The Pennsylvania Psychologist

Vol. 80, No. 2

FEBRUARY 2020 • UPDATE

Behavioral Health Workforce Shortages in Pennsylvania

Samuel Knapp, Ed.D., ABPP
Director of Professional Affairs

Researchers at the Institute for Healthcare Outcomes described three goals of health care which are to: (1) improve the patient's experience in the health care system; (2) improve the health of the population; and (3) reduce health care costs (Institute of Health, 2019). Since then, Brodenheimer and Sinsky (2014) identified a fourth goal which is to improve the quality of work for health care professionals. The ability of Pennsylvania to meet these goals for mental health services is compromised by the lack of an adequate mental health workforce. The patient's experience in the health care system is less rewarding if health care providers are overworked or have long waiting lists. The health of the population will not improve if patients cannot easily access (or cannot access at all) health care services. Also, health care costs for many patients will increase if their mental health needs are not addressed. Finally, health care workers who are overly stressed will be less likely to produce the best health care outcomes and they will be more likely to leave the field or retire early.

Mental Health Needs in Pennsylvania

Almost 17% of Pennsylvanians experienced some form of mental illness in the last 12 months and about 4% experienced a serious mental illness such as major depression, bipolar disorders, or schizophrenia (Mental Health America, 2020). In addition, those with psychological distress are more likely to misuse alcohol or other drugs. Non-White Americans have significantly less access to mental health services. Like other states, rural and inner-city areas of Pennsylvania have the greatest shortage of providers and many rural hospitals in Pennsylvania are financially at the point of closure (Kacik, 2019). Like other states, Pennsylvania has a shortage of psychiatrists and has a high percentage of persons with mental illnesses within its correctional system. Pennsylvania lacks adequate services for persons with serious and chronic mental disorders.

In addition, two recent trends within Pennsylvania increase the demand for behavioral health services beyond what most other states experience. First, 18% of Pennsylvanians are 65 or older (the 7th highest percentage among American states; Pennsylvania State Data Center, 2017) and this percentage is expected to increase. Older persons have more medical conditions that require health care interventions. Also, the rate of deaths from opioid use in Pennsylvania is twice the national average. Aside from the human tragedy involved, the opioid crisis has strained emergency departments and first responders.

On the positive side, however, Pennsylvania has a rate of uninsured that is lower than most other states, in part because Pennsylvania has a high rate of Medicare beneficiaries and because Pennsylvania has engaged in Medicaid expansion under the Affordable Care Act. It has many training institutions for health care professionals and currently most of the state is experiencing economic expansion, allowing patients to afford health care services.[1]

Continued on page 2

1. Mental Health America ranked Pennsylvania as the number 1 state in terms of addressing the mental health needs of its citizens (Mental Health America, 2020). In creating these rankings, the authors relied heavily on the percentage of citizens have health care insurance which Pennsylvania does have. Also, Pennsylvania has a strong public education system that includes IEPs for 15% of its children. Although Pennsylvania's strength in these areas should not be minimized, other analyses using different variables might have reached much different rankings.

PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION

The Pennsylvania Psychologist
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112
papsy.org

Continued from page 1

Reasons for the Mental Health Care Provider Shortage

The shortages in medical services for persons with mental illnesses are caused by long standing historical, geographic, and social patterns, and policy decisions. The lack of an adequate workforce results in unnecessary suffering; an over reliance on emergency departments for mental health conditions; poorer outcomes, especially for persons with serious and persistent mental illnesses; high rates of untreated opioid misuse; and unnecessarily higher health care costs for medically ill patients with comorbid mental health disorders. The shortage is amplified by geographic maldistribution of health care professionals. Patients in rural areas and ethnic and cultural minorities are especially underserved.[2]

One reason for the lack of an adequate workforce is that reimbursements for mental health care services have traditionally fallen below that of comparable services for physical health care services. Also, bureaucratic burdens lessen the quality of work life for many mental health care professionals, causing them to leave the field, retire early, or move away from direct patient care. Furthermore, mental illness still has a stigma attached to it, thus making it less likely that afflicted individuals will advocate for better health care.

Ironically, the Affordable Care Act and Mental Health Parity and Addiction Equity Act has increased the gap between the patient demand for services and available providers by requiring insurance companies to offer policies with a core set of benefits that included mental health services. In addition, it expanded the number of Pennsylvanians who had health insurance by creating the health care marketplace and allowing for the expansion of Medicaid. Those with mental health needs with insurance coverage are more likely to seek mental health services than those with no insurance coverage.

Mental Health Care Provider Shortage Areas

Shortages in the workforce are especially acute for those who can prescribe psychotropic medications, for the treatment of older adults, for residents in Pennsylvania prisons and in state hospitals, those covered under Medicaid and Medicare programs, children, and for those who misuse alcohol or other drugs.

Shortage of Prescribers

The use of medications for the treatment of mental illness is not without controversy. First, although psychotropic medications should be an essential and integral part of any system they are often prescribed even when behavioral treatments are more effective. For example, the American College of Physicians has endorsed cognitive-behavior therapy for insomnia as the first line treatment of insomnia (Qaseem et al., 2016). Nonetheless patients often request, and physicians are likely to prescribe medications for sleep, even though the long-term benefit of these medications for sleep has not been established. Similarly, behavioral treatments for pain management are underutilized which is one of the many factors contributing to the opioid epidemic (Darnell, 2019). The underutilization of behavioral interventions is due to many reasons including patient demand generated by drug advertising, lack of training on the part of physicians, and the shortage of behavioral health providers available to provide evidence-based behavioral interventions.

Also, some scholars claim that FDA approved drugs do not convey the benefits that their manufacturers purport (see for example, Ioannidis, 2016). Furthermore, medical marijuana is now approved for several mental health conditions in Pennsylvania, although the scientific support for its use for the treatment of mental health problems is exploratory at this point and marijuana or its extracts should not be used as a front-line treatment for any mental health disorder (Walsh et al., 2017). Finally, the costs of medications have been a major factor in the increase of behavioral health care costs. In 2014 medications accounted for 27% of all behavioral health care costs. The costs of prescription medications as a percentage of total behavioral health expenses has declined slightly in recent years due primarily to an increased use of generic drugs (SAMSHA, 2016).

Despite these limitations, psychotropic medications are essential for treating many conditions. Nonetheless, Pennsylvania has a shortage of physicians. A report by the Joint State Government Commission in 2019 stated that Pennsylvania needs an 11% increase in primary care physicians from 2010 to 2030 to keep pace with the demand for services. Even though Pennsylvania trains many physicians, Pennsylvania retains only 57% of its active physicians (compared to 67% of physicians nationwide). The shortage is more acute in rural areas of the state. Currently, 14% of Pennsylvanians live in a medical shortage area.

This shortage of psychiatrists is even more acute. A report by the National Council for Behavioral Health (2017) claimed that there was a 6.4% shortage of psychiatrists in 2013, and that this shortage is expected to increase over time. Although I do not have data specific to Pennsylvania, the number of active psychiatrists in the United States decreased from 2008 to 2013 and most psychiatrists are older than 55 and one in four is 65 or older (Olfson, 2016). There is a need for a substantial increase in the number of psychiatrists simply to maintain the present supply, which is still inadequate. Unfortunately, psychiatric residencies are not being filled enough to meet the demand even though other medical specialties are showing increases in their numbers. Even an influx of foreign-trained psychiatrists has failed to close this gap. Furthermore, many psychiatrists have cash-only practices, thus making them inaccessible to patients who rely primarily on insurance to cover health care costs.

Continued on page 4

2. Ethnic and cultural minorities are also underrepresented among health care providers, including psychologists (Pearson Vue, 2016). Over the last 20 years, the psychology workforce has started to become more diverse. By encouraging minority students to apply to graduate schools, and nurturing and supporting ethnically diverse students, the racial and ethnic composition of psychology is beginning to change. In 2014, persons of color received 25% of the doctoral degrees in psychology (Christidis, Stamm, & Lin, 2016).

GET READY FOR PPA 2020

LEAD BY EXAMPLE

PPA2020 will be held at the Lancaster Marriott at Penn Square

Learn...Lead...Change: Psychologists as Learning Leaders

PPA is excited to welcome Dr. Sandra Shullman, as this year's Keynote Speaker! Dr. Shullman is a Managing Partner at the Columbus Office of Executive Development Group, LLC and she is also currently president of APA. She was honored by the American Psychological Association in 2012 with the APA Award for Distinguished Contributions to Professional Practice for her organizational and leadership development work. Join us for Dr. Shullman's FREE Keynote Luncheon on Wednesday, June 17 at 11:30 am.

Psychology in Pennsylvania Luncheon

This year's luncheon features Dr. Peter Langman, PPA member, and winner of this year's Public Service Award! Dr. Langman is well-known for his research on school shooters, but he is also making a name for himself in the area of home-grown extremism. This presentation challenges this view, providing an overview of the psychology of perpetrators of ideological mass violence, including jihadists and white supremacists. This luncheon will be held on Thursday, June 18 at 11:45 am.

Click here to learn about all the special events that we have planned for PPA2020!

Already planning to attend? Reserve your room today! PPA rooms are available at the discounted rate of $149/night + tax. Make your reservation online by clicking here. Discounted rates are available until Tuesday, May 26. It is likely that we will sell out of rooms at this rate, so we recommend make your reservation as soon as possible!

Continued from page 2

The shortage of psychiatrists can be compensated by utilizing advance practice nurses or physician assistants with special training in prescribing psychotropic medications and by enacting legislation that would permit specially trained psychologists to prescribe medication. Recent changes in the regulations for licensed psychiatric outpatient clinics now permit advanced practice nurses to prescribe psychotropic medications in those facilities (55 PA Code §1153.2 et seq.). In addition, several states now authorized psychologists to receive additional training and acquire a special credential to prescribe psychotropic medications. Eligible psychologists must be licensed, have a doctoral degree in psychology, a post-doctoral master's degree in psychopharmacology, supervised experience as a psychopharmacologist, and pass a national examination on psychopharmcology. It is estimated that 300 psychologists now prescribe psychotropic medications in New Mexico, Louisiana, Iowa, Idaho, and Illinois.

The Pennsylvania Department of Corrections and County Jails

Pennsylvania's prisons and jails hold almost 87,000 persons (including 48,000 in the Pennsylvania Department of Corrections) of whom one-third have a mental illness and 9.5% have a serious mental illness (Simmons-Ritchie, 2019). The closing of many state hospitals and the reduction in size of the existing state hospitals, combined with a lack of appropriate community-based services, has resulted in many mentally ill persons living in the community without adequate supports or treatment. Many persons with serious and untreated mental illnesses commit crimes and end up in jails or prisons. Although they may not have engaged in behavior violent enough to justify an involuntary psychiatric hospitalization, they nonetheless may have committed a series of petty crimes that are disturbing to the community, resulting in their incarceration.

Many persons who used to reside in state hospitals in Pennsylvania have been unable to find the community supports needed to ensure their ability to live in the community and they end up in county jails or a state prison. To help address this concern, numerous counties in Pennsylvania have developed mental health courts or other problem-solving courts that are designed to divert non-violent mentally ill persons out of jail and into treatment. According to the Unified Judicial System of Pennsylvania (2018), Pennsylvania had 21 adult mental health courts. Other problem-solving courts, such as those dealing with substance misuse, DUI's, veterans, or prostitution also help many persons who have co-existing mental health problems.

The Pennsylvania Department of Corrections is the single largest provider of mental health services in Pennsylvania. The Department of Corrections has had recent success in recruiting more psychologists through aggressive recruiting and by creating training opportunities in state prisons. Nonetheless, it still has not reached its desired complement of psychologists and still has numerous vacancies.

In addition to being humane, ensuring adequate mental health services in prisons reduces costs in at least two ways. First, prisoners with inadequately treated mental illnesses are likely to be uncooperative as a result of their mental illnesses; thus, increasing the workload of the correctional staff. When they receive adequate treatment, they are more likely to cooperate with correctional staff and become less of an administrative burden on the prisons. Second, mental health services in prisons reduce the rate of recidivism. According to a study by the Pennsylvania Department of Corrections, inmates who participated in the Recidivism Risk Reduction Incentive (RRRI) had shorter prison stays and lower rates of recidivism than inmates who did not participate in the program (the 5-year recidivism rate was 46% compared to 54% for non-participants). The RRRI includes programs to meet the needs of the inmates including mental health treatment (Bucklen, 2018). It is estimated that this program saved the Commonwealth of Pennsylvania more than $400 million.

In-Patient Hospital Services and Pennsylvania State Hospitals

Pennsylvania has a shortage of psychiatric beds which declined from 1,850 in 2010 to 1,344 in 2016 (Treatment Advocacy Center, n.d.). Psychiatric hospitalizations are not without their controversies. Nonetheless they are needed to manage complex medication issues and to protect patients from harming themselves or others, especially when outpatient supports are not adequate. The decline in beds puts greater demands on hospital emergency departments which must deal with patients in crisis who should be in the hospital, or which must hold seriously mentally ill patients for many hours until a psychiatric hospital bed can be found.

As desirable as it is to have services delivered in the community, some patients cannot live successfully in the community and need long-term hospital stays. Pennsylvania still needs some functioning state hospital system and will need such a system for the foreseeable future. Unfortunately, the number of filled psychology positions in state hospitals has declined very sharply in recent years which compromises the quality of service to hospital patients.

Service Recipients in Medicaid and Medicare Programs

Medicaid is the single largest financer of mental health services in the United States and is especially important for the treatment of persons with serious and persistent mental illnesses.

Continued on page 6

3. In addition to the low reimbursement, many psychologists are also frustrated by the degree of psychiatric oversight found in licensed outpatient psychiatric clinics. Although psychologists may act fully autonomously in most other facilities or in their independent practices, in licensed psychiatric outpatient clinics psychiatrists need to supervise their professional activities, including their treatment plans. Part of this is due to arcane Medicare requirements than condition reimbursement in these facilities on physician oversight. A bill before Congress, the Medicare Patient Access Bill (HR 884), would eliminate this unnecessary federally imposed requirement.

You're Invited

PennPsyPAC's Taste of Pennsylvania Fundraiser

Enjoy Pennsylvania Dutch desserts and wines from the Cullari Vineyard, owned by PPA member Dr. Salvatore Cullari while supporting PennPsyPAC.

Wednesday, June 17, 2020

7:30 - 9:30 PM ★ William H. Montgomery House ★ Lancaster, PA

Located inside the Lancaster Marriott at Penn Square
25 South Queen St, Lancaster, PA 17603
During PPA2020 Convention

Tickets are $50 per person

CLICK HERE TO RESERVE YOUR TICKETS TODAY!

Contributions may also be mailed to
PennPsyPAC
5925 Stevenson Avenue, Suite H
Harrisburg, PA 17112.

PennPsyPAC
MINDING WHAT MATTERS

According to state campaign laws, only individuals and other political action committees are permitted to make contributions.
PennPsyPAC contributions are not tax deductible as charitable contributions for federal income tax purposes.

Continued from page 4

For example, approximately two thirds of persons diagnosed with schizophrenia receive services reimbursed by Medicaid. Nonetheless, reimbursement rates under Medicaid are low and the participation of psychiatrists and psychologists within Medicaid is especially low.[3] The Medicaid rates in Pennsylvania are 67% of those of Medicare, and only 15 states pay less in Medicaid than Pennsylvania according to that standard (Huen-Johnson et al., 2017). This low rate of reimbursement has made it difficult for many publicly funded community mental health centers to continue to operate. In addition to the low reimbursement rates, unnecessarily onerous record keeping requirements, and other arcane state standards add an additional burden to service providers.

Because Pennsylvania has so many older adults, we are more directly impacted by changes in the Medicare program. Over the last 20 years, Medicare rates for psychologists have dropped nationwide, resulting in many psychologists leaving the Medicare program entirely and opting for fee-for-service contracts with Medicare patients. Even now, CMS has proposed an additional 7% decrease in the reimbursement rates for psychologists and social workers to go into effect in 2021. Even if this rate cut is stopped, it sends a message to psychologists that they might not be able to count on Medicare to provide a consistent reimbursement level over time.

The problems caused by declining reimbursement for Medicare patients was verified in the insurance surveys conducted by The Pennsylvania Psychological Association in 2009, 2012, and 2014. One of the questions asked of psychologists was whether their Medicare patients could find someone willing to treat them within two weeks. The percentage who stated that Medicare patients could find someone to treat them within two weeks fell from 75% in 2010 to 61% in 2012 and 39% in 2014 (Knapp, 2015). Since Medicare rates for psychologists have continued to fall relative to the cost of living, the access problems for Medicare patients are likely even more severe now. Many nursing homes are unable to find psychologists to meet their demand for services.

Treatment of Children

The delivery of mental health services to children is more time intensive than the delivery of comparable services to adults. Working with children requires navigating parental consent and child protective services laws, and often coordinating services with pediatricians, schools, and extended family members. Unfortunately, insurance companies pay the same rate per hour for children as they do adults, meaning that much of the work involved in working with children is uncompensated. Also, children are more likely to be on Medicaid, the lowest paying health care insurer (children make up 44% of Medicaid enrollees; Kaiser Family Foundation, 2016) and have greater access problems. Child psychiatrists are very hard to find (Joint State Government Commission, 2019).

Alcohol and Other Drugs

Drug and alcohol problems have a high comorbidity with mental illness. Pennsylvania has been especially impacted by the opioid crisis, which is due to a combination of overprescribing, underlying predispositions to addiction among certain patients, and social conditions such as poverty, unemployment, and hopelessness.[4] Treatment of these patients require specialized services, including physicians specially trained in addiction medicine and counselors and psychologists with specialized training in addictions.

Ways to Increase Patient Access

Additional ways to increase access would be to expand opportunities for telehealth services, expand integrated care services, improve the reimbursement levels of mental health professionals, and change laws to ease the mobility of health care professionals across state lines.

Telehealth

Making telehealth services available for mental health patients would be one step in reducing the workforce shortage. Telehealth services are especially important for patients who live in rural areas, have mobility problems which make it difficult for them to go to the office of a practitioner, or who have rare disorders where it is not possible to find a qualified professional nearby. For example, telemedicine may be used to treat opioid misuse disorders in rural areas which have acute shortages of health care personnel (Rubin, 2019). The reimbursement levels for telehealth need to be appropriate for the services being provided such as payment on par with other health care services.

Telehealth services, however, cannot compensate entirely for the lack of a physically present workforce. Some patients should not be treated with telehealth services. A mental health care provider may, at times, need to know the local resources for making a psychiatric hospitalization, seek specialized medical care for a patient, or mobilize local resources for a patient. Sometimes only professionals who are physically present and know the local resources, or who work in conjunction with a health care professional who is physically present, can gather those resources for their patients.

Integrated Care

According to the *biopsychosocial model of disease,* disease is not simply a function of physical forces, but the result of a combination of biological, social, and psychological factors (Engel, 1980). Many primary care visits involve some social or

4. The Pennsylvania data is hard to interpret. Pennsylvania has had opioid deaths that are twice the national average, but Mental Health America claims that the overall rate of misuse of alcohol or other drugs is 7.2%, less than the nationwide average of 7.3% (Mental Health America, 2020). Perhaps this apparent discrepancy occurs because the Pennsylvanians are more likely to use the type of drugs (opioids or opioid derivatives) that have more lethal consequences.

psychological component, whether it is the treatment of pain or insomnia, treatment of a physical disorder that is not being controlled because of patient noncompliance, a disorder caused by life style decisions of the patient, such as smoking, eating, or drinking to excess, or a mental illness itself.

Collaborative care or integrated care models allow for the treatment of patients within a primary care or specialized medical setting. The collaborative work of medical and behavioral health providers leads to a better coordination of care and improved patient outcomes, increased patient access to mental health services, decreased costs, greater patient satisfaction, and improved quality of work for health care professionals.

Integrated care leads to greater patient access to mental health services. Nationwide non-specialists (primarily primary care physicians) provide about 30% of all behavioral health care (SAMSHA, 2016). Often the delivery of services by non-specialists is appropriate; at other times it occurs because no mental health specialists are available. However, if these physicians had easy access to behavioral health providers, such as in an integrated care setting, it would help ensure that patients will get appropriate behavioral health services.

Integrated care reduces health care costs. A small percentage of patients, known as super utilizers, account for a high percentage of health care costs. About 1% of patients account for 20% of all health care costs and 5% of all patients account for 50% of all health care costs (Agency for Health Care Research, 2019). Although high utilization can be due to many causes, many persons who use high amounts of medical care have a co-existing mental health condition. When that mental health condition is treated, health care costs are likely to go down substantially. For example, one study found that medical costs of super utilizers were reduced 25% when patients received access to mental health treatment (Borde et al., 2017).

Integrated care improves physician satisfaction with their work. Physicians and other medical professionals like having psychologists and other mental health professionals integrated into their practices because they can deal with behavioral problems that are outside of the expertise of most physicians. Patients who once were non-compliant with treatment may become compliant. Patients who had frequent emergency room visits, may use the emergency rooms less often, and so on.

Finally, the *mental health care provider workforce does not only treat mental illness but also deals with a wide range of behaviors that impact health*. This includes, but is not limited to, evaluations of persons for medical devices or procedures such as a liver transplant or bariatric surgery; the treatment of persons with chronic pain or insomnia; interventions to improve patient adherence to medical regimens; and wellness or life style interventions directed at excess weight, smoking, the lack of exercise, or the overuse of alcohol or other drugs.

Reimbursement Levels

Reimbursements for mental health professionals are less than those of other comparably trained health care professionals. Psychiatrists are among the lower paid specialty physicians (19th out of 29 medical specialties; Kane, 2019) and psychologists get paid less than optometrists and podiatrists who have comparable levels of education.[5] Other mental health workers get paid less than comparably trained individuals.[6]

Students in psychology often have large debts upon graduation. In 2014 students graduating with a doctoral degree in professional psychology (e.g., clinical, counseling, neuropsychology) averaged $100,000 in school debt (Winerman, 2016) or about 180% of expected income for their first year of employment past licensing. The high debt loads discourage students from going into the field of psychology. In addition, their financial demands make them more likely to seek the most lucrative employment so that they can decrease their student debt. Other health care professionals have similar problems with their debt load. Unfortunately, Medicare does not allow psychologists to receive reimbursement for the work that their trainees perform with Medicare patients, even though such training funds are allocated for medical students.[7]

Scholarships and loan repayment programs, such as the National Health Service Corps (NHSC), have had success in recruiting and retaining mental health professionals to work in underserved areas. Most of those who participate in these programs continue to practice in underserved areas after completing their NHSC commitment.

Mobility Issues

The movement of psychology licensees across states is burdensome because the criteria for licensing vary considerably among different North American jurisdictions. A psychologist may easily meet the licensing requirements in several states but fail to meet the licensing requirements in another state. Other health care professionals have similar problems. One might argue that mobility issues are not relevant to workforce shortage because as many professionals will leave Pennsylvania as enter it. However, as

Continued on page 8

5. Determining salaries is difficult because different methodologies for determining salary are used. Here, I relied on US News data for all three professionals which reported that podiatrists make an average of $148,000 a year (Podiatrists Salary, 2017); optometrists $110,000 (Optometrists Salary, 2017), and psychologists $97,000 (Psychologists Salary, 2017). Lesser trained mental health professionals, such as social workers, professional counselors, or marriage and family therapists make considerably less than psychologists.

6. The average college graduate will earn $50,000 a year in their first job (Hess, 2019). I could not find salaries for bachelor's level mental health workers but found that the average salary of social workers was $46,000, regardless of years of experience (Social Work Salary, 2019). Unfortunately, these web sites often do not describe the methodology they used in determining the salaries. I suspect that the website I looked at must have excluded those with MSW degrees. Nonetheless, I believe that the trend for paying less for mental health services occurs across the educational spectrum.

7. Commercial insurers typically do not pay for supervised services unless the supervising professional is in the room at the same time the service is being conducted. This means that the trainees cannot generate any additional income for their work making it financially unsustainable for most clinics or hospitals to bring on trainees. Therefore, students must go into debt to pay for school and must go deeper into debt to work for free or for very low paying jobs to get the supervision they need to become licensed.

Continued from page 7

noted above, greater mobility does not refer only to physical presence in Pennsylvania, but also the availability to provide telehealth services, which are especially important to reduce access problems in rural Pennsylvania and in inner cities.

Next Steps

PPA is continuing to work to improve the public health of Pennsylvanians in many ways. For example, PPA has endorsed bills that will improve the mobility of psychologists across state lines through the PSYPACT legislation. In addition, the PSYPACT legislation will allow for telehealth services in the cooperating states. Furthermore, PPA is in a coalition with other health care provider and consumer groups to support legislation requiring insurers in Pennsylvania to reimburse for telehealth services.

Anti-trust laws prohibit PPA from influencing commercial insurers about the relevant reimbursement rates, but PPA and other organizations can work to influence Medicare's reimbursement rates which can have a ripple effect across all insurers. This last year PPA helped mobilize thousands of psychologists across the state to respond to proposed cuts to psychology services under Medicare. PPA also works to promote integrated care and to ensure adequate access to psychological services in correctional and other state facilities.

References

Agency for Health Care Research and Quality. (2019 February). *High utilizers of health care*. Retrieved from https://effectivehealthcare.ahrq.gov/products/high-utilizers-health-care/key-questions

Borde, D., Pinkney, J., & Leverence, R. (2017). How we promoted sustainable super-utilizer care through teamwork and taking time to listen. *NEJM Catalyst*. Retrieved from https://catalyst.nejm.org/superutilizer-care-teamwork-barriers-to-care/

Brodenheimer, T., & Sinsky, C. (2014). From triple to quadruple aim: Care of the patient requires care of the provider. *Annuals of Family Medicine, 12,* 573-576.

Bucklen, K. B., Hiester, M., & Lategan, D. (2018). *Recidivism risk reduction incentive 2018 report*. Harrisburg, PA: Pennsylvania Department of Corrections.

Christidis, P., Stamm, K., & Lin, L. (2016 May). Latest class of psychologists is more diverse. *Monitor on Psychology,* 24.

Darnell, B. D. (2019). *Psychological treatments for patients with chronic pain*. Washington, DC: American Psychological Association.

Engel, G. (1980). The clinical application of the biopsychosocial model. *American Journal of Psychiatry, 137,* 535-544.

Hess, A. (2019). College graduates expect to earn. . . Retrieved from https://www.cnbc.com/2019/02/15/college-grads-expect-to-earn-60000-in-their-first-job-few-do.html

Huen-Johnson, H., Menchine, M., Goldman, D., & Seabury, S. (2017). *The cost of mental illness: Pennsylvania facts and figures.* Los Angeles, CA: Leonard D. Schaeffer Center for Health Policy & Economics, University of Southern California:

Institute for Health. (2019). The Triple Aim Initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Ioannidis, J. P. A. (2016). Why most clinical research is not useful. PLoS Med, 13 (6), e1002049, *Joint State Government Commission. (2019 April). Pennsylvania Healthcare Workforce Needs.* Retrieved from http://jsg.legis.state.pa.us/resources/documents/ftp/publications/2019-04-10%20Update%20WEB%20Healthcare%208.13.19.pdf

Kacik, A. (2019, February 20). Nearly a quarter of rural hospitals are on the brink of closure. *Modern Healthcare*. Retrieved from https://www.modernhealthcare.com/article/20190220/NEWS/190229999/nearly-a-quarter-of-rural-hospitals-are-on-the-brink-of-closure

Kaiser Family Foundation. (2016). The Pennsylvania health care landscape. Retrieved from https://www.kff.org/health-reform/fact-sheet/the-pennsylvania-health-care-landscape/

Kane, L. (2019). *Medscape's physician compensation report*. Retrieved from https://www.medscape.com/slideshow/2018-compensation-psychiatrist-6009671#2

Knapp, S. (2015 April). PPA Conducts third insurance survey. *The Pennsylvania Psychologist,* 1, 8-9.

Mental Health America. (2020). Mental Health in America. Retrieved from https://mhanational.org/issues/mental-health-america-prevalence-data

National Council for Behavioral Health (2017). *The psychiatric shortage: Causes and solutions*. Retrieved from https://www.thenationalcouncil.org/about/national-mental-health-association/medical-director-institute/access-paper-release-final-3-28-17-final/

National Institute of Mental Health. (2019). Mental Illness. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Olfson, M. (2016). Building the mental health workforce capacity needed to treat adults with serious mental illness. *Health Affairs, 35,* 983-990.

Optometrists salary. (2017). Retrieved from https://money.usnews.com/careers/best-jobs/optometrist/salary

Pearson Vue. (2016 November). *Association of State and Provincial Psychology Boards Examination for Professional Practice in Psychology (EPPP) Job Task Analysis Report*. Retrieved from https://cdn.ymaws.com/www.asppb.net/resource/resmgr/eppp_/ASPPB_2016_JTA_Report_Public.pdf

Pennsylvania Data Center. (2017). Population growth and change: 2010-1017. Retrieved from https://pasdc.hbg.psu.edu/Data/Research-Briefs/PA-Population-Estimates

Podiatrists salary. (2017). Retrieved from https://money.usnews.com/careers/best-jobs/podiatrist/salary

Psychologists salary. (2017). Retrieved from https://money.usnews.com/careers/best-jobs/psychologist

Qaseem, A., Kansagara, D., Forciea, M. A., Cooke, M., & Denberg, T. D. (2016). Management of chronic insomnia disorder in adults: a clinical practice guideline from the American College of Physicians. *Annals of Internal Medicine, 165*(2), 125-133.

Rubin, R. (2019). Using telemedicine to treat opioid use disorder in rural areas. *Journal of the American Medical Association, 322,* 1929-1031.

SAMSHA. (2016). *Behavioral health spending and use accounts, 1986-2014.* HHS Publication No. SMA-16-4975, Rockville MD: Substance Abuse and Mental Health Services Administration.

Simmons-Ritchie, D. (2019, January 5). Nearly one third of Pennsylvania's prisoners are mentally ill. Pennlive. Retrieved from https://www.pennlive.com/midstate/2015/07/pennlive_estimates_that_a_thir.html

Social Worker Salary. (2019), Retrieved from https://www.payscale.com/research/US/Job=Social_Worker/Salary

The Unified Judicial System of Pennsylvania. (2018 February 6). Problem Solving Courts. Retrieved from http://www.pacourts.us/judicial-administration/court-programs/mental-health-courts Treatment Advocacy Center. (n.d.). Pennsylvania. Retrieved from https://www.treatmentadvocacycenter.org/browse-by-state/pennsylvania

Walsh, Z., Gonzalez, R., Crosby, K., Thiessen, M. S., Carroll, C., & Bonn-Miller, M. O. (2017). Medical cannabis and mental health: A guided systematic review. *Clinical Psychology Review, 51,* 15-29.

Watkins, K. E., Paddock, S. M., Hudson, T. J., Ounpraseuth, S., Schrader, A. M., . . . & Sullivan, G. (2016). Association between quality measures and mortality in individuals with co-occurring mental health and substance use disorders. Journal of Substance Abuse Treatment, Winerman, L. (2016 April). The debt trap. *Monitor on Psychology,* 44-50.

Wimerman, L. (2016 April). The dept trap. *Monitor on psychology.* 44-50.

Can Increases in a Minimum Wage Make a Difference in Suicide Rates?

Samuel Knapp, Ed.D., ABPP, Director of Professional Affairs

Suicides, which have been increasing in the United States in the last 20 years, have many interacting causes. Nonetheless, poor economic conditions are associated with an increased rate of suicide on both an individual and social level. For example, Stone et al. (2018) found that one in six persons who died from suicide in the United States had recent financial problems or a job loss shortly before their deaths. Other persons who died from suicide had other legal, health, or marital problems with economic implications. Also, persons with lower incomes are more likely to die from suicide during any economic cycle. National rates of suicide tend to increase during periods of economic recession and decline during periods of economic growth (Mann & Metts, 2017). The current American economy is an exception because suicide rates are rising at a time of economic growth. Nonetheless, the economic growth is not benefitting all Americans equally and many Americans continue to struggle economically, and some evidence suggests that economic distress in the face of economic inequality may be especially pernicious (Daly, Wilson, & Jackson, 2013).

The link between economic insecurity and suicide is understandable when considering the psychological factors associated with suicide. According to ideation-to-action theories of suicide, suicide occurs when people have acquired the capability of killing themselves combined with the desire to do so. The acquired capability of suicide refers to a loss of the fear of death that occurs through habituation to violence or suffering either as a perpetrator of violence, a victim of violence or physical suffering, or a witness to physical suffering and death. The desire to die usually occurs when people feel socially isolated, hopelessness, perceived burdensomeness (a feeling that they are a burden to others), or to have a sense of entrapment so that suicide is the only way out (Knapp, 2020).

Economic distress could be linked to suicide through several of these psychological or social mechanisms. For example, when faced with a job loss, those with lower incomes may have fewer resources to draw upon and they may have fewer good job options when faced with a job loss. So, when persons with highly marketable skills, such as accounting, loses their job, they are more likely to have a financial reserve, a reasonably good likelihood of finding a good paying job in the future, and a lower likelihood of feeling hopelessness or perceived burdensomeness. On the other hand, when unskilled workers lose their job, they are less likely to have a meaningful financial reserve, be less able to find a good paying job, and would have a higher likelihood of feeling hopelessness or perceived burdensomeness.

Often, unskilled workers live with chronic stress because of job insecurity and know that they can be easily replaced. In addition, those with lower incomes may live in neighborhoods that are less safe and therefore more subject to crime victimization or they may have to accept jobs that exposes them to more risk of physical harm, Furthermore, some persons with low paying jobs may have pre-existing mental or physical conditions that prevent them from getting higher education and better jobs. Finally, lower incomes are associated with less access to those health care resources that could prevent a suicide.

If economic distress is related to suicide, can government economic policies such as an increase in minimum wage impact suicide rates? Increases in minimal wage on the state or local levels may vary depending on the jurisdiction. Furthermore, some suggest that other low wage workers may see a bump in their income as a result of an increase in minimum wage. Cooper (2019) estimated that an increase in the federal minimum wage would impact 40 million workers, 60% of whom work full-time.

An increase in the minimum page may also have health effects in addition to economic effects. A review found that the impact of an increase in minimum wage on health was inconsistent across many studies, although many of these studies focused on global health for the population in general (Leigh, Leigh, & Du, 2019). Nonetheless, a different picture emerged when looking at the impact of a minimum wage increase on suicide alone. Gertner et al. (2019) looked at data over a 10-year period and found that, on the average, an increase of one dollar in the minimum wage led to an average of a 1.9% decrease in suicide rates in the impacted states. Kaufman et al. (2020) looked at data over 26 years but focused their analysis on suicide among lower paid workers. They found decreases in suicide rates ranging from 3% to 6% among lower paid workers following increases in the minimum wage.

As encouraging as this data is, one must be cautious. The evaluation of the impact is difficult because minimum wage increases differ across states and sometimes within states. Furthermore, the increase in minimum wage may have occurred in conjunction with other changes impacting the health or income of workers, such as the expansion of Medicaid in that state as allowed by the Affordable Care Act or by an increased

Continued on page 10

1. In another study, Rambotti (2020) found that participation in food stamps was linked to reduced suicides among men, even when controlling for confounding factors.

Continued from page 9

utilization of food stamps.[1] Also, economists disagree on the impact of an increase in minimum wage on the actual income of workers, claiming, among other things that increases in minimum wage may be accompanied by an increase in job loss or a decrease in hours offered to minimum wage workers, thus resulting in no appreciable increase in the actual incomes of low paying workers. So, it is possible that the decrease in suicide due to an increase in the minimum wage would only occur during a growth economy when worker cutbacks in income were less likely to occur.

References

Cooper, D. (2019 February 5). Raising the minimum wage to $15 by 2024 would impact 40 million American workers. Economy Policy Institute. Retrieved from https://www.epi.org/publication/raising-the-federal-minimum-wage-to-15-by-2024-would-lift-pay-for-nearly-40-million-workers/

Daly, M/C/. Wilson, D. J., & Johnson, N. J. 2013). Relative status and well-being: evidence from U.S. suicide deaths. *The Review of Economics and Statistics, 95,* 1480-1500.

Gertner, A., Rotter, J. S., & Shafer, P. R. (2019). Association between state minimum wages and suicide rates in the U.S. *American Journal of Preventive Medicine, 56,* 648-654.

Leigh, J. P., Leigh, W. A., & Du, H. (2018, February 27). Minimum wages and public health: A literature review. Retrieved from https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3176217

Kaufman, J. A., Salas-Hernández, L. K., Komro, K. A., & Livingston, M. D. (2019). *Journal of Epidemiology and Community Health,* 1-6. https://dx.doi.org/10.1136.jech-2019-212981

Knapp, S. (2020). *Suicide prevention: An ethically and scientifically informed approach*. Washington, DC: American Psychological Association.

Mann, J.J., & Metts, A. V. (2017). The economy and suicide: An interaction of societal and interpersonal risk factors. *Crisis, 38,* 141-147.

Rambotti, S. (2020). Is there a relationship between welfare-state policies and suicide rates? Evidence from the U. S. states, 2000-2015. *Social Science and Medicine, 246,* https://doi.org/10.1016/j.socscimed.2019.112778

Stone, D. M., Simon, T. R., Fowler, K. A., Kegler, S. R., Yuan, K., Holland, K. M. . . . Crosby, A. E. (2018). Vital signs: Trends in state suicide rates—United States, 1999-2016 and circumstances contributing to suicide—27 states. *MMWR: Morbidity and Mortality Weekly Report, 67,* 617-624

Classifieds

Update on Supervised Experience Requirements for Licensure

Over the summer and into the fall of 2019, representatives from the Pennsylvania Psychological Association and the Pennsylvania State Board of Psychology had discussions as to the type of hours that would count towards the supervised experience requirement.

As a result of these discussions, the Pennsylvania State Board of Psychology adopted the following statement. It is posted on its website under Board Announcements:

At its August 12, 2019 meeting, the Board voted to waive §41.32 of the Board's regulations for applicants who began a doctoral program accredited by the American Psychological Association (APA) on or after September 2015. Therefore, graduates of APA accredited doctoral programs who began their doctoral program on or after September 2015, are not required to submit documentation of supervised experience because the Board has determined that APA accredited doctoral programs require successful completion of 2 years of supervised experience as part of the doctoral program.

Additional clarification from the Board's October 7, 2019 meeting: Although the Board has waived §41.32 of the Board's regulations for applicants who began an APA accredited doctoral program on or after September 2015, the Board must receive a letter from the doctoral program's Director of Clinical Training which identifies the amount of practicum that was completed (number of months and number of hours for each practicum experience) to confirm that the applicant has completed at least 12 months and at least 1750 hours of practicum experience. An applicant that has NOT completed at least 12 months and at least 1750 hours of practicum experience would be required to complete additional supervised experience prior to the issuance of the license.

Understanding this Statement

PPA has received several questions from Members seeking to better understand this Statement and asking for clarification as what this statement means. As such, for applicants who began their program on or after September 2015, there are now three (3) ways that applicants can have their hours count towards the 1750 Hours Requirement: a) by completing 1750 hours of supervised experience**; b) by completing a practicum that meets the standards as set forth in APA Practicum document; or (c) a combination of (a) and (b).

**Please note the recent change from post-doctoral experience to supervised experience. This change now allows for both post-doctoral experience and any experience received after completion of internship hours.

Example: A student is taking a year to complete a dissertation. During this year, the student would like to accrue supervised hours. With the new change, these supervised hours received during the year that the student completed their dissertation, can accrue towards the supervised experience requirement.

Documentation required to submit practicum hours to the Board

For applicants that began their program on or after September 2015, the applicant's Director of Training will need to write a letter that states the number of hours of practicum taken by the student applicant.

What if the applicant entered the graduate program prior to September 2015?

Applicants that do not qualify because they entered the graduate program prior to September 2015, may be reviewed by the Board on a case by case basis. The applicant must provide the Board with the following documentation: a letter from the applicant's Director of Training that states the number of hours that the practicum student took, and a detailed narrative of the practicum hours received (dates that the student took the practicum, name of the supervisor, where the practicum took place, the type of experience completed at the practicum). Also, the supervisor should complete the post-doc form to the best of their ability. (The Board noted that there will be missing information on the form, but the supervisor should fill out as much as possible).

Reviewing Mobility and Jurisdiction Issues

Applicants who may be moving into another jurisdiction should look at the requirements of the state to which they are moving. Not all states allow practicum hours to be counted towards the experience requirement. If an applicant is moving to another state, the applicant may want to consider taking a traditional post-doctoral experience so that you will not have to complete another one due to the move to another state.

2020 PPA Continuing Education

PPA is continuing its long-standing tradition of offering high-quality CE programs to psychologists. In 2020, we are expanding the options. We hope you'll join us for one or more of these programs!

Calendar

The following programs are being offered either through cosponsorship or solely by PPA.

February 26, 2020
Capacity Assessments with Seniors
Webinar

April 3, 2020
Spring Continuing Education Conference
Hotel Monaco
Pittsburgh, PA

June 17-20, 2020
PPA2020 Annual Convention
Lancaster Marriott at Penn Square
Lancaster, PA

June 23-26, 2021
PPA2021 Annual Convention
Kalahari Resort & Convention Center
Pocono Manor, PA

Home Study CE Courses

Act 74 CE Programs

Older Adults at Risk to Die From Suicide: Assessment Management and Treatment—1 CE

Assessment, Management, and Treatment of Suicidal Patients (Extended)—3 CEs

Essential Competencies When Working with Suicidal Patients—1 CE

Act 31 CE Programs

Pennsylvania Child Abuse Recognition and Reporting—3 CE Version

Pennsylvania Child Abuse Recognition and Reporting—2 CE Version

General

Integrating Diversity in Training, Supervision, and Practice for Graduate Students (Podcast)—1 CE

Introduction to Telepsychology, Part 1, 2, and 3 (Webinar)—1 CE each

*Introduction to Ethical Decision Making**—3 CEs

*Mental Health Consent and Confidentiality When Working with Children**—3 CEs

*The New Confidentiality 2018**—3 CEs

This program qualifies for 3 contact hours for the ethics requirement as mandated by the Pennsylvania State Board of Psychology.

Act 74 CE Programs qualify for the suicide requirement mandated by the Pennsylvania State Board of Psychology.

Act 31 CE Programs have been approved by the Department of Public Welfare and the Pennsylvania Department of State to meet the Act 31 requirements.

For a full listing of our home studies, download our catalog here, or visit our online store.

For CE programs sponsored by the Pennsylvania Psychological Association, visit papsy.org.

Registration materials and further conference information are available at papsy.org.