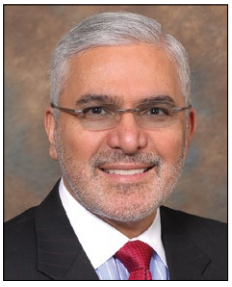
The psychiatry workforce pool is shrinking. What are we doing about it?

Peter F. Buckley, MD



Henry A. Nasrallah, MD

Are shrinks shrinking? Two recent reports about the apparent failure of succession planning and workforce development in psychiatry are provocative and worrisome.

The dilemma of a diminishing workforce pool might seem more the province of medical school deans, psychiatry department chairs, and psychiatry residency training directors, but our ability to recruit and retain psychiatrists is, in reality, everyone's concern—including hospitals, clinics, and, especially, patients and their families. Even without knowledge of the specialty or any numerical appraisal, for example, it is common knowledge that we have a dire shortage of child and adolescent and geriatric psychiatrists—a topic of widespread interest and great consequence for access to mental health care.

Tracking a decline

The very title of a recent provocative paper[1] in *Health Affairs* says it all: "Population of US practicing psychiatrists declined 2003-13, which may help explain poor access to mental health care." In an elegant analysis, the authors expose (1) a 10% decline in the number of psychiatrists for every 100,000 people and (2) wide regional variability in the availability of psychiatrists. In stark contrast, the number of neurologists increased by >15% and the primary care workforce remained stable, with a 1.3% increase in the number of physicians, over the same 10 years.

At the beginning of the psychiatry workforce pipeline, the number of medical students who choose psychiatry remains both small (typically, slightly more than 4% of graduating students) and remarkably stable over time. Wilbanks et al,[2] in a thoughtful analysis of the 2011 to 2013 Medical School Graduation Questionnaire of the Association of American Medical Colleges, affirm and, in part, explain this consistent pattern. They note that the 4 most important considerations among students who select psychiatry are:

- personality fit
- specialty content
- work–life balance
- role model influences.

Some of these considerations also overlap with those of students in other specialties; the authors also note that older medical students and women are more likely to choose psychiatry.

continued

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Here is what we must do to erase the shortage

It does appear that, despite scientific advances in brain and behavior, expanding therapeutic options, and unique patient interactions that, taken together, should make a career in psychiatry exciting and appealing, there are simply not enough of us to meet the population's mental health needs. This is a serious problem. It is our professional obligation—all of us—that we take on this shortage and develop solutions to it.

At its zenith, only about 7% of medical students chose psychiatry. We need to proactively prime the pump for our specialty by encouraging more observerships and promoting mental health careers through community outreach to high school students.

We must be diligent and effective mentors to medical students; mentorship is a powerful catalyst for career decision-making.

We need to make psychiatry clerkships exciting, to show off the best of what our specialty has to offer, and to cultivate sustained interest among our students in the brain and its psychiatric disorders.

We need to highlight the momentous advances in knowledge, biology, and treatments that now characterize our psychiatric profession. We need to advocate for more of these accomplishments.

We must be public stigma-busters! (Our patients need us to do this, too.)

And there is more to do:

Collaborate. In delivering psychiatric health care, we need to expand our effectiveness to achieve more collaboration, greater extension of effect, and broader outreach. Collaborative care has come of age as a delivery model; it should be embraced more broadly. We need to continue our efforts to bridge the many sister mental health disciplines—psychology, nursing, social work, counseling—that collectively provide mental health care.

Unite. Given the inadequate workforce numbers and enormous need, we will diminish ourselves by "guild infighting" and, consequently, weaken our legislative advocacy and leverage. We need to embrace and support all medical specialties and have them support us as well. We need to grow closer to primary care and support this specialty as the true front line of mental health. We also need to bridge the gap between addiction medicine and psychiatry, especially given the high level of addiction comorbidity in many psychiatric disorders.

Foster innovation. The deficit of psychiatric workers might be buffered by innovations in how we leverage our expertise. Telepsychiatry, for example, is clearly advancing, and brings psychiatry to remote areas where psychiatrists are scarce. Mobile health also has great potential for mental health. As one of us (H.A.N.) highlighted recently,[3] as genetics become more molecular, what has been the *potential* of clinically applicable pharmacogenomics might become *reality*. Psychiatry needs to make progress toward personalized medicine because the disorders we treat are extremely heterogeneous in their etiology, phenomenology, treatment response, and outcomes.

The appeal of working with mind and brain

The extent to which we can convey unfettered optimism about the role of psychiatry in medicine and the relentless progress in neurobiological research, together, will go a long way toward attracting the best and brightest newly minted physicians to our specialty.

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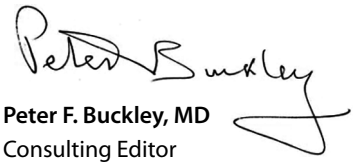
The brain is the last frontier in medicine; psychiatry is intimately tethered to its unfolding complexity. With millennials placing a higher premium on work–life issues, the enviable balance and quality of life of a psychiatric career might now be particularly opportune, enhancing the quantity and quality of professionals that we can attract to psychiatry.



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We have a dire shortage of child and adolescent and geriatric psychiatrists—a problem of great consequence for access to mental health care