Good morning, Senator Gerratana, Senator Somers, Representative Steinberg, and esteemed members of the Public Health Committee:

My name is Margaret Watt. I am a resident of Norwalk and here today as Executive Director of the Southwest Regional Mental Health Board. Our role is to engage the various stakeholder groups in our communities in the planning and monitoring of the behavioral health system. As such, I am here to speak in favor of HB 6483, An Act Establishing a Task Force Regarding the Impending Shortage in the Psychiatry Workforce, which we are grateful to Rep. McCarthy-Vahey for putting forward following discussions with our Catchment Area Councils.

The Regional Mental Health Boards conduct region-wide needs assessments every two years, carry out reviews and evaluations of services and needs during each year, and identify issues and needs on an ongoing basis by convening and participating in many coalitions, committees, and forums at the grassroots level. Consistently, one of the important messages we hear—from both consumers and providers—is that access to psychiatrists is a significant barrier to care.

Not everyone who experiences a mental health or substance use issue needs to work with a psychiatrist. However, for those who want and need psychiatric medication and seek out or are referred to a psychiatrist, the wait can be 2 to 3 months. When a person is experiencing extreme emotions, paralyzing anxiety, recurrent thoughts of suicide, or unbearable side effects, a long wait to gain access to needed expertise can be not only agonizing but also a literal risk of harm or death.

Just recently one of the amazing young women who worked on our TurningPointCT.org website—an online peer support community by and for young people in CT—talked with me about her ongoing challenges with medication. She has bipolar disorder type II and does not respond to most medications. She has reached the maximum dosage of the only medication that has really worked for her and it has become ineffective. She was so disheartened to feel herself once more spiraling into more and more constant thoughts of suicide, and this time feeling that she didn’t have other solutions to try. And at this critical time, she couldn’t get to her APRN for at least a month—and she’s one of the people lucky enough to already have psychiatric care.

In my written testimony I have attached a summary of a report we wrote in 2016 looking at these issues in our part of the state. I want to highlight a few key points here:

- Psychiatrists are already in such demand that they can command salaries that put them out of the range of public and nonprofit healthcare organizations. For example, last year potential hires turned down a salary of $200,000 at a public agency in the Greater Bridgeport area. As a publicly funded program, the agency can’t really afford to pay more than that.
- Nationally, in the next 8 years there is an anticipated shortage of 46,000-90,000 psychiatrists due to an aging workforce that is increasingly retiring and/or working fewer hours, as well as a decrease in the number of doctors interested in entering the field. One reason new doctors are less interested is the expense of education and training. Another is the evolution of the practice: Many psychiatrists spend the majority of their time in 15-minute med management visits with very large caseloads, sometimes working with 400-500 clients. There are still further shortages in sub-specialty areas like Child and Adolescent Psychiatry.
- The state of CT already has identified Mental Health Professional Shortage Areas in every county. In these areas, it is possible to use National Health Service Corps loan reimbursement programs to attract professionals for a couple of years of service in high-need communities. However, these areas still experience shortages. Furthermore, not all areas that CT communities perceive as being in need rank as vulnerable enough in comparison with other states to qualify. It then becomes the state’s job to address this issue.

We believe that there is unlikely to be one single solution to this issue. Instead, there may be a combination of:

- Incentive programs to entice people into the field
- Expansion of telepsychiatry programs to increase access to the prescribers who are available
- Reenvisioning of the role of psychopharmacology in treatment
- Solutions to the issues prescribers see as preventing them from participating in insurance plans
- Prohibitions on direct advertising by pharmaceutical companies to consumers, to decrease demand, and
• Modifications of scope of practice to increase the types of providers who can prescribe. For example, 4 states now allow psychologists who receive advanced training to prescribe. CT ranks last in using Physician Assistants in the workforce, but there are Psychiatric PA’s who have a full additional year of training in psychiatry who are used by many states to extend the workforce.

And there may be other solutions. For this reason, we support creation of a task force to begin to address this problem before it gets worse. I also urge that any group that works on this challenge involve not only prescribers and mental health professionals but also consumers and people in recovery.

Thank you for support important means of access to care for people with mental health and/or substance use disorders.
FINDINGS & RECOMMENDATIONS: AVAILABILITY & GAPS IN PSYCHIATRIC WORKFORCE

During 2015, Southwest Regional Mental Health Board (SWRMHB) investigated barriers to behavioral healthcare in southwestern Connecticut. Because of widespread concern about the availability of mental health providers, especially prescribers, SWRMHB partnered with a Yale School of Public Health team to survey prescribers. SWRMHB’s Catchment Area Council (CAC) members assisted in creating a dataset to identify the availability of four types of behavioral health providers.

Is the Number of Providers Adequate to Meet the Region’s Needs?

SWRMHB estimates that there are a total of 1631 behavioral health providers (including psychiatrists and psych nurses, psychologists, and social workers) in Southwestern CT.

- This estimate translates to a ratio of 235 providers per 100,000 population.
- The estimated ratio of 62 clients per social worker is significantly higher than the caseload range of 40:1 – 50:1 for community mental health services found by the National Association of Social Workers.
- Currently, less than half the population estimated to need mental healthcare is receiving services. With the current workforce, in order to reach all residents in need, each mental health provider (all types) would have a caseload of 79 clients. Each social worker would serve a caseload of 133 clients.
- A commonly recognized need is for bilingual providers. In a phone survey of 59 large behavioral health programs and clinics, SWRMHB found that 42% of adult and 59% of child mental health agencies and programs reported Spanish-language capability. 11% of adult and 29% of child practices had Haitian Creole capability. 50% of substance use practices contacted had Spanish-language capability and two reported competence in Haitian Creole. 9% overall had access to a phone translation service.

The Case Load Capacity Calculator at http://clcc.cm-innovators.com is a tool that can help providers identify appropriate caseload ratios compared to programs with similar scope of practice and service delivery model.

What are the Barriers to Finding Prescribers?

SWRMHB estimates there are approximately 32 prescribers per 100,000 population in Southwest CT, which falls within HRSA guidelines recommending a 26:100,000 ratio. However, access is difficult and becoming worse:

- A shortage of 46,000-90,000 psychiatrists is expected nationally by 2025, due to demographic trends. Between 1995 and 2013, the US population increased by 37%, while the number of psychiatrists rose by only 12%.
- 59% of US psychiatrists are age ≥55 and retiring or reducing their workload. Psychiatrists responding to SWRMHB’s survey reported working an average of 29.6 hours per week, with 8 out of 44 respondents* reporting working fewer than 10 hours per week.

*Representing 17% of prescribers in the region
Apparent gaps include expertise in child/adolescent psychiatry, geriatrics, and addictions. Hoarding is an area of concern. 27% of prescribers responding to the SWRMHB survey reported that they were trauma informed.

The primary barrier in Southwest CT at present is financial.

- Because psychiatrists can command large salaries, they are unevenly distributed across the private and nonprofit sectors. In 2015, a large state-funded agency had difficulty meeting salary requirements; potential hires turned down offers of $200,000.
- At one community hospital, a psychiatrist’s retirement required reallocating a caseload of >400 clients.
- Costs of care are prohibitive—even for those who are privately insured. Among 44 responding psychiatrists* in the region, 23 don’t accept any insurance, >1/2 accept private insurance, <1/2 accept Medicare and/or Medicaid, and just 19 provide a sliding-fee scale. Half of private-practice prescribers responding neither accept insurance nor offer a sliding-fee scale.*Representing 17% of prescribers in the region
- Many prescribers responding to the survey felt strongly that participating with insurance affects their ability to provide quality care. They recommend streamlining or unifying insurance, minimizing requirements for prior authorization, and decreasing copays and deductibles. Several advocated for a single-payer system.

### What Solutions Can Help Bridge the Gap?

1. **Proactively address the impending shortage of psychiatrists:** Protect funding for the Access Mental Health CT program, which uses telepsychiatry to provide pediatricians with access to prescribers. Expand the program beyond pediatrics in order to make it available to a wider range of providers. Explore other models of telepsychiatry. 57% of responding prescribers indicated that telepsychiatry could “definitely” or “probably” play a role in their practice. Respondents were most interested in using telepsychiatry to work with their existing clients remotely or to provide consultation to primary care providers.

2. **Expand or further the scope of work of other providers.** Psychiatric APRNs could prescribe suboxone for addiction. In 4 states (Illinois, Iowa, Louisiana, and New Mexico), psychologists who receive additional training can prescribe psychiatric medication. Psychiatric Physician Assistants (PA-CAQ) have a full year of psychiatric training beyond the PA degree and are used in many states to extend the workforce. Explore ways to hire and use more people in recovery.

3. **Use the National Health Service Corps loan repayment and other incentive systems to expand the pool of professionals entering psychiatry.**

4. **Provide opportunities and incentives to providers to learn Spanish and to fill other gaps such as hoarding.**

5. **Break down procedural difficulties in using insurance to increase provider participation:**
   - Streamline systems and reduce paperwork to the extent possible.
   - Consider placing all insurance formularies on a single website.
   - Seek solutions to prescribers’ sense of “responsibility but no power” and of being undercompensated.
   - Better promote the benefits of participating with insurance companies. (Providers have noted that reimbursements from HUSKY are not only easy but also quicker and better paid than private insurance.)
   - Investigate other system reforms, such as tort reform.
   - Identify ways to reduce the consumers’ financial burdens, for example, by reducing their co-pays and deductibles or by requiring providers to participate in insurance and/or provide a sliding fee scale.

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<th>Type of Visit</th>
<th>Charges Noted by Responding Prescribers</th>
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<tr>
<td>Maintenance Visit</td>
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