Psychiatry In Crisis: Impacts on Primary Care, Patient Safety and Public Healthcare Policy

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There is a general shortage of healthcare providers, ranging from physicians to physical therapists. These shortages will reach crisis levels when more than 30 million people are mandated in 2103 to acquire healthcare insurance and are added to pool of prospective patients. Even now, absent those more than 30 million, it is difficult to schedule an appointment with a primary care provider. Thus, healthcare reform will not and cannot guarantee access to care or to timely medical care. This holds true particularly in locations where physicians are in short supply, are not accepting new patients, or where physicians reject certain types of medical insurance, such as Medicare and Medicaid.

We can see the results of shortages by looking at what has happened in one medical specialty. There is a growing shortage of psychiatrists in the USA. This shortage has fueled a mental health crisis by severely limiting access to psychiatric care for those in need of mental health services.[77-80] As a result, it is estimated that 70 percent of primary care physicians nationwide reported difficulty in obtaining high-quality outpatient mental health services.[81,82] Shortages in psychiatry is a not a new phenomenon. The AMA reports that the supply of U.S. psychiatrists shrank 27 percent between 1990 and 2002.[82] Meanwhile, physician staffing industry data indicate that demand for psychiatrists increased by 16 percent over that same time period (www.LocumTenens.com *2005 Compensation and Employment Survey-Psychiatry*). The factors driving this crisis are, indeed, complex. For example, medical students are increasingly less attracted to mental health rotations. The number of American medical school graduates choosing psychiatric residencies is also dwindling, further adding to the shortage and the problem of access to psychiatric services.[83]

At the same time, the aging of the psychiatrist population is decreasing access. Almost half (46%) of the more than 20,000 U.S. psychiatrists are 55 years or older, compared to approximately 35% of all U.S. physicians, according to the AMA.[84] Adding further to the problem of psychiatric access is the fact the pool of available physicians across all categories also is shrinking. The government estimates that it would take an additional 16,000 physicians to serve the needs of the 35 million Americans who live in underserved areas.[85] This gap is expected to widen to 24,000 physicians by 2020. Psychiatry is well aware of this access problem. 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 (*APRIE*)).

The access issue in California, for example, is quite severe. With about 36 million people, there are about 5 available psychiatrists for every 100,000 Californians. The shortage of psychiatrists in California has been a continuing problem for the past two decades.[86] Other states also have reported shortages of psychiatrists. With one out of five American's experiencing a diagnosable mental health condition, a Harris Interactive Survey conducted in 2004 conducted on behalf of *Psychology Today* and Pacific Behavioral Health showed that only one-third receive the treatment they need.[87] The reality is that currently there are not enough psychiatrists, nor in the future will there be enough psychiatrists to fill the exploding needs of those seeking psychiatric care in California or elsewhere.[88] The shortage of psychiatrists has profoundly affected the penal systems, state hospitals, and county mental health facilities that provide services to millions of patients, nationwide. For fiscal year ending 2004, the state of California reported that it was unable to fill 191 vacancies for psychiatrists to serve in positions in county-operated mental health programs and state hospitals.[89]

States are experiencing vacancies for psychiatrists across every program category, especially in programs servicing children, adolescents and the elderly.[90] Experience in California demonstrates what others states have long faced. 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, not all of the psychiatrists on this panel are board-certified as child and adolescent psychiatrists. Only 44% of California psychiatrists listing a specialization in child and adolescent psychiatry are board-certified, compared to 63% who are board-certified in general psychiatry. Board certification in family practice and internal medicine is more than 75%. The shortage of child and adolescent psychiatrists has reached a crisis level and the American Academy of Child and Adolescent Psychiatrists (AACAP) describes it as "staggering."[91] But, urban areas and large states such as California are not the only ones affected by psychiatric shortage. As a general statement, access to healthcare in rural areas of America is severely limited, access to behavioral healthcare even more so.[138]

No one disputes the need or the extent of the shortage in psychiatry. As is true with the shortage in general psychiatry, the shortage in child psychiatry is not likely to be reversed. Geriatric populations are even in more desperate need of psychiatric care, especially when one considers that only 40% of the geriatric psychiatry residency slots are filled 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."[91] What is important about the shortage in psychiatry is the impact that it has on behavioral healthcare, primary care, and overall healthcare policy. As the shortage of psychiatrists has increased dramatically over the past two decades, primary care physicians have had to take up the slack for their colleagues. Behavioral healthcare has been shifted to primary care physicians even though they lack the training, skills, and time to treat these disorders. Consequently, about 83% of the prescriptions for psychotropic drugs are issued in primary care settings. The effect on patients has been disastrous as behavioral health treatment simply cannot be effectively or efficiently provided in a primary care venue. The following discussion addresses some key issues regarding the problem of psychiatric access resulting from psychiatric shortages.

Primary Care and the Treatment of Behavioral Health Disorders

Psychotropic medications have become the first line treatment for most mental health conditions. Shortages of psychiatrists have forced primary care physicians to shoulder the burden of providing first line medication treatment. The use of antidepressant medications has become so ubiquitous that more than 70% of all antidepressants are prescribed by primary care physicians.[92-97] Another factor explaining this trend is that physicians and patients have been lulled into believing that these medications are safe and without serious side effects. Now, with many more years of data, many studies are showing that antidepressant medications are not as safe as previously thought, especially without careful and knowledgeable monitoring.[98] This places many primary care physicians in a very difficult and potentially high-risk situation. Due to lack of psychiatric access, they are *de facto* prescribing the psychotropic medications that patients *may* need and hoping that no adverse drug events occur. Unlike behavioral health practitioners, primary care physicians cannot provide the important follow-up care and concurrent psychotherapy that the majority of these patients require.

Primary care is not the best venue for the evaluation, diagnosis, and treatment of mental disorders. Studies repeatedly demonstrate that many primary care physicians do not provide mental health patients the requisite minimal standard of care.[99-101] 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 the minimal standard of care with only 53% of the standard designated for depression and 10% of the standard for substance abuse issues being met.[3] These failures can be ascribed to the challenges inherent in evaluating mental disorders and finding an appropriate medication regimen, if even necessary, that will help these

patients. Recognition of major depressive disorder in primary care remains a challenge[102] and one study showed that primary care physicians missed the diagnosis of major depression in 66% of patients with the illness.[103] Adding to the problem, psychiatric clerkships are not popular choices in medical school, further adding to the primary care physician's inability to correctly diagnose and treat the broad range of mental health concerns that present in their offices.[104,105]

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 behavioral disorders is not met, then those patients do not have access to appropriate care. Ability to get an appointment in a reasonable time period and at a reasonable price will be of little value if a patient cannot receive care appropriate to his condition and need.

Public Policy Questions That Psychiatry and Primary Care Must Answer

Psychiatry has failed to increase its numbers despite several proposals that have been advanced since at least 1980.[79] These 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.[106] The continued and growing shortage raises many serious longevity issues for psychiatry as a medical specialty and for organized medicine as a whole. To patients, however, this issue has much more importance. The long-term prospect for psychiatry to remain relevant to behavioral health practice and policy is poor and questionable. The challenge to organized medicine resulting from severe psychiatric shortage raises many questions. Can primary care physicians continue to provide adequate mental health services to their patients as the number of psychiatrists decline as the number of patients increases? Will patients continue to accept primary care physicians as their primary behavioral healthcare provider? As the number and complexity of psychotropic medications grows will primary care physicians continue to be willing to put their patients and themselves at risk by prescribing psychotropics? Given the shrinking supply of all categories of physicians, will there be enough primary care physicians to deliver behavioral health services? Lastly, is a primary care setting the best alternative to providing behavioral 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. Until now, both psychiatry and primary care physicians have not advanced a

single workable solution to any of these questions. Moreover, both have fought and resisted any effort by psychologists, nurses, and other healthcare professions, who have advanced workable and safe solutions, to remedy this crisis. Organized medicine has used the same slogan, "concern for patient safety", that they used at the turn 20th century when they tried to restrain others from providing "hot baths" as a medical treatment. Medicine has a long history of using patient safety as a tool to protect, expand, and save its own practice. The control that medicine has over healthcare practice and policy is probably the single most important factor in explaining rising healthcare costs while at the same time decreasing outcomes when compared to other developed healthcare systems.

Prescriptions For Medication Only Are Not The Answer

Prescriptions for many types of psychotropic medications are starting to decrease. Prescriptions for SSRI antidepressants have decreased about 20% from their 2003 levels.[107] 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.[107a-111] Similarly, prescriptions for psychostimulants to treat ADD and ADHD have decreased due to reports of deaths associated with their use.[112-114] Many studies show that atypical antipsychotics are not as safe as once thought and may not be as effective as many "old" line antipsychotics.[115-125] In fact, the overwhelming evidence shows that the most successful outcomes in mental health treatment are a result of medications used concurrently with psychotherapy[126-128] or psychotherapy alone.[129,130] In spite of the clear findings of the outcome research on this issue, the vast majority of physicians continue to write prescriptions they know to be ineffective and non-beneficial without first establishing a valid diagnosis from a psychologist or psychiatrist, when available. It is inconceivable that this situation will improve when so many more patients will be added to the treatment rolls.

The lessons from these studies together with the problems of treating behavioral health disorders in a primary care setting are clear: one model for providing this health care in the short--term is an integrated model in which both medications, when necessary, and psychotherapy are provided by a psychologist and a collaborating physician.[131,132] In the long term, specially trained psychologists who can prescribe medications is the best model. The severe shortage of psychiatrists, coupled with their abandonment as a profession 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. In those states where psychologists are authorized to prescribe, access to care, patient care safety have been

increased without a single complaint or case of harm being reported. Nevertheless, both psychiatry and organized medicine have fought and resisted psychology prescribers for almost two decades.

Changes In Public Policy Are Needed

Assuming the obvious that psychiatry is unlikely to increase in sufficient numbers to make a difference and primary care settings are not the best venue for treating mental disorders, alternatives must be found. A proven solution exists. Clinical psychologists with advanced post-doctoral training in psychopharmacology should be granted prescriptive authority and used to prescribe and monitor medications for patients suffering from behavioral disorders when indicated. These skilled healthcare professionals have and will continue to become partners with physicians, ensuring patients have access and receive a higher standard of care than is 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 and medical psychology afford the best chance for patients to receive competent treatment where access to psychiatrists is restricted or absent.

The arguments that psychiatry and medicine have raised against psychologists prescribing should no longer be looked at by the public or policymakers as valid. The argument that the only way psychologists can safely prescribe is through medical school training simply has no merit. Let's be clear on these issues: Harm to patients through errors in prescriptions are a result of those trained in medical school. Thus, simply having graduated from a medical school has not protected patients from harm. It is the type of education and training that is the salient issue. Appropriately trained psychologists have written hundreds of thousands of prescriptions to military personnel and their families without any incidents or reports of patient harm[133-137].

Moreover, psychologists in New Mexico and Louisiana and those prescribing under military contract serving soldiers in Iraq and Afghanistan 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 continues with those prescribing psychotropic medications. Surely, doctoral-level psychologists with many years of experience evaluating, diagnosing, and treating mental disorders, who have undergone post graduate training in clinical psychopharmacology, and have passed both a supervised internship in prescribing and national boards in psychopharmacology, can perform safely and effectively.

Many psychologists already are *de facto* prescribers. Routinely, psychologists recommend and advise physicians and other prescribers regarding 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 the 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 stellar safety record of prescribing psychotropic medications.

We can see an example of the impact that prescribing psychologists can have on access by revisiting the vacancy problem in California State mental hospitals and County mental health facilities discussed earlier. The statewide mental health system typically has several hundred vacancies for psychiatrists at any given time due to the shortage. Statewide, there are more than 600 psychologists presently employed in the mental health system, excluding contract providers. Many of these psychologists have completed training in psychopharmacology. If the state and county mental health system were able to use the full training and skills of these psychologists, there would be no shortage of personnel in a very short period of time. These psychologists can provide medication management services to patients without any increase in costs since they are already in the system.

With the exception of electroconvulsive shock, which many psychologists find objectionable and not an effective treatment, there are few services psychiatrists provide and that psychologists could not. In California, psychiatrists are prohibited by law from providing routine medical work-ups on incarcerated patients or patients in state hospitals. They must employ 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 important addition that psychologists deliver psychotherapy and most psychiatrists do not. Both have hospital privileges and both are licensed as independent practitioners. So why does psychiatry and organized medicine fight and resist what would obviously be a sound solution to the present and growing crisis?

In California, as elsewhere, the answer is clearly economic. Based on the newly established salary of more than $250,000 that a psychiatrist is paid, the State of California could save a minimum of $50,000,000 if psychologists were used 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 through Medicare and other government programs. However, the greater cost is to patients, who are unable to have adequate access to psychiatrists, who simply are not available.

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 as well as a formalized supervisory period. Yet, nowhere 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 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.

Opposition from psychiatry and organized medicine will continue to disenfranchise patients and hurt their credibility with legislators who must respond to the mental health 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. All parties to an adversarial struggle may have a lot to lose with a continued turf battle but patients will be the real collateral casualties.