MERRITT HAWKINS
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White Paper Series

Examining topics affecting the recruitment and retention of physicians and advanced practice professionals

The Silent Shortage

A White Paper Examining Supply, Demand and Recruitment Trends in Psychiatry

A resource provided by Merritt Hawkins, the nation's leading physician search and consulting firm and a company of AMN Healthcare (NYSE: AMN), the largest healthcare workforce solutions company in the United States.

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Introduction

Merritt Hawkins, the nation's leading physician search and consulting firm, produces a series of surveys, white papers, speaking presentations and other resources intended to provide insight into physician recruiting, physician supply and demand, physician compensation trends and a range of related topics.

In addition to its own research and analysis, Merritt Hawkins is contracted by third parties to conduct various research projects. Third parties that Merritt Hawkins has partnered with on such initiatives include **The Physicians Foundation, the American Academy of Physician Assistants, the North Texas Regional Extension Center/Office of the National Coordinator for Health Information Technology, the Society for Vascular Surgery, the Maryland State Medical Society, Trinity University, the Indian Health Service, the American Academy of Surgical Administrators, and the Association of Managers of Gynecology and Obstetrics.** Merritt Hawkins also has submitted oral and written expert testimony to **Subcommittees of the Congress of the United States.**

IMPACT OF COVID-19

This white paper examines supply, demand, and recruiting trends in the specialty of psychiatry, **which have been significantly affected degree by the COVID-19 pandemic.** The U.S. Congress acknowledged this fact when it included $425 million for mental health care in the $2 trillion stimulus package meant to address the fallout of Covid-19, and another $50 million for suicide prevention. Signs of mental distress as a result of the pandemic have increased, according to an April 10, 2020 article in the *Wall Street Journal,* which stated, "ComPsych Corp., a Chicago-based provider of employee-assistance programs covering more than 118 million individuals, said it saw a 30% increase in calls related to suicide, domestic violence and other severe mental-health issues."

An April, 2020 survey by the Kaiser Family Foundation found that almost half of all U.S. adults (45%) said the pandemic had affected their mental health, while 19% said it had had a "major impact." (*The Impact of Coronavirus on Life in America. Kaiser Family Foundation. April, 2020*).

Prescriptions for anti-anxiety drugs spiked 34% between February 16 and March 15, and also increased for antidepressants (18.6%) and anti-insomnia drugs (14.8%), according to a report from Express Scripts (*America's State of Mind: U.S. Trends in Medication Use For Depression, Anxiety & Insomnia*). Companies like Ginger and TalkSpace that deliver virtual mental health care have seen a massive surge in

demand for services during the pandemic, with increases of 50% to 65% in February and March, 2020 (*Open Minds/Strategy and Innovation Institute. April 23, 2020*).

There were 45,799 suicides in the U.S. in 2020, up from 42,773 in 2014, and suicide was the 12th leading cause of death, according to the CDC. The suicide rate increased by 30% from 2000 to 2020, the CDC reports.

A Lack of Emphasis

The shortage of physicians in the United States has been well documented, with a variety of organizations, including the American Medical Association (AMA), the Health Resources and Services Administration (HRSA), the Association of American Medical Colleges AAMC), and multiple state medical and specialty societies projecting a doctor deficit.

In June, 2021, the AAMC projected a shortage of up to 124,000 physicians by 2034. The AAMC report emphasized that while primary care doctors will be in short supply, the steepest deficits may be among specialist physicians who care for the elderly, including psychiatrists. The report projected a shortage of up to 48,000 primary care physicians by 2034 but an even larger shortage of 78,000 specialists.

The reference in the AAMC physician shortage projections to psychiatrists is welcome because psychiatry often has been overlooked in physician supply discussions.

The lack of emphasis given to the psychiatry shortage is partially rooted in pervasive stigmas about mental illness in the United States. Those suffering from depression and other forms of mental illness frequently are reluctant to discuss their problems, and are often reluctant to seek treatment. While the symptoms of those with heart, lung, orthopedic or other physiological problems typically are readily apparent, the symptoms of those with psychological problems often are not.

In addition, mental illnesses generally cannot be addressed through medical procedures, but only made manageable through long-term treatment with drugs and/or therapy. Hospitals and clinics tend to be procedure oriented, a "cleaner" form of medicine where the appropriate surgery/intervention is performed and the next patient is addressed.

Historically, if government and other payers pay well for a procedure, particular attention is given to that procedure. Cardiology procedures and orthopedic surgery procedures usually fall into this highly desirable

"profit center" category. Psychiatry, by contrast, is not a profit center for most hospitals (psychiatric services are not covered by some insurance companies) so such services sometimes are not given a high priority.

As a general rule, mental health problems in the United States, their causes, cures and those who suffer from them, tend to be swept under the carpet.

For these reasons, Merritt Hawkins refers to the dearth of psychiatrists as the "silent shortage."

Prior to examining supply and demand trends in the specialty, below is a brief history of psychiatry as a medical specialty in the U.S. and the current scope of services provided by psychiatrists.

History and Scope of Psychiatry

A psychiatrist is defined by the American Psychiatric Association (APA) as a medical doctor who specializes in the diagnosis, treatment, and prevention of mental health illness, including substance use disorders. A psychiatrist has earned a medical degree (either M.D. or D.O.) in addition to completing a four-year residency program in psychiatry and additional specialized fellowship training as applicable. They are board certified by the American Board of Psychiatry and Neurology and must be re-certified by written and oral examination every 10 years.

Psychiatry and inquisition into the human mind has a long-established history in the United States. According to the APA, in 1812 Benjamin Rush, M.D., considered the Father of American Psychiatry, published the first psychiatric textbook in the U.S., called Inquiries and Observations on Diseases of the Mind. In 1844, superintendents from the existing 24 mental hospitals met and established the Association of Medical Superintendents of American Institutions for the Insane, considered the precursor association to the APA. Throughout the 19th century, significant work was done to reorient the management and placement of mentally ill patients, emphasizing the movement of "insane" individuals from incarceration and inhumane treatment through the creation of state mental hospitals.

The American Psychiatric Association received its modern name in 1921. The time following saw great advancements for psychiatry in the United States. Somatic therapy methods were introduced into psychiatry in the 1930s, including the use of insulin, metrazol, and electro-convulsive therapy. In 1946, Congress passed the National Mental Health Act, establishing the National Institute for Mental Health and providing federal funds for mental disorder research, training for professionals, and community services for the first time. In 1955, psychoactive drugs were introduced in the United States, with widespread implementation leading to increased discharges from state mental hospitals (a reduction from 560,000 hospital beds and 315 public mental hospitals to 53,000 beds and 230 hospitals over the past half-century). As the APA has moved into the 21st century, continued evaluations on proper treatment protocols, implementation of research, and overall organization have remained a top priority.

Source: "APA History", American Psychiatric Association

Psychiatrists today work in a wide range of specialties and practice settings. Specialties for which certification is granted include:

- Child and adolescent psychiatry
- Geriatric psychiatry
- Forensic (legal) psychiatry
- Addiction psychiatry
- Pain medicine
- Psychosomatic (mind and body) medicine
- Psych/Family Medicine
- Pediatrics/Psychiatry
- Psychiatry/Neurology

Practice settings are wide-ranging for psychiatrists, including community health centers, clinics, private practices, general and psychiatric hospitals, prisons, government and military settings, university medical centers and other settings. About 50% of psychiatrists in the United States work in private practice.

A Growing Demand and Focus

The shortage of psychiatrists in the United States is driven in part by a growing need for psychiatric services. Consider:

- One in every five adults in America experiences some form of a mental illness
- Nearly one in 20 adults in America (13.6 million) live with a serious mental illness
- 60% of adults with a mental illness received no mental health services in the previous year
- Suicide is the 3rd leading cause of death in youths ages 10-24.
- The average delay between onset of mental health symptoms and intervention is 8-10 years
- Over $193 billion dollars in lost earnings a year result from serious mental illness mental illness.
- 24% of state prisoners have “a recent history of a mental health condition”

Source: National Alliance on Mental Illness (NAMI; www.nami.org)

In March, 2017, the National Council of Behavioral Health (NCBH) released a report compiled by a 27-member panel of experts drawn from providers, payers, government agencies and psychiatric associations. The report indicates there is a national shortage of psychiatrists that is about to spiral out of control, with 77% of U.S. counties reporting a severe psychiatrist shortage.

Joseph Parks, MD, medical director of the NCBH, was quoted as follows:

> *"Two-thirds of primary care physicians report that they have trouble getting psychiatrist services for their patients. So, they go to the emergency rooms. There has been a 42% increase in the number of patients going to the emergency room for psychiatric services in the past three years, but most of them are not staffed with psychiatrists. They try to get into an inpatient bed, but hospitals have been closing their psychiatric units because they can't find psychiatrists to hire and staff to run them. It is truly becoming a crisis." (HealthLeaders, March 30, 2017).*

In June, 2016 it was reported that for the first time the largest share of healthcare spending in the U.S. is on mental health disorders. An estimated $201 billion dollars was spent on mental disorders in the U.S. in 2013, the most recent year data is available, followed by heart disease, trauma, cancer and pulmonary conditions *(HealthLeaders, June 14, 2016*).

Approximately one in five adults in the U.S (43.8 million people, or 18.5% of the population) experience mental illness in a given year, with only 41% receiving mental health services. Among adults with a serious mental illnesses, just 62.9% received health services in the past year, according to the National Alliance on Mental Illness, while nearly one in 20 adults in America -- or 13.6 million people -- live with a serious mental illness. The mental health challenges facing the VA system have been widely noted as they struggle to cope with high incidences of post-traumatic stress syndrome and high suicide rates among veterans.

The **alarmingly high suicide rate among U.S. military veterans** has placed additional focus on the need for additional psychiatric services. According to the Veterans' Administration, "risk for suicide was 22 percent higher among Veterans when compared to U.S. non-Veteran adults. After adjusting for differences in age, risk for suicide was 19 percent higher among male Veterans when compared to U.S. non-Veteran adult men. After adjusting for differences in age, risk for suicide was 2.5 times higher among female Veterans when compared to U.S. non-Veteran adult women. The current analysis indicates that in 2014, an average of 20 Veterans a day died from suicide." *(U.S. Department of Veterans Affairs. VA Conducts Nation's Largest Analysis of Veteran Suicide. Press Release. July 7, 2016).*

Suicide rates are not just rising among veterans, however. According to the CDC, the suicide rate nationally has increased by approximately 33% since 1999. Suicide is particularly prevalent in rural counties, where the rate is 35% higher than in urban counties, the CDC reports.

Also putting need for psychiatric services in the national spotlight are **ongoing mass shootings** perpetrated by assailants with mental health challenges and disorders.

Problems Surface in the ED

In March of 2017, the Agency for Healthcare Research and Quality (AHRQ), a branch of the Department of Health and Human Services (HHS) released a statistical brief likely to cause consternation among providers of behavioral health services.

According to the brief, emergency department visits by adults with suicidal thoughts more than doubled from 2006 to 2013. On average, these visits rose by 12% each year over the seven year period.

By 2013, 1% of all adult ED visits were related to suicidal thoughts, up from 0.4% in 2013. In 2013, over 71% of ED visits linked to suicidal thoughts resulted in a hospital admission, compared to 19% of all other types of ED visits. The average length of stay for suicidal patients increased from 5.1 days to 5.6 days. The cost of these visits and subsequent hospitalizations rose from $600 million in 2006 to $2.2 billion in 2013.

The following comments are taken from a report completed by the National Council Medical Director Institute, an organization of mental health and drug addiction providers:

> *"In hospital EDs, lack of access to psychiatric services stands out among all other medical diagnoses, averaging up to 23 hours for some dispositions. The resulting extended waits have impacts on the full scope of care in the ED that, at times, can reduce access in the ED for more acute medical presentations and lead to poorer outcomes for psychiatric patients.*
>
> *The shrinking number of inpatient psychiatric services has become a significant obstacle to improved access. Beds have been eliminated due to lower rates of reimbursement compared to other medicalsurgical procedures and due to difficulty recruiting psychiatrists to staff the inpatient units.*
>
> *The pool of psychiatrists working with public sector and insured populations declined by 10 percent from 2003-2013. Aging of the current workforce, low rates of reimbursement, burnout, burdensome documentation requirements and restrictive regulations around sharing clinical information necessary to coordinate care are some of the reasons for the shrinkage."*
>
> *Source: The Psychiatric Shortage: Causes and Solutions. National Council Medical Director Institute. March 28, 2017*

Rising Rates of Recruitment

Merritt Hawkins, the largest physician search firm in the U.S., has seen demand for psychiatrists increase significantly among its clients over the last decade.

In the 12-month period between April 1, 2021 and March 31, 2022, psychiatry was Merritt Hawkins' third most requested type of physician search engagement (not including advanced practitioners such as NPs), trailing only family medicine and radiology on the list of most in-demand physician specialties *(see Merritt Hawkins 2021 Review of Physician and Advanced Practitioner Recruiting Incentives).* This was the seventh consecutive

year that psychiatry has occupied the one of the top three spots on the list. In 2017, psychiatry ranked 9th among Merritt Hawkins' most requested searches (see below):

Merritt Hawkins Top Ten Most Requested Physicians by Specialty

2022	2007
Family Medicine	Family Medicine
Radiology	Internal Medicine
Psychiatry	Hospitalist
OBGYN	Radiology
Internal Medicine	Orthopedic Surgery
Anesthesiology	Cardiology
Cardiology	General Surgery
Gastroenterology	Emergency Medicine
Hematology/Oncology	**Psychiatry**
Hospitalist	Gastroenterology

Recruiting psychiatrists, particularly into inpatient psychiatric service settings, is extremely difficult and is considered by Merritt Hawkins to be one of the most difficult, if not the most difficult, physician search assignments in the market today.

Salary Offers Increasing

The growing demand for psychiatrists is reflected in the average salaries being offered to recruit them. The chart below shows average salary offers made to psychiatrists over the last several years as tracked by Merritt Hawkins' 2022 Review of Physician and Advanced Practitioner Recruiting Incentives, with average starting salaries for psychiatrists increasing 7% year-over-year

Average Salary Offers/Psychiatry

2022	**$299,999**
2021	$279,000
2020	$276,000
2019	$273,000
2018	$261,000
2017	$263,000
2016	$250,000
2015	$226,000
2014	$217,000

Source: Merritt Hawkins 2022 Review of Physicians and Advanced Practitioner Recruiting Incentives.

The chart below shows average compensation for psychiatrists as tracked by a variety of different sources. These numbers show total compensation for psychiatrists rather than the starting salary numbers tracked by Merritt Hawkins.

Total Compensation/Psychiatry

American Medical Group Association	$299,250
Sullivan Cotter	$292,297
Merritt Hawkins	$299,000
MGMA	$277,808
ECG Management	$258,527

Uneven Distribution

There are currently approximately 33,000 general psychiatrists in active practice in the U.S., excluding specialists such as those in child and adolescent and other specialty areas. A distribution of these general psychiatrists by state can be seen below, with the top 5 most populous states of California, New York, Texas, Pennsylvania and Florida comprising 41% of all psychiatrists and 37% of the general population.

State	Number of Psychiatrist	Percentage of Psychiatrist	Percentage of U.S. Population
California	4,535	14.9%	12.1%
New York	3,342	11.0%	6.1%
Texas	1,644	5.4%	8.7%
Florida	1,517	5.0%	6.4%
Massachusetts	1,399	4.6%	2.1%
Pennsylvania	1,362	4.5%	3.9%
Illinois	1,151	3.8%	3.9%
New Jersey	1,021	3.4%	2.8%
Ohio	902	3.0%	3.6%
North Carolina	874	2.9%	3.2%
Maryland	864	2.8%	1.9%
Virginia	797	2.6%	2.6%
Michigan	792	2.6%	3.1%
Georgia	725	2.4%	3.2%
Connecticut	606	2.0%	1.1%
Washington	584	1.9%	2.3%
Arizona	553	1.8%	2.2%
Missouri	478	1.6%	1.9%
Colorado	465	1.5%	1.7%
Minnesota	456	1.5%	1.7%

Tennessee	451	1.5%	2.1%
Wisconsin	428	1.4%	1.8%
Oregon	406	1.3%	1.3%
Indiana	354	1.2%	2.0%
South Carolina	350	1.1%	1.5%
Louisiana	348	1.1%	1.4%
Kentucky	287	0.9%	1.4%
Alabama	279	0.9%	1.5%
Oklahoma	269	0.9%	1.2%
Kansas	220	0.7%	0.9%
Washington, D.C.	198	0.7%	0.2%
New Mexico	191	0.6%	0.6%
Arkansas	188	0.6%	0.9%
Rhode Island	181	0.6%	0.3%
Utah	178	0.6%	1.0%
Iowa	176	0.6%	1.0%
Maine	173	0.6%	0.4%
Nevada	171	0.6%	0.9%
Hawaii	162	0.5%	0.4%
New Hampshire	153	0.5%	0.4%
Mississippi	145	0.5%	0.9%
West Virginia	120	0.4%	0.6%
Nebraska	114	0.4%	0.6%
Vermont	105	0.3%	0.2%
Idaho	70	0.2%	0.5%
Delaware	70	0.2%	0.3%
Montana	69	0.2%	0.3%
Alaska	66	0.2%	0.2%
South Dakota	57	0.2%	0.3%
North Dakota	57	0.2%	0.2%
Wyoming	32	0.1%	0.2%

Distribution of psychiatrists can also be displayed on a per capita basis. The average nationwide is 9.35 psychiatrists per 100,000 people. A breakdown by state is below:

State	Psychiatrists/100,000
Washington, D.C.	28.53
Massachusetts	20.39
Rhode Island	17.08
Connecticut	16.89

New York	16.84
Vermont	16.84
Maryland	14.28
Maine	12.95
California	11.47
New Hampshire	11.39
Hawaii	11.35
New Jersey	11.34
Pennsylvania	10.64
Oregon	9.80
Virginia	9.41
New Mexico	9.15
Illinois	8.99
Alaska	8.92
North Carolina	8.51
Colorado	8.29
Minnesota	8.18
Michigan	7.95
Washington	7.89
Arizona	7.88
Missouri	7.82
Ohio	7.74
Kansas	7.55
North Dakota	7.55

Louisiana	7.43
Wisconsin	7.39
Delaware	7.28
Florida	7.23
South Carolina	6.97
Georgia	6.95
Oklahoma	6.84
Tennessee	6.72
West Virginia	6.61
Montana	6.57
South Dakota	6.55
Kentucky	6.44
Arkansas	6.26
Nebraska	5.94
Utah	5.74
Alabama	5.72
Nevada	5.70
Iowa	5.59
Wyoming	5.52
Indiana	5.31
Mississippi	4.86
Idaho	4.08
National Average	**9.35**

Source: AMA Master File/MMS

As these numbers demonstrate, psychiatrists are not evenly distributed throughout the country, with considerably more psychiatrists concentrated in the Northeast -- historically the location of the preponderance of physician training programs.

Psychiatrists Needed Per 100,000 Population

According to the late Richard "Buz" Cooper, M.D. of the University of Pennsylvania, a noted national authority on physician supply, distribution and utilization, a population of 100,000 can support 14.7 psychiatrists, or one for every 6,800 people (this is a national average and may vary based on the economic, demographic and healthcare considerations of local areas). As the numbers above indicate, all but six states fall below this average.

Shortage Areas for Mental Health

The United States is currently facing a mental illness coverage crisis, one in which a large percentage of the population is suffering from mental illness, and current resources available drastically underserve those in need. As indicated by the National Alliance on Mental Illness (NAMI), nearly 44 million adults experience mental illness in a year, with 60% of those adults receiving no mental health services in the previous year. In addition, 50% of youths ages 8-15 with a mental illness received no health services in the previous year. This lack of treatment leads to real consequences, including lost income/production, unemployment, homelessness, and harmful behaviors that can lead to suicide.

There are currently 3,968 mental health care health professional shortage areas in the U.S., and more than 50% of the country does not have the necessary amount of practitioners to meet the needs of their area. Below is a list of all 50 states showing the percent of mental health care need that is met per state. The list was compiled by the Kaiser Family Foundation. The percent of need met is computed by dividing the number of psychiatrists available to serve the population of the area, group, or facility by the number of psychiatrists that would be necessary to eliminate the mental health HPSA (based on a ratio of 30,000 to 1 psychiatrist or 20,000 to 1 where high needs are indicated).

Percent of Mental Health Need Met Per State

Location	Total Mental Healthcare HPSA Designations	Percent of Need Met	Practitioners Needed to Remove HPSA Designation
Alabama	51	45.6%	83
Alaska	63	22.7%	8
Arizona	95	24.1%	204
Arkansas	43	63.3%	33
California	339	43.9%	167
Colorado	62	76.5%	23
Connecticut	28	32.0%	63
Delaware	10	25.6%	6
District of Columbia	9	59.8%	3
Florida	143	49.8%	83
Georgia	91	42.3%	123

Hawaii	27	64.0%	4
Idaho	36	58.0%	24
Illinois	123	69.5%	71
Indiana	53	43.4%	106
Iowa	67	60.8%	30
Kansas	63	56.5%	17
Kentucky	90	72.0%	34
Louisiana	109	41.6%	83
Maine	51	35.8%	8
Maryland	49	66.3%	32
Massachusetts	57	55.0%	19
Michigan	191	41.4%	73
Minnesota	59	61.4%	30
Mississippi	41	77.8%	59
Missouri	83	69.1%	89
Montana	69	25.5%	21
Nebraska	75	76.3%	9
Nevada	31	59.2%	44
New Hampshire	19	94.9%	1
New Jersey	31	71.9%	4
New Mexico	63	29.5%	45
New York	147	43.1%	120
North Carolina	88	52.2%	25
North Dakota	50	83.1%	9
Ohio	97	56.6%	59
Oklahoma	108	25.2%	64
Oregon	75	50.5%	44
Pennsylvania	116	61.9%	37
Rhode Island	10	100.0%	0
South Carolina	46	55.0%	40
South Dakota	49	15.2%	22
Tennessee	63	38.6%	88
Texas	333	46.8%	193
Utah	37	62.9%	47
Vermont	23	NSD	NSD
Virginia	50	61.0%	35
Washington	112	40.4%	71
West Virginia	83	66.1%	22
Wisconsin	103	20.8%	212
Wyoming	16	73.9%	6

Source: Henry J. Kaiser Family Foundation

As these numbers indicate, only half of all states have met 50% or more of their mental health care need, while some states have not met even a quarter of their need. Merritt Hawkins reported in its study The

Physician Workforce in Texas, conducted on behalf of the North Texas Regional Extension Center, that 185 counties in Texas have no general psychiatrist.

The March, 2017 report by the National Council Medical Director Institute referenced above indicates the following:

Moreover, the (psychiatric) workforce is unevenly distributed geographically across the country. Seventy-seven percent of counties are underserved and 55 percent of states have a "serious shortage" of child and adolescent psychiatry. Even in urban and suburban geographic areas with adequate ratios of psychiatrists, the supply of psychiatrists who work in inpatient and outpatient psychiatric facilities has been reduced by psychiatrists who practice exclusively in cash-only private practices. These practitioners now make up 40 percent of the workforce, the second highest among medical specialties after dermatologists.

Source: The Psychiatric Shortage: Causes and Solutions. National Council Medical Director Institute. March 28, 2017

Aging Outlook/Limited New Supply

Psychiatrists are on average among the oldest types of physicians in the U.S. Of the approximately 31,000 active psychiatrists, 59% are 55 years of age or older, placing psychiatrists third on the list of the oldest types of physicians (see below).

Percent of Physicians 55 and Older

Specialty	Percentage
Pulmonology	73%
Oncology	66%
Psychiatry	59%
Cardiology	54%
Orthopedic Surgery	52%
Neurology	50%
General Surgery	48%
Ophthalmology	48%
Urology	48%
Radiology	47%
Gastroenterology	45%
Neurological Surgery	45%
Otolaryngology	45%
Anesthesiology	44%
Dermatology	43%
Hematology/Oncology	41%
Internal Medicine	40%
Vascular Surgery	40%
Family Practice	38%
Obstetrics/Gynecology	38%
Pediatrics	38%
Emergency Medicine	34%
Nephrology	34%

Source: AMA Physician Master File

Given the large percentage of psychiatrists over the age of 55, it can be anticipated that many psychiatrists will retire in the near future.

Addressing the Challenge

Although the Affordable Care Act (ACA) included provisions to increase mental health coverage, the current results are mixed. In 2008, the Obama administration passed the Mental Health Parity and Addiction Equity Act of 2008, requiring insurance companies to offer the same amount of coverage for mental health/substance abuse disorders as medical procedures. Under this law, insurance plans must cover 10 Essential Health Benefits, including mental health disorders. However, the specific services covered by each category are not specified, and may vary largely from state to state (See Obamacare Hasn't Propelled Mental Health Treatment, US News, October 2014). In addition, the fate of the ACA under the Trump administration currently is in doubt.

Some states, such as Texas, Wisconsin and Alaska, have programs in place that financially reward psychiatrists for practicing in underserved areas. Through two new medical schools, Wisconsin is adding ten new psychiatry residents positions by 2017. In February, 2015, Wisconsin initiated the Child Psychiatrist Consultation Program in which child psychiatrists are on-call through phone or email to consult with primary care physicians.

In addition, Illinois, New Mexico and Louisiana are the first states to pass laws allowing psychologists to prescribe pharmacological drugs (in at least the case of Illinois, they can only do so in cooperation with a physician). In addition, mental health and psychiatric nurse practitioners and physicians assistants also may take on more of the mental health workload. The increased use of telemedicine also shows promise as a way to deliver mental health services to high-need areas.

Recruiting Conditions and Recommendations

Recruiting psychiatrists today is extremely challenging due to the large number of openings. Job openings for psychiatrists have been pervasive for years, but the recruiting picture has been complicated recently by the growing number of telepsychiatry practice opportunities that are being offered.

Prior to the COVID-19 pandemic, telepsychiatry opportunities were available to psychiatrists but the level of compensation was significantly lower than what they would typically be offered in an on-site setting. At that time, some psychiatrists were happy to take a pay cut if they were offered the opportunity to work from home.

By contrast, after the onset of COVID, virtually all psychiatrists began working from home and were not obliged to take a pay cut in order to do so. The majority of employers reasoned that this would be a temporary situation lasting a few weeks or months, at which point psychiatrists would return to practicing on-site. Therefore, there was no requirement that psychiatrists working from home accept a cut in pay.

As is well known, the pandemic has lasted significantly longer that was originally anticipated. Psychiatrists have become habituated to working from home and the majority believe they can provide care remotely without diminishing quality.

Today, we are seeing some employers encouraging psychiatrists to come back on-site, but many psychiatrists have resisted.

Given the prevailing demand for psychiatrists, employers generally are not in a position to reduce pay for psychiatrists if they want to continue working from home. To do so would severely impair their ability to recruit new psychiatrists and retain the ones they have. As a result, most employers find they must offer the same level of compensation to psychiatrists whether they are working on-site or working remotely.

The movement toward telepsychiatry also reduces the importance of location as a factor influencing compensation. In the past, employers in locations thought to be highly desirable often offered psychiatrists compensation that was on the lower end to the spectrum. Candidates would accept lower compensation to be in a desirable area.

Telepsychiatry, however, typically takes location out of the compensation equation. The difference makers in telepsychiatry recruiting today come down to compensation and the number of patients the psychiatrist is expected to see per day. This altered scenario is obliging employers to increase compensation while at the same time often reducing required daily patient encounters. These are very favorable conditions for telepsychiatry candidates but challenging and sometimes frustrating conditions for employers. In today's market, employers often find they are required to engage in a bidding war to secure qualified candidates.

The degree of recruiting difficulty increases in psychiatric sub-specialties, which have traditionally been challenging to recruit. Demand for addiction psychiatry is growing due in part to the depression and drug use caused by COVID-19, demand for geriatric psychiatry is growing due to aging demographics, as is demand for Consultation Liaison Psychiatrists. Perhaps the most difficult positions to fill are for inpatient psychiatrists. Traditionally, few candidates prefer this type of work.

Compensation

Psychiatry candidates usually focus on the base salary when considering compensation. Often, they do not factor the bonus potential into their evaluations as bonuses are not guaranteed. They frequently assume bonus potential thresholds are purposely set at unrealistically high levels. As of the latter part of 2022, competitive base salaries for psychiatrists are in the $325,000 to $350,000 range and may go higher for inpatient positions.

In addition to offering competitive compensation, psychiatry positions can be made more attractive by offering 100% telepsychiatry, whether inpatient or outpatient, and that is the direction the market is going. If not, the hybrid model (50% remote/50 % on-site) is an alterative. The opportunity to work a four-day week also is attractive. Some facilities offer psychiatrists an incentive to supervise advanced practice professionals (APPs). In a recent instance, a Merritt Hawkins client offered psychiatrist candidates a $12,000 supervision stipend per APP per year.

Low patient volumes in the 10-12 patients per day range for outpatient also are considered attractive. The dedicated support of psychiatric RNs and MAs, and a 7-on, 7-off schedule for inpatient positions are additional features that many candidates find favorable.

Flexibility and Urgency

It is important to be flexible in terms of practice structures and candidate parameters. There is a valuable resource of psychiatrist candidates available who have J-1 visa and H-1B visa requirements so it is a good idea to understand the immigration requirements of these candidates. It cannot be overstressed that a sense of urgency is of the utmost importance. Given the number of opportunities psychiatrist candidates have to choose from, it is important to have an efficient system of communication and decision making in place so that offers can be made in a timely manner.

It is advisable to consolidate calls through Zoom or Teams meetings with as many decision makers as possible so that decisions are made quickly. With improvements in technology, on-site visits only need to take place if candidates are considering relocation or insist on visiting a place locally. Today, many facilities decide on a candidate solely through remote meetings and do not meet them face-to-face.

Conclusion

In addition to the recommendations referenced above, it is important when recruiting psychiatrists to follow the general best practices for all types of physician recruiting. These include a thorough analysis of the opportunity to assess strengths and weaknesses, clear lines of communication, agreement on candidate parameters, appropriate resource allocation, responsiveness, and the sense of urgency.

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