**Early onset of child mental illnesses is predictive of lower school achievement, an increased burden on the child welfare system and greater demands on the juvenile justice system, resulting in an annual economic cost of $247 billion in 2007 (IOM, 2009).**

# Child and Adolescent Psychiatry Workforce Crisis:
## *Solutions to Improve Early Intervention and Access to Care*

## The Solution

We can only improve the lives of children and adolescents suffering with mental illnesses if we have an appropriate workforce in place and alternative models to promote early intervention and prevention services. AACAP encourages Congress and the Department of Health and Human Services to act on the following:

**Encourage more medical students and general psychiatry residents to enter child and adolescent psychiatry training by:**

- Providing loan repayment and scholarships for all children's mental health professionals.
- Designating child and adolescent psychiatry as a National Health Services Corps primary care specialty service.

**Allow for early intervention and prevention of mental illness by:**

- Providing demonstration grants to develop and study the effectiveness of pediatric primary care and mental health care collaboration and consultation models.
- Support funding for an Accreditation Council for Graduate Medical Education approved program that would allow pediatricians to complete 36 months of additional training to be eligible for specialty certification in both adult psychiatry and child and adolescent psychiatry.

**Address flaws in the Medicare GME Program:**

- Remove the graduate medical education cap to allow for an increase in the number of child and adolescent psychiatry residents permitted under the Medicare Graduate Medical Education Program.
- Extend the board eligibility period for child and adolescent psychiatry residents and fellows from four years to six years.
- Allocate payments for both direct medical education and indirect medical education funding for child and adolescent psychiatry.
- Expand the definition of a "children's hospital" to include a freestanding psychiatric hospital with 90 percent or more inpatients under the age of 18.

"Children on the waiting list don't just quietly wait. Their problems get worse and they deteriorate. They often end up in the emergency room or being admitted to a child psychiatric hospital for problems that had they been treated earlier, would be less costly."
*- Greg Fritz, M.D.*
*child and adolescent psychiatrist*

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now more than 8,500 members strong, the AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental illnesses. AACAP supports research, continuing medical education and access to quality care. Child and adolescent psychiatrists are the only medical specialists fully trained in the treatment of mental illness in children and adolescents.



AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

**Government Affairs**
3615 Wisconsin Avenue, N.W.
Washington, D.C.20016 - 3007
Phone: 202.966.7300 Fax: 202.966.2891
E-mail: gov@aacap.org Website: www.aacap.org

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY
WWW.AACAP.ORG

**Half of all lifetime cases of mental illness begin by age 14 and three quarters by age 24 (NIMH, 2005).**

**There are approximately 8,300 practicing child and adolescent psychiatrists in the country (AMA, 2012). However, the need was projected to be 30,000 by 2000 (COGME, 1990).**

## The Concern

Mental illness impacts 20 percent of our nation's youth; half of all lifetime cases of mental illness begin by age 14 and three-quarters by age 24. Unidentified and untreated early-stage mental illnesses in children and adolescents are associated with school failure, teenage childbearing, unstable employment, substance use, violence, and high risk of developing co-occurring mental disorders (NIMH, 2005). Despite the availability of effective treatment, there are average delays of 8 to 10 years between the onset of symptoms and intervention--critical developmental years in the life of a child. The longer the lag time is between symptom onset and treatment, the more difficult and costly mental illness is to treat and the greater the burden becomes on our public health system.

One reason for the delays in treatment is access to trained pediatric mental health professionals. For over a decade, numerous reports and studies have shown that the paucity of children's mental health professionals affects access to early intervention and mental health services. A Surgeon General Report (1999), the Annapolis Coalition on the Behavioral Health Workforce (2003), the IOM (2009), and a Children's Hospitals report (2012) have reported on the urgency of addressing the critical workforce shortages in children's mental health. This shortage places a burden on pediatricians, family physicians, and other clinicians to identify children for referral and treatment decisions, resulting in children sometimes receiving inadequate care from clinicians who lack the necessary pediatric mental health training. In order to ensure that children and adolescents receive appropriate mental health assessment and treatment, we need more professionals trained to treat this age group, such as child and adolescent psychiatrists.

A child and adolescent psychiatrist is a physician who specializes in the diagnosis and the treatment of disorders of thinking, feeling, and/or behavior affecting children, adolescents,

and their families. A child and adolescent psychiatrist offers families the advantages of a medical education and medical responsibility for providing comprehensive care. Child and adolescent psychiatry training requires four years of medical school, at least three years residency training in general psychiatry with adults, and two years of additional specialized training in treating children, adolescents and families.

## The Demand for Child and Adolescent Mental Health Services

- Only about 20 percent of children and adolescents with mental illnesses receive some kind of mental health services (the Surgeon General, 1999), and only a small fraction of them receive an evaluation and treatment by a child and adolescent psychiatrist.

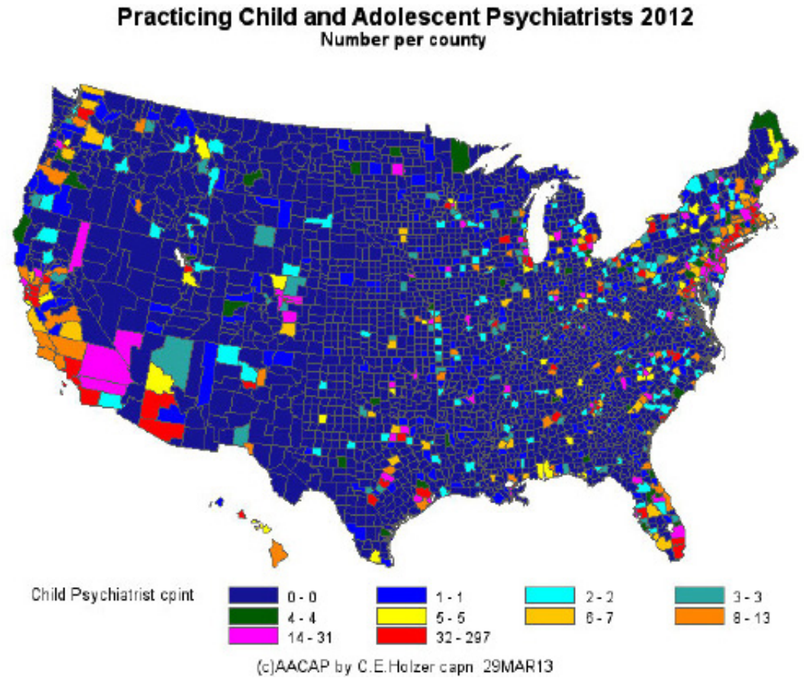
- The population of children and adolescents under age 20 is projected to grow by about 33 percent in the next 40 years from about 84 million to 112 million by 2050 (U.S. Bureau of the Census, 2010).

- The Bureau of Health Professions reported that the demand for the services of child and adolescent psychiatry is projected to increase by 100 percent between 1995 and 2020 (Department of Health and Human Services, 2000).

- According to a 2012 Children's Hospital Association survey, appointments for child and adolescent psychiatric care far exceeds the prevailing benchmark of a two-week wait time in children's hospitals. The average wait time is 7.5 weeks.

- A Health Affairs study reported that pediatricians were more likely than other primary care physicians to be unable to refer their patients to outpatient mental health services due to a shortage of providers (Cunningham, 2009).

"My experience is that there are not enough pediatric psychiatrists in my area, so we are forced to come up with creative ways to get services for children. Those ways take time and usually have a waiting list."
*- Mother of a child with mental illness*




## The Undersupply of Child and Adolescent Psychiatrists

- There are approximately 8,300 practicing child and adolescent psychiatrists in the country, of which 83 percent report their primary type of practice as direct patient care (AMA, 2012).

- There is a severe maldistribution of child and adolescent psychiatric services in the U.S., with children in rural areas and areas of low socioeconomic status having significantly reduced access. The ratio of child and adolescent psychiatrists per 100,000 youth ranges from 4.9 in Idaho to 56.9 in the District of Columbia with a national average of 12.9 (AMA, 2012).

- Child and adolescent psychiatry is ranked first among medical specialities with the highest percentage (57.4%) of acting physicians practicing in the same state where they trained (AAMC, 2010).

## Funding and Recruitment Challenges

- Medicare's support for physician training has been frozen since 1997. Unless the number of residency training positions expands at the nation's teaching hospitals, the U.S. will face a declining number of physicians per capita just as the baby boomers swell the Medicare rolls (AAMC, 2010).

- Increasing educational debt, pressure and incentives to pursue a primary care career, a long training period, further specialization of medicine and reimbursement problems, are some of the facts that discourage medical students from choosing a career in child and adolescent psychiatry.

- The average medical education debt in 2012 was $155,978 for public school graduates and $183,066 for private school graduates (AAMC, 2012).

- About 20 percent of U.S. medical schools do not sponsor child and adolescent psychiatry residency programs and the majority of U.S. medical students have minimal or no clinical clerkship experience in child and adolescent psychiatry. With only about 25 percent of medical students taking a clerkship rotation in child and adolescent psychiatry, a growing critical void exists in the recruitment and education of future physicians (Dingle, 2008).

"The most common inquiry we receive at the Balanced Mind Foundation is where to find a child psychiatrist."
*- Susan Resko, Executive Director*
*The Balanced Mind Foundation*