment of Nebraska nurses into the psychiatric mental health nursing specialty. As psychiatric services become integrated into primary care, clinics providing integrated care may host additional clinical training experiences that are complementary to experiences available in-patient and out-patient psychiatric settings. To meet an increased demand for integrated mental health care, Delaney (2016) advocates expanded roles for PMH RNs, which includes delivery of protocol-based care within stepped-care models, care coordination within the community, and engagement of patients and families in primary care. Exposure of nursing students to developing roles for PMH nurses may motivate graduates to pursue careers in PMH nursing (Phoenix, 2019). Consistent with recommendations to increase visibility of psychiatric nurses (Phoenix), BHECN has promoted student interest in psychiatric mental health nursing by including the specialty in informational brochures, supporting Psychiatric Nursing Interest Groups for nursing students, and supporting Psychiatric Nursing Workforce Summits.

To increase the number of qualified applicants to fill PMH nurse positions, Colleges and Schools of Nursing can increase the curricular content and clinical experiences in psychiatric mental health nursing so that graduates have the beginning knowledge and skills to assume an entry-level position as a PMH nurse. The development of academic-practice partnerships (Sebastian et al., 2018) between Colleges and Schools of Nursing and psychiatric clinical settings can improve both education and practice by aligning the nursing missions of education, scholarship, and service delivery. The integration of psychiatric services into primary care dovetails with the adoption of a concept-based, integrated curriculum model, currently popular in Colleges and Schools of Nursing. Integrated models support teaching important nursing concepts across nursing specialties. Students have opportunities to apply psychiatric mental health nursing concepts to several patient populations, and thus, experience applicability of psychiatric nursing in a number of practice settings. PMH nursing educators can address critical health-care issues and PMH skills through integrated curricula, such as substance misuse and motivational interviewing, to address the physical and mental health of patients and families. Nursing faculty who have graduate degrees in psychiatric mental health nursing are critical to the success of the integrated curricular models for the developing the psychiatric mental health nursing workforce (Rice, Stalling, Monasterio, 2019; Gail Stuart, personal communication, 09/12/2018).

Hospitals and clinics that hire PMH nurses can also recruit PMH nurses from experienced RNs who are willing to transition to psychiatric settings or provide new nurses with additional mentoring by experienced PMH nurses and additional specialty education. Continuing education programs addressing foundational PMH nursing knowledge and skills, such as the American Psychiatric Nurses Association's Transitions in Practice program (Adams, 2015), can facilitate recruitment, retention and job satisfaction of either new or experienced RNs who chose to work in inpatient psychiatric settings.

Summary:

This report provides information about Nebraska health-care facilities' employment, recruitment, hiring, and expected duties of PMH RNs and LPNs**.** Where feasible, we explored differences between urban and rural facilities for selected topics. A higher percentage of rural facilities than urban facilities completed surveys. Results indicated that participating urban and rural facilities employed a comparable number of RNs and LPNs. Overall, when compared to urban facilities, rural facilities experienced more difficulty recruiting PMH nurses and greater use of contracted nurses to fill open positions. Urban and rural facilities identified similar duties for PMH nurses in their setting. We explored Implications for workforce development based on the survey results.

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