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The Psychiatrist Shortage & Nurse Practitioners

The Elephant in the Room

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I have become increasingly concerned about the future for our younger colleagues, particularly those in training.

Psychiatrist shortages: Two years ago, Mark Komrad, MD, circulated a link to a Medscape summary article and download of the then just-released report *The Psychiatric Crisis: Causes and Solutions*, generated by a panel addressing the "severe shortage of psychiatrists and the dearth of mental health services in the United States." The report was released by the National Council Medical Director Institute, which advises the National Council for Behavioral Health.

It chided psychiatrists for failing to address the needs of underserved rural communities, for not being adequately available for referrals from primary care physicians, and for not accepting Medicaid and other insurance, etc. It cautioned that the average age of practicing psychiatrists was greater than that of other specialties, so that many psychiatrists might be expected to soon retire, and estimated a current shortage of 2,800 psychiatrists in the U.S. with the deficit likely to grow to 6,090 by 2025. The report did note that psychiatrists were burning out, often did not have ancillary staff to help, and were burdened with EMRs taking time away from interacting adequately with patients.

Solutions offered included: 1) encouraging the deployment of collaborative care and telepsychiatry, 2) shifting from fee-for-service models to bundled payments, 3) "cutting red tape" (eg, reducing documentation and conducting shorter psychiatric evaluations), 4) employing "measurement-based care" and "open access" scheduling, and 5) expanding the use of other mental health practitioners. There were 13,815 psychiatric clinical nurse practitioners then, projected to number 17,900 in 2025. Psychiatric physician assistants (then 1033; expected to increase but no projections offered) would help, as would board-certified psychiatric pharmacists (then 955, projected to exceed 2,400 in 2025). Prescribing psychologists would also increase in numbers, but no projections were offered.

Some of the proposed remedies struck me as reasonable, some were quite disturbing, but what I would like to address in more detail were the recommendations for expansion of the use of non-physicians. This proposal did not receive any formal objection from our professional psychiatric associations.

It is true that some areas lack psychiatrists—typically, rural areas where other health professionals are also absent. It is true that there is a particular shortage of child psychiatrists. Complicating the projections, primary care physicians, including pediatricians, prescribe most psychotropic medications in our system.

I do not doubt that there are shortages of psychiatrists for the present and near-term. The growth and aging of our population, the epidemic of addictive disorders and hopeful expansion of insurance coverage, would argue for concern regarding adequate access

to psychiatric care. There is also apprehension about psychiatrists potentially retiring earlier. This is understandable, given increasing burdens of annoying electronic medical records, frustrating and demeaning experiences with prior authorization, very short inpatient stays commonly leading to patients being discharged receiving large dosages of multiple medications and questionable diagnoses, and patients shifting from one insurance plan to another, and often from one psychiatrist to another, with less opportunity to develop continuing therapeutic relationships. There are reasons why psychiatrists, like other physicians, are suffering very high rates of burnout. However, the number of psychiatry residents is increasing, and telepsychiatry and collaborative care are now being employed more often to improve access.

But there is a much larger issue: the rapidly increasing number of psychiatric nurse practitioners being trained, each of whom may be paid perhaps 2/3 of a psychiatrist's salary. Those organizations hiring "prescribers" are likely to find this idea attractive. There are also licensed PAs, but such individuals choose to practice in the mental health field less frequently. (However, the 2019 update to the AAMC report referenced below predicts that if current trends continue, the number of licensed PAs will also more than double by 2032.)

The relatively rapid growth in numbers of NPs: The American Association of Nurse Practitioners website reported that as of January 2019 there were more than 270,000 nurse practitioners licensed in the US, with more than 26,000 completing their academic programs in 2016-2017. Of these, 95.7% prescribe medications, and in 2018, the mean full-time base salary for NPs was just $105,903.

Initial laws granting limited practice under a physician's supervision were just the proverbial "camel's nose getting into the tent." These were rapidly supplanted by NPs being granted unsupervised, independent practice status. National standards for nurse practitioner training programs are lacking, and their training is certainly several years less than that of our psychiatry residents.

Current workforce projections for the next 13 years: The 2019 update of the American Association of Medical Colleges report "The Complexities of Physician Supply and Demand: Projections from 2017 to 2032" projected that by 2032, there will still be physician shortages. If current trends continue, the number of NPs, however, will nearly double by 2032 (from the 248,000 that were estimated to be licensed in 2018). An increasing number of NPs are practicing in the mental health field. This report suggested that there was an estimated shortage of 5,906 psychiatrists in 2017, shrinking to 3,400 in 2032. This report's modeling approach and data sources are also used by the federal government (which, moreover, also contracts with the same independent consultants who produced it). The National Center for Workforce Analysis report "Projecting the Supply of Non-Primary Care Specialty and Subspecialty Clinicians: 2010-2025" (US Department of Health and Human Services Health Resources and Services Administration) noted that the supply of physician FTEs in all non-primary care is expected to grow by 21% between 2010 and 2025, while the supply of non-primary care Advanced Practice Nurses is expected to grow by **141%**. The FTE supply of psychiatrists was predicted to grow by **5%** during this period (44,200 to 46,500), while the FTE supply of psychiatry APNs was predicted to grow by **156%** (from 7,000 to 17,900).

Do the Math. Even if these projections are accurate for the next 13 years, that is not long enough to guide our junior colleagues: Our trainees give up significant years of their lives working intensely in college, medical school and residency, while often incurring substantial debts. They should be looking at a career that will be economically and professionally viable for 35 or 40 years in return. This time frame is much longer than the usual workforce projections I have found. Psychiatrists are experiencing burnout at disturbing percentages—though not much differently than other physicians—but financial pressures may lead them to continue working in their field for longer hours for less pay, for even more years. If current trends continue, this alone would reduce employment opportunities for psychiatrists, as well as drive down psychiatrist salaries in the face of the less-expensive NPs. Business values primarily consider cost, and economic return.

We should do something. We need to pay attention to this issue. I don't find significant dialogue or guidance regarding it. We certainly observe that many of our members work alongside of, or themselves employ, NPs. We applaud when more residency training programs open up and when more medical school graduates are choosing psychiatry. (It's also applauded by the clinical services where they serve, as residents work longer hours and are even cheaper labor than NPs).

I don't hear adequate realistic discussion about what our junior colleagues can really expect in their professional lives. We talk about burnout, but we are not adequately addressing core issues that fuel it. A root-cause analysis of burnout will highlight increasingly burdensome pressures on our colleagues, as well as our de-professionalization.

Most urgently, be considerate to our younger colleagues: If we really believe that NPs perform equivalently to psychiatrists, then this should be openly acknowledged. Have medical school and psychiatric residency training replaced by nurse practitioner schools and nurse practitioner post-graduate clinical training. Counsel our colleagues to choose the simpler, more viable path.

If we believe otherwise, we certainly are not arguing effectively.

Our younger colleagues should expect us to openly recognize and address this issue. They should not expect less of us.