The Impact of Psychiatric Shortage on Patient Care and Mental Health Policy:

The *Silent Shortage* That Can No Longer Be Ignored.

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Word count: 3600

Abstract

Context: Shortages of U.S. psychiatric providers began receiving serious attention in the 1980's. Currently, this trend continues and has reached crisis proportions.

Objective: The effects of psychiatric shortages are frequently reported anecdotally. This study reports on a telephone survey of Los Angeles County psychiatrists to document how lack of access to psychiatric care is affecting patients.

Design: 420 calls by a mock patient over a six week period were made to all psychiatrists who were listed in the SuperPages of Los Angeles County. The mock patient attempted to obtain an appointment for a medication consult describing serious symptoms in need of attention.

Setting: Out patient, private practice mental health.

Results: 229 psychiatrist's offices resulted in only 28 appointments with an median cost of $450 for an initial evaluation. Waiting time for 80% of the appointments made exceeded five weeks.

Conclusions: The results suggest that the present shortage of psychiatrists now affects all but the most affluent and unnecessarily adds to the burdens of primary care physicians. The authors discuss possible solutions to both the lack of access to psychiatric care and the long term shortage of psychiatrists.

INTRODUCTION

There is a crisis in the mental health system that has been referred to as the "Silent Shortage"[1.] Although not a new problem,[2,3,4] it refers to the growing shortage of psychiatrists in the USA [5, 6,7] and world wide [8, 9.] This shortage has severely limited access to psychiatric care for those in need of mental health services. A survey on patient care, Therapy in America-2004, estimated 27% of Americans had received some mental treatment in the last two years while 30% who needed treatment had not received care.[10] Shortages of U.S. psychiatric providers began receiving serious attention in 1980. It is estimated that 70 percent of primary care physicians nationwide reported difficulty in finding high quality outpatient mental health care for their patients.[11] Thus, psychiatric shortage and access has become a major issue in mental health services. [12,13,14]

The number of American medical school graduates choosing psychiatric residencies continues to decline adding to the problem [13]. The AMA reports that the supply of U.S. psychiatrists shrank 27 percent between 1990 and 2002. Meanwhile, physician staffing industry data indicate that demand increased by 16 percent over that same time period [13, 14]. Moreover, the aging of the psychiatrist population also is affecting access. Almost half (46%) of the psychiatrists in the U.S. are 55 years or older, compared to approximately 35% of all U.S. physicians [14, 15]. Data presented at the American Psychiatric Association Annual Meeting concluded that these trends in the psychiatric workforce are leading to access problems (APA's Office of Research and the American Psychiatric Institute for Research and Education). Simply stated, currently, there are not enough psychiatrists, nor in the future is there likely to be enough psychiatrists to fill the increasing needs of those seeking psychiatric care.

The access issue in California was selected to address psychiatric shortage because of its diverse and growing population. Shortages of psychiatrists in California has been a continuing problem for the past two decades.[15] It has affected the penal system, state hospitals, and county mental health facilities that provide services to over 500,000 patients.[16] For fiscal year ending 2004, the state reported that it was unable to fill 191 vacancies for psychiatrists to serve in positions in county operated mental health programs and state hospitals.[17]

Vacancies for psychiatrists fall across every program category but especially in programs servicing children, adolescents, and the elderly. There are only 209 psychiatrists listed in the California Children Services Provider Panel that serves children through the state MediCal Program (Medicaid) or through other state funded programs. Although the panel serves children and adolescents, only 44% of California psychiatrists listing this specialization are board certified. This compares to 63% who are board certified in general psychiatry. Board certification in family practice and internal medicine is over 75%.[18] The shortage of child and adolescent psychiatrists has reached a crisis levels. The American Academy of Child and Adolescent Psychiatrists (AACAP), describes it as "staggering".[7, 19] The shortage in this subspecialty is not likely to be reversed. Primary care venues are not equipped to treat child and adolescent patients with mental disorders. Geriatric populations are even in more desperate need of psychiatric care, especially when one considers that only 40% of the geriatric psychiatry residency slots go unfilled each year. “There are not enough trainees in the pipeline, so we won’t even be able to keep up with those who are retiring,” Dr. Kenneth Sakauye, chair of APA’s Council on Aging told “Psychiatric News (Psychiatric News, April 4, 2003, Volume 38, Number 7)..

It is difficult to obtain an exact count of the number of psychiatrists who are providing services in private and outpatient settings, in California. [7, 19] In 2004 the number of California physicians licensed and specializing in psychiatry was estimated to be 4,500 [17]. However, this over-estimates the number of psychiatrists available to provide direct care to the 36 million residents of California. A good, working estimate is that there are only 3567 psychiatrists in California who are providing direct patient care. This estimate is based on the number of psychiatrists who hold a license, a local address, a telephone and fax number. Many psychiatrists are either retired, teaching, have limited practices, are practicing out-of-state, or are not seeing patients, yet they maintain a California license. The need for direct psychiatric care, excluding children and adolescents in California, is estimated to be 16.6 per 100,000 population.[19] Yet, placed in the best possible light, there are only 10 licensed psychiatrists per 100,000 population in California. Access to psychiatry for the uninsured population, estimated at over 6 million persons, appears to be almost non-existent. If children, adolescent and geriatric populations are included in the above statistic, the extent of the psychiatric shortage would present a much more daunting picture. The shortage of psychiatrists in California's rural areas poses serious access problems to those in need [7, 19.] However, why should psychiatric access in large populated areas where the vast majority of California psychiatrists practice [7,19] be so much greater? The purpose of the present survey is to assess access to psychiatrists in Los Angeles County, California.

METHOD

Survey of Psychiatrists in Private Practice in Los Angeles County

Los Angeles County was selected for the survey due to its large population, which exceeds 12,000,000 and its high concentration of psychiatrists is estimated to be 14.79 per 100,000. Three direct mail marketing companies were contacted to obtain a correct census of psychiatrists practicing in Los Angeles County. Direct marketing firms are a good source for this type of data because they must verify the information of their labels before offering them for sale. The average number of psychiatrists with valid addresses was 500. This low number was surprising since the AMA data base lists approximately 800 psychiatrists with valid addresses in Los Angeles County. The Superpages.com site used to obtain the sample for this survey yielded only 229 psychiatrists with both valid addresses and phone numbers.

An independent firm was hired to conduct the survey. They developed the script in consultation with the principle author of this study. They hired a female mock patient who was instructed to call every number on the list over a 45 day time period (December 2005 through January 2006). The mock patient reported being 32 years of age and complained of feeling "really depressed" for over 6 weeks and unable to sleep for 3 weeks. The patient further reported feeling "really down and hopeless," and "not knowing what to do." She requested an evaluation for medication. In order to provide an incentive to increase the likelihood of obtaining an appointment, the mock patient stated that she would pay cash. The mock patient recorded the date and time the number was called, the name of the psychiatrist or practice name called, the cost of the consultation and the outcome of the call. The mock patient was instructed to call back each respondent and cancel any appointment that was made. She was also instructed to call back any number two additional times over different days if an answering machine was reached or if she was told by office personnel that a return call would follow but did not occur.

RESULTS

The mock patient made a total of 420 calls, including call backs to the 229 psychiatrists. Ten numbers were improperly listed. Ninety-five calls were picked up by answering machines and 8 numbers failed to have any type of pick-up. Five psychiatrists would not make an appointment because of pending vacations. Seven offices would not consider seeing the mock patient until she completed a screening questionnaire. Of the 229 listings for psychiatrists, 55 (27.2%) were not accepting new patients and 20 (8.8%) provided no definitive date for an appointment. Only 28 psychiatrists (12.3%) were able to make an appointment with the caller. Of this 28, only 2 (7.1%) were able to accommodate her within one week and more than 35% reported a wait of a month or more (See Figure 1). The median cost of an initial consultation was $450. Figure 2 depicts the costs of an initial evaluation obtained from 38 psychiatrists.

Figure 1: 28 available psychiatrists that were able to take patients in 1 to 10 weeks.

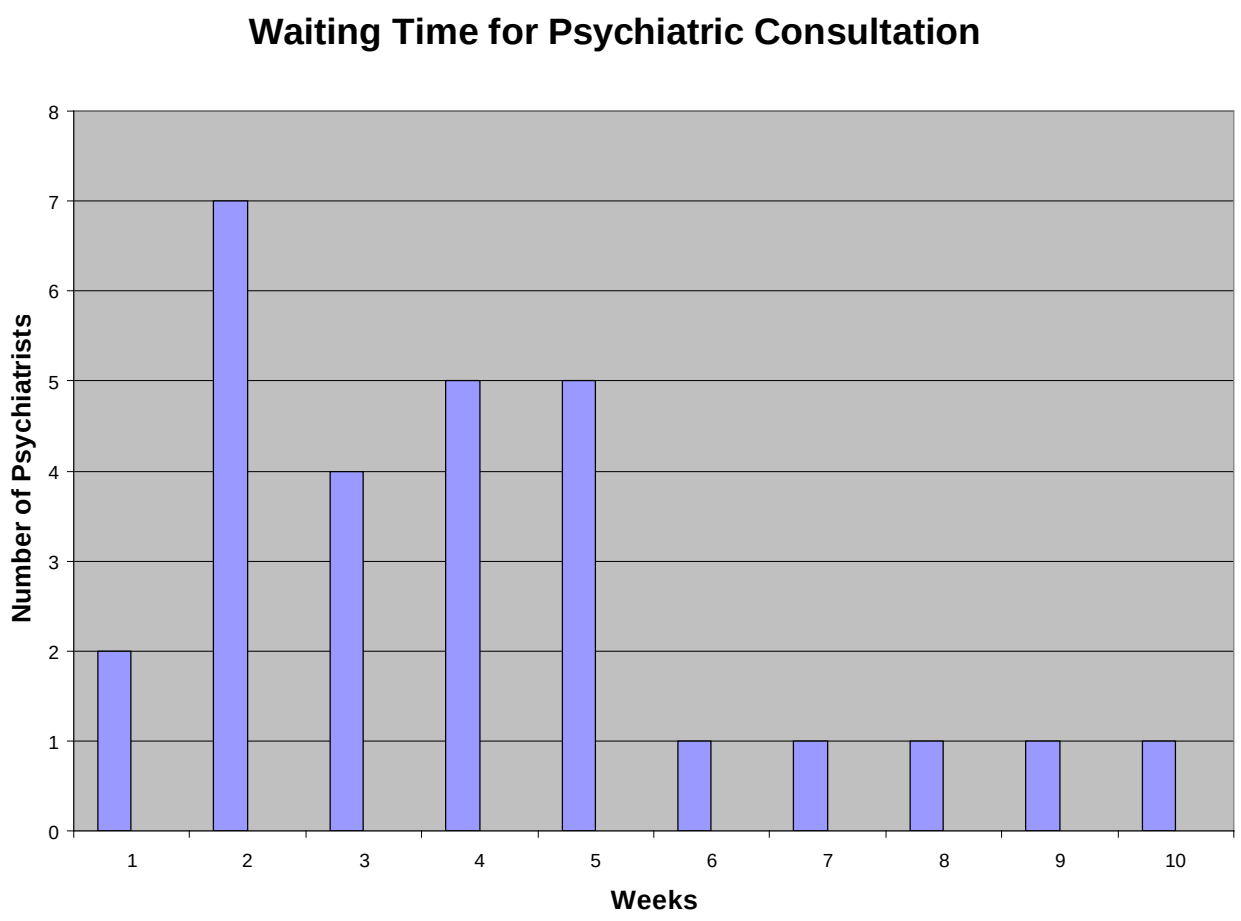
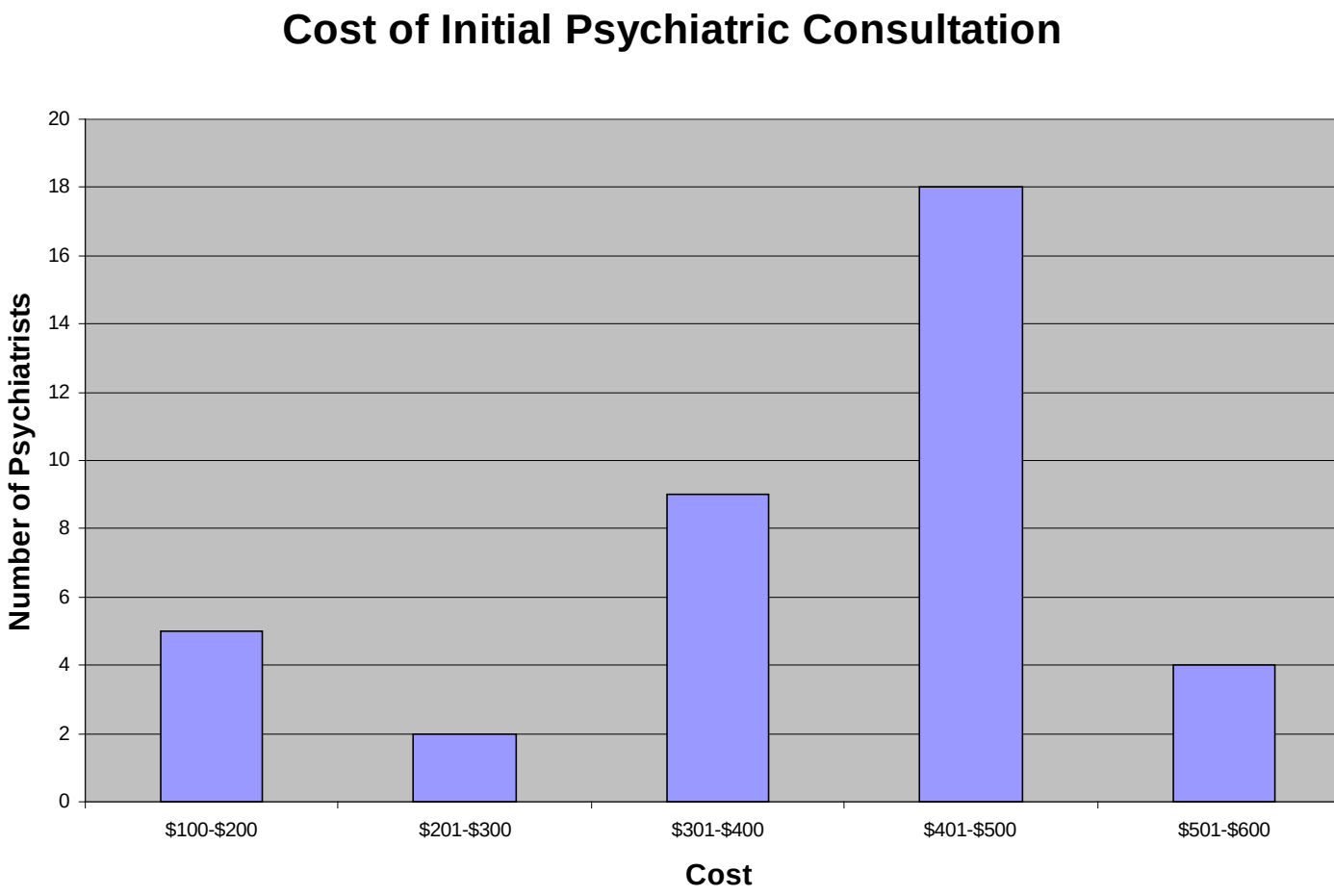


Figure 2: Number of psychiatrists charging from <$200 to <$600 for initial consultation.



DISCUSSION

This survey suggests that even in urban Los Angeles County, with 14.7 psychiatrists per 100,000 population [7], access is severely limited and costly. A sizeable number of psychiatrists were not taking new patients. Wait times ranged from 1 week to 10 weeks, with the majority of psychiatrists falling into the 2 to 5 week range. High costs for an initial psychiatric consultation severely limits access to only those with significant financial resources. Thus, psychiatric shortage and restricted access of those in need of psychiatric services may not be limited to rural areas.

Primary Care and the Treatment of Mental Health Disorders

Shortages of psychiatrists have forced primary care physicians to shoulder the burden of providing first line medication treatment. An analysis of the timeline for anti-depressants shows that the use of medications has become so ubiquitous that 70% to over 80% of all antidepressants are prescribed by primary care physicians.[20] This same study shows that many patients never even get to see a psychiatrist. Physicians and patients ten to accept that these medications are relatively safe. Now, with many more years of data, evidence demonstrates that anti-depressant medications are not as safe as previously thought, especially without careful monitoring.[21,22,23] This places many primary care physicians in a very difficult situation. Due to lack of psychiatric access they are forced to prescribe the bulk of psychotropic medications. However, unlike mental health practitioners, primary care physicians are unlikely to provide the important follow up care and concurrent psychotherapy that these patients require.

Clearly, primary care physicians are doing their best to fill the void created by the shortage of competent psychiatrists. However, primary practice is not the best venue for the evaluation, diagnosis, and treatment of mental disorders. Both recent and past studies.[24, 25, 26] show that many

primary care physicians are not very skilled at providing mental health patients the requisite standard of care.[20, 27] In fact, one of the largest studies looking at the standard of care provided in primary care settings shows that patients who are depressed or experiencing problems from substance abuse receive care significantly below that required for those problems, with only 53% of the standard designated for depression and 10% of the standard for substance abuse issues being met [27.] These failures are not a result of incompetence but can be ascribed to the difficulties inherent in evaluating mental disorders and finding an appropriate medication regimen, if even necessary, that may help these patients.

The inherent problems of providing mental health care in primary care settings directly impacts access to care. If the care received is not adequate to the needs of the patient and, the standard of care to treat mental disorders are not met, then those patients, too, do not have appropriate access to care. This is an unfortunate fallout resulting from the psychiatric shortage, which is not likely to improve.

Psychiatry's Proposals to Increase the Number of Psychiatrists

Psychiatry has failed to increase its numbers despite many touted proposals that have been advanced since at least 1980. These proposals include increasing the number of psychiatric nurse practitioners and physicians assistants to be psychiatric "extenders," the use of teleconferencing, and training primary care physicians to prescribe psychotropic medications.[28] The continued shortage raises many serious longevity issues for psychiatry as a medical specialty and for organized medicine, as a whole. The long term prospects for psychiatry to remain relevant to mental health practice and policy are not good. Declining numbers over such a long time period and psychiatry's inability to provide adequate access to patients does not appear to

be reversible. The challenge to organized medicine resulting from severe psychiatric shortage raises additional questions. Can primary care physicians continue to provide adequate mental health services to their patients as the number of psychiatrists decline? Will patients continue to accept primary care physicians as their primary mental healthcare provider? More importantly, as the number and complexity of psychotropic medications grows, will primary care physicians continue to be willing to prescribe psychotropics? Lastly, is a primary care setting the best alternative to providing mental health treatment? The answers to these questions and the policy decisions underlying them will determine whether or not psychiatry and organized medicine act in the best interests of patients or continue to sit back and watch the access crisis grow.

There Is An Alternative

Prescriptions for many types of psychotropic are starting to decrease. Prescriptions for SSRI anti-depressants have decreased about 20% from their 2003 levels.[29] This is mostly ascribed to the reports of increases in suicidal behaviors and the subsequent "black box" warnings ordered by the FDA for these types of medications. Similarly, prescriptions for psychostimulants to treat ADD and ADHD have decreased due to reports of deaths associated with their use. Atypical neuroleptics are not as safe as once thought [30,31] and may not be as effective as many "old" line antipsychotics. In fact, the overwhelming evidence shows that the most successful outcomes in mental health treatment are a result of medications used concurrently with psychotherapy [32,33,34] or psychotherapy alone. [35,36]

The lessons from these studies together with the problems of treating mental health disorders in a primary care setting are clear: the best model for providing mental health care is an integrated model where both medications and psychotherapy are provided by a single practitioner [37.] The

severe shortage of psychiatrists, coupled with their abandonment of providing psychotherapy, make it difficult for psychiatry to be part of the overall solution. In fact, psychiatry may be the obstacle. Primary care physicians are simply unable to provide effective integrated treatment due to lack of time and appropriate training.

Assuming that psychiatry is unlikely to increase in sufficient numbers and primary care settings are not the best venue for treating mental disorders, alternatives must be found. We propose that clinical psychologists trained in psychopharmacology should be utilized to provide psychotropic medications for mental health patients. These skilled mental health professionals will continue their partnership with physicians ensuring increased access and a higher standard of care than now available. Several states and the United States Armed Forces have already turned to psychologists to prescribe psychotropic medications. Putting aside "turf" issues, psychologists trained in clinical psychopharmacology are the best chance that patients have to receive adequate treatment where access to psychiatrists is restricted or absent.

The arguments that psychiatry have raised against psychologists prescribing should no longer be looked at by organized medicine as valid. The argument that the only way psychologists can safely prescribe is through medical school training simply has no merit. Appropriately trained psychologists have written hundreds of thousands of prescriptions to military personnel and their families without any incidents or reports of patient harm.[38] Psychologists in New Mexico and Louisiana and those prescribing under military contract serving soldiers in Iraq have demonstrated that they can prescribe safely and provide high quality service. These psychologists work side by side with primary care providers and psychiatrists as colleagues. Collaboration is inherent in all psychological practice and will continue with those prescribing

psychotropic medications. Surely, independent, doctoral level psychologists with many years of experience evaluating, diagnosing and treating mental disorders and who also have a post graduate degree in clinical psychopharmacology and have passed both a supervised internship in prescribing and who have passed national boards in psychopharmacology can perform safely and effectively.

Moreover, psychologists already are *defacto* prescribers. Routinely, psychologists recommend and advise physicians and other prescribers the appropriate psychotropic medications to be prescribed for a patient's mental health condition. Prescriptions are filled and the psychologist monitors and manages the patient while on medications. Physicians rely on psychologist's expertise in evaluating, diagnosing, and treating mental disorders. Now, with their extensive training in clinical psychopharmacology, physicians can also rely on psychologist's safety record of prescribing and managing psychotropic medications. [39]

An example of the impact that prescribing psychologists can have on access is to revisit the vacancy problem in California state mental hospitals and county mental health facilities discussed earlier. The statewide mental health system has over 191 vacancies for psychiatrists. There are over 600 psychologists presently employed in the mental health system, excluding contract providers, statewide. Many of these psychologists have completed training in psychopharmacology. If the state and county mental health system were able to utilize the full training and skills of these psychologists, there would be no shortage of personnel. These psychologists could provide medication management services to patients without any increase in costs since they are already in the system.

There is no service that psychiatrists provide that these psychologists could not. Psychiatrists are prohibited by law from providing routine medical work ups on incarcerated patients or patients in state hospitals. They must utilize an internist or general practitioner for medical services. Private hospitals generally follow the same practice. Aside from prescribing medications, psychologists perform the same services as psychiatrists do with the addition that psychologists deliver psychotherapy and most psychiatrists do not. Both have hospital privileges and both are licensed as independent practitioners.

Based on the typical salary of $150,000 that a psychiatrist is paid, the State of California could save a minimum of $28,000,000 if psychologists were utilized to the full extent of their training. This dollar savings does not include the costs of benefits. Moreover, with the numbers of psychologists already employed in these settings, there would be no future shortage. Other savings can be realized because psychologists pay for their own psychopharmacology training while psychiatric training is subsidized. However, the greater cost is to patients who are unable to have adequate access to psychiatrists who simply are not available.

While exact numbers are difficult to come by, California clearly comprise the greatest majority of those trained in psychopharmacology.[40] We submit that there is no proposal, either from psychiatry or, any other entity, that would increase the number of psychiatrists for patient care as quickly and effectively. Several surveys of psychologists show that if legislation allowed for them to prescribe, over 60% would seek and complete the post-doctoral training in clinical psychopharmacology. In California, this could ultimately add over 8000 additional clinical psychopharmacologists. Shortages in other states are likely to be eliminated as psychologists continue to complete training in clinical psychopharmacology. Clearly, patients would benefit from the integrated care provided by psychologists who are trained to provide both psychotherapy and medication, where indicated, and in collaboration with a physician.

Psychologist clinical psychopharmacology programs terminate in a post doctoral Masters of Science in clinical psychopharmacology or its equivalent. The mean clock hours in subjects such as biochemistry, anatomy and physiology, neuroscience, and other relevant subjects surpass those required by nurse practitioner and physician assistant programs. The 130 mean clock hours in pharmacology surpass those obtained by physicians through four years of medical school, which typically averages only 90 hours.[41] Table 1 presents a comparison of the mean clock hours in the comparable, relevant training across prescriber classes. In addition to the classroom training, psychopharmacology programs require a supervised practicum, typically with a physician. In states where legislation allows psychologists to prescribe, supervision and collaboration with a physician is required. The period of internship lasts longer than that required for nurse practitioners and physician assistants, which in most states is only six months, and can range up to two years.

Clearly, while psychiatry and some in organized medicine attack the scope of psychologist's training in psychopharmacology, the objective comparison of that training to other healthcare professionals who are allowed to prescribe medications shows that psychologists have greater training where it is needed and require greater testing and a longer and more formalized supervisory period. Yet, no where in the many proposals advanced by psychiatry to address and alleviate psychiatric shortage are psychologists given any consideration despite clear and objective evidence that psychologists are a safe and cost effective solution that can immediately provide patients with quality care. This glaring omission can be ascribed to many factors, including well intentioned concerns by some. However, as psychologists are economic competitors of psychiatrists, one must suspect that this is a major factor for resisting a proposal that is both workable and accepting to patients. Access is either an important issue or its not.

Table 1

Comparison of Training For Psychologists, NPs, and PAs

In Coursework Relevant To Prescribing.

Reported In Mean Clock Hours [1]

Category	**NP**	**PA**	**Psychologists** [2]
Biochemistry	0	11	36
Pharmacology	42	54	130
Neurosciences	0	0	78
Psychopharmacology	0	0	108
Totals	**42**	**65**	**352**

[1] Mean clock hours can be converted to semester hours by dividing by 14. Mean clock hours allows comparisons between diverse programs. Data obtained from Sechrest & Coan, (2002) and from the programs of all post doctoral psychopharmacology programs offered to psychologists.

[2] All groups require additional courses and supervised internship. NP and PA programs generally require six months of a supervised internship. Clinical Psychopharmcology programs require a minimum one year supervised practicum by a licensed, independent prescriber.

Collaboration Is the Solution

There is an old saying that "the best thing to do when riding a dead horse is to dismount". This is the time to put aside adversarial posturing and think about the patients who need mental health services. It is in the public interest to "dismount" and have organized medicine and psychology collaborate for the welfare of our patients. The most effective collaboration would be for the parties to sit down and, in good faith, agree on a plan to design and implement legislation that will serve as a model for every state legislature to provide for prescriptive authority for psychologists. Model legislation could spell out training issues, supervisory periods, formularies, and collaboration. It is clear that absent a good faith effort to include psychologists in the solution to alleviate the shortage of psychiatrists, psychologists, on a state by state strategy, will continue to obtain prescriptive authority. Time is the only issue.

Opposition from psychiatry and organized medicine will continue to disenfranchise patients and impact their credibility with legislators who must respond to this crisis. As just a few more states pass prescriptive authority legislation, other states will quickly follow as the positive experiences from states allowing prescriptive authority are seen. As the number and complexity of psychotropic medications enter the market, primary care physicians might become less agreeable to continue prescribing these medications. All parties to an adversarial struggle may have a lot to lose with a continued turf battle but patients are the real collateral casualties.

Author Information

As the principal author, Dr. Caccavale had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

None of the authors see or have any conflicts of interest, including financial interests and relationships and affiliations relevant to the subject of this manuscript.

None of the authors received any financial support from any person or entity relevant to this manuscript.

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