**AACAP “Back to Project Future”**

**Section II**

**OVERVIEW OF COMING DECADE**

**What’s Facing Child and Adolescent Psychiatry?**

Child and adolescent psychiatrists (CAPs) are facing both challenges and opportunities over the coming decade. Advances in our understanding of psychopathology, diagnoses, and treatment have greatly improved CAP’s ability to treat the most impaired children and adolescents. At the same time stigma, work force shortage, and inefficiency in the delivery of care cause more than three-quarters of our nation’s most vulnerable children not to receive the care that they need. While recent efforts to integrate the delivery of mental health care within primary medical care are promising, child and adolescent psychiatrists can be isolated within their own practices or marginalized within larger systems of care. Financial pressures can lead CAP’s to be used and seen primarily as prescribers of medication, utilizing only a portion of their training and skills.

Healthcare reform as implemented through the Affordable Care Act (ACA) has the potential to radically change the way healthcare and mental health care are accessed and delivered. The changes that have been proposed within in the ACA and that are already taking place are envisioned to improve the efficacy and efficiency with which health care is accessed and provided. The integration of mental health care within primary medical care is an active component of those changes. How this integration will be fully implemented is not entirely clear. What is clear is that CAPs need to be actively engaged in the design, implementation, and ongoing function of these new models of healthcare delivery.

In the coming decade, our nation will experience continued population growth and increasing need for mental health care for children and families struggling with mental illness. While there continues to be stigma against people with mental illness and those that support them, there is also an emerging trend with increased public knowledge, understanding and more accurate perception of mental illness. As a result of mental health parity and expansion of insurance coverage through the ACA, the number of children and adolescents seeking care will increase. The changing demographics of our nation will continue to increase the ethnic and cultural diversity of our patients. Our country is experiencing disproportionally higher growth in geographic regions, such as the Southwest, with fewer child and adolescent psychiatrists. CAPs will be working with increasing numbers of non-English speaking families. We are also increasingly aware that our society will likely continue to struggle with economic and racial disparities. Our communities will continue to struggle with cyclical trauma and violence. We
know very well how greatly these psychosocial factors can influence children’s mental and physical health.

We are at the cusp of great change in our health care system. Much of the expansion of health coverage through the ACA will be through Medicaid and other public sector systems. CAP trainees and practitioners must be prepared to work with these populations and within public sector systems of care. Numerous innovative models of care are emerging, including integrative and collaborative care models and tele-psychiatry. CAPs must carefully consider how best to collaborate with mid-level practitioners and advance practice nurses (APRNs). CAP practitioners and training programs will likely continue to operate in an environment of ongoing resource scarcity. We will witness a transition away from fee-for-service and towards demonstration of value. It will no longer be enough to advocate for more resources. We will have to demonstrate greater value for our efforts.

We are already fortunate to benefit from an explosion in neuroscience and psychological research that benefits child and adolescent psychiatrists’ work with children and families. Over the next decade, we are likely to experience continued rapid growth of our knowledge base. We must help all CAPs keep pace with these innovations, and also help them better translate and disseminate these findings to our patients in the community. While advances in neuroscience and our understanding of psychopathology ultimately improve the quality of our care, efficient means of integrating these developments into practice must continue to evolve. The future also presents us with opportunities to adapt by providing improved models of care delivery to a larger number of individual patients and their families, utilizing newly developed skills, techniques, and technologies.

In summary, child and adolescent psychiatrists of the future must extend their reach to meet the increasing public health need and demand for high quality services. CAPs will also need to develop skills and knowledge in consulting and collaborative relationships, leadership skills, advocacy, and improving access for those populations that have been difficult to reach. CAPs will also need to preserve their unique values and strengths - including psychotherapy skills and the ability to work therapeutically with individual children, adolescents, and their families.

What are the Key Issues?

Several key issues emerge for child and adolescent psychiatry in the coming decade. First is the need to reaffirm our professional identity. Over past few decades the field of child psychiatry grew by great leaps and bounds. While our workforce has never been able to meet the mental health needs of our nation’s children, we grew from a small academic based profession in the 1960’s to a work force of more than 7000 CAPs. Within that same time period CAPs shifted responsibilities from providing mostly individual and family therapy to providing a wider range of biological, social, and psychological therapies. The intervention level was typically focused on the relationships between the CAP, the patient, and his or her family. One of the key aspects
of the ACA is improvement in the efficacy and efficiency of healthcare delivery. Many of the models proposed for achieving these improvements call for integration of specialty based care, such as child psychiatry, within the medical home or primary care setting. Specialists such as CAPs will have greater involvement in models of collaborative care where, in addition to treating children and adolescents with severe psychiatric illness, we will also serve as consultants and team members for primary care based clinicians who will be responsible for treating psychiatric illness within the primary care setting.

National healthcare reform is changing the way we conceptualize, prevent and manage illness. With the ACA come medical homes, Accountable Care Organizations (ACOs), and movement away from tertiary care facilities to an increased community locus of care. The educational system will also undergo radical reform with a new career development emphasis for all specialties starting with medical school, extending through graduate medical education and into post-graduate licensure, credentialing and life-long learning. The Accreditation Council of Graduate Medical Education (ACGME) has created a new conceptual framework, the “Milestones” that embody this developmental perspective and will include the Next Accreditation System (NAS). This new framework will have significant impact on all training and education programs.

There is increasing awareness of the incidence, prevalence and risk of psychiatric disorders with appreciation that over 50% of these disorders begin in childhood. Child and adolescent psychiatry remains the greatest shortage specialty with only about 7000 active practitioners, and 400 graduates a year. Currently there is a significant mal-distribution of CAPs with the largest numbers in urban/metro areas and large rural areas of the country with almost no CAPs. There needs to be both an increased workforce with a greater reach and a multidisciplinary healthcare model to care for the many children and families needing treatment. The rapid growth of knowledge in our field also requires that CAP practitioners maintain the highest degree of evidence-based knowledge, skills and attitudes. Many of these changes will require CAP clinicians and educators to re-define the professional identity of CAPs and to assume new skills.

The nation’s health care system is moving from a past emphasis on procedures to a future emphasis on quality and value in healthcare throughout a person’s life. This shift emphasizes long-term mental and physical health in the context of the greater society – an approach inherent in basic CAP core values. It also brings a new emphasis on prevention, early detection and intervention that requires better public education about development, mental health and illness in order to promote truly patient-centered care. Major health care system reorganization will require development of better quality outcome measures at both individual and population levels. CAPs will need to choose the most appropriate outcome measures for the provision of care in particular settings and populations. These outcomes will guide the transition from traditional one doctor-one patient practice to the more patient-centered, multisystem, collaborative, and cross-disciplinary team approach. The CAP workforce of the future needs to be able to navigate these complex systems of care and also to appreciate the need to demonstrate value.
Other significant trends and changes will also affect CAPs. The demographics of the U.S. population are changing significantly. Non-English speaking immigrants are a growing population. Providing health care access to populations underserved for cultural, economic, or geographic reasons needs to be a priority for CAPs in the coming decade. The advances in technology that have changed the way we live and practice medicine will continue to accelerate. CAPs will need to integrate electronic medical records into practice and become fully literate and facile with the use of tele-psychiatry, web based screening and treatment, and the uses of social networking.

Health care reform will continue to promote major changes that will come from national, state, and local governments and also insurers, corporations, and other public institutions. CAPs must understand, prepare for, and actively influence health care reform. CAPs should be prepared to work collectively with other groups on advocacy, health care policy, fiscal and legislative proposals at local, state and national levels. With such major change occurring, mentoring during and after residency will be increasingly important for CAPs. Future leaders in this change endeavor will require mentorship and networking especially during the transition from training to practice. CAPs have a great opportunity to lead current health care reform based on their traditional strengths in working collaboratively with other systems and unique position as practitioners who can integrate perspectives from physical and mental health and education, policy and research.

Where will research go in the coming decade?

To set the stage for the recommendations and action items that follow, let’s first consider where research in child mental health is likely to go over the next decade. How can AACAP promote research over the next decade that will have a large positive impact on the prevention and treatment of mental disorders in youth? This is an essential question being considered by Back to Project Future.

Prevention and treatment are the bread and butter of what we care about as child psychiatrists. The methodology for prevention and treatment studies continues to improve but these improvements are largely incremental. The past several decades have brought improvements in statistical methodology (e.g. adoption of random effects regression approaches instead of traditional last observation carried forward analyses), assessment instrumentation, and overall design strategies more closely mapping real-world treatment approaches (e.g. equipoise stratification). But the trialist of two decades ago would take little time to get up to speed on these improvements. Our treatment approaches, both pharmacological and psychotherapeutic have changed somewhat but again these changes are normal progress rather than large unexpected leaps.

There are also reasons to think that the decade ahead may see prevention and treatment studies that use novel and potentially powerful new methods in combination with current methods—
these are likely to come from advances made in other areas of developmental neuroscience. For example, treatment targets that are related to measurable neural system endophenotypes may allow identification of particular treatment-responsive groups now hidden by our current categorical symptom-based diagnostic system (e.g. the RDoC initiative). Better understanding of the genetic underpinnings for psychiatric disorders in children offer the potential to find novel treatment approaches.

Improvements in technology have also led to a number of ongoing trials of computer and smartphone approaches to psychotherapy or psychotherapy augmentation—a likely area for progress over the coming decade.

External trends and dynamics have significantly decreased the quantity of prevention and treatment studies. Many psychiatric medications are coming off patent and thus will never be further studied by industry. NIH funding has decreased overall and also reduced specifically for clinical treatment studies. The overall dip in NIH funding and the uncertainties for the next few years suggest that the funding climate for treatment studies is unlikely to improve soon. There is, however, substantial reason to hope that even though reduced funding for research may continue for several years, we are likely to see improvement later in the decade.

In addition to new approaches to prevention and treatment there will be gains in the area of services research such as: case identification, access to services, training of therapists, monitoring of therapeutic progress, design of service delivery systems, specific needs of different subgroups, and expanding care delivery systems to meet unmet needs (e.g. juvenile justice, etc.). Much of services research over the next decade will be an extension of current methodologies. And, like for prevention and treatment, incorporation of new technologies including smartphones will offer interesting new opportunities. The decade ahead will be an exciting time for services research with the changes that will come from the Affordable Health Care Act. The ultimate shape and extent of these changes is not yet clear but are likely to be positive and substantial. Experts are needed in child psychiatry services research to study and understand the impact of these changes on the care provided by CAPs.

The range of science important to improve our care of youth with mental disorders is broad. Improvements in our understanding of epidemiology and nosology of disorders as well as basic questions on assessment of symptoms, stress, social interactions, etc. will synergistically improve our other studies in youth.

The decade ahead should be an exciting one for basic and translational research in normal development, developmental neuroscience, imaging, and genetics. Some of this work will be led by child psychiatrists and some will not but it is critical that we have child psychiatry researchers who can participate as full team members in these investigations—the clinical perspective and clinical experience provided by child psychiatry is critical to formulating the right questions. The clinical promise of these studies is straightforward—understanding genetic and
environmental risk factors and the neural circuitry involved in psychiatric disorders can lead us
closer to understanding the causes of disorders and thereby give us more specific treatment
targets. Developmental neuroscience approaches are critical to understanding the
developmental-specific aspects of the development of psychiatric disorders. Imaging and other
approaches that more directly evaluate brain circuitry and function can give us more specific
targets for our treatment. Predicting how and when basic and translational work will impact
child psychiatry practice is challenging. The promise is enormous and the path from
understanding more about the mechanism of disease to treatment development is inevitably long.

Finally, ongoing development during childhood and adolescence makes clinical work both more
complicated and more interesting. By working with children CAPs have the opportunity to
intervene when neural systems are more plastic, when behavior is more malleable, and before
long-term sequellae of psychiatric disorders have become ingrained. Thus, with continuing
research in our field and the ongoing work of practicing child and adolescent psychiatrists, there
is enormous opportunity to improve the mental health of our nation’s youth in this coming
decade.

What Issues, Challenges and Opportunities Are Ahead?

The scope of changes facing the field of child & adolescent psychiatry over the coming decade is
profound. Within each of the challenges and issues lie true opportunities to improve the delivery
of mental health care. CAPs will be challenged to change fundamental aspects of how they have
traditionally worked. It is doubtful that opportunities to work in private practice will altogether
disappear. Still if we are to meet the mental healthcare needs of our nation’s children and
adolescent, rather than resisting the changes that will occur, we have to opportunity to assist in
the design, development and implementation of models of care that hold the promise of greatly
increasing access to effective treatment for the large number of children who currently receive
none.

With the advent of new and emerging healthcare systems, child and adolescent psychiatrists will
have opportunities to work in close collaboration with pediatricians and allied health
professionals in many new settings including schools, community health centers, medical homes
and within ACOs. This aligns well with the aims and priorities of other primary care specialties
(e.g. American Academy of Pediatrics, American Academy of Family Physicians), providing for
potentially fertile opportunities for child psychiatry. The great challenges will be to train the
workforce in new areas such as working within population health and public health frameworks.
This will have a major impact on fellowship training and continuing medical education in
healthcare financing, implementation and organization. The field will need leaders in these
emerging areas, in addition to administration of training programs and programs in both the
public and private sectors.
In the future, training programs and maintenance of certification will require new educational tools for teaching, learning and credentialing. The opportunities are great for innovations in information technology, simulation, and new educational pedagogy. The use of telepsychiatry and other digital media for teaching and learning bring opportunities for distance learning and bringing expertise to students and practitioners in regions with limited resources. At the same time, there will be tremendous challenges for the educational system as we increasingly need to demonstrate the effectiveness of learning and ideally on the outcomes of educational products. At this time there are no “gold standards” for assessment of knowledge, skills and attitudes in medical school, residency, fellowship or post-graduate education in real-time with patients. We need to develop seamless means of assessing clinical effectiveness that take into account the increasing regulatory burden already faced by physicians at all levels of training and administration.

Given the continued shortage of CAPs, the field needs to promote the specialized and unique role of child and adolescent psychiatry. As a field, we must educate medical and allied health professionals and the public about children’s mental health issues and also the unique skills, roles and services provided by CAP in a variety of settings (e.g. hospitals, schools, courts, community agencies, teaching institutions, etc.). CAPs will need to increase their role in educating all medical students about critical knowledge in child psychiatry. The serious shortage of CAPs will also require our participation in partnerships with pediatricians, family physicians, nurses, and other allied health professionals. The challenges here will be how such partnerships are developed and how to pay for such efforts. There are opportunities in the healthcare reform movement, yet the great challenge will be to keep costs down as payments for healthcare will likely be decreasing in the future. At the same time CAPs need to challenge the continued demand to do “more with less”. Over the past few decades this has resulted in decreasing time with patients and an increase in the fragmentation of care for many patients. CAPs need to work with our allies (patient/family groups, AAP, AAFP, APA) to shape and advocate for appropriate recognition and payment for services. Learning how to partner and advocate in the public sphere will be an increasingly vital role for CAPs.

All these efforts will require new multi-disciplinary models for teaching and life-long learning. However, graduate medical education funding is likely to be cut back severely, and little funding may be available for post-graduate educational efforts. The great challenge for the field is to improve our educational system, with evidence-based teaching, new models of effective educational methods, and reliable and valid learning assessment methods in times of fiscal constraint. Innovative cost-effective methods of teaching and learning at all educational levels will be needed.

Access to quality psychiatric care for all children, adolescents and their families must be a priority. While this continues to be a great challenge in light of insurance restrictions, CAPs need to increase advocacy efforts targeted to: greater parity in mental health care; expanded use of tele-psychiatry and other digital media for assessment, consultation and treatment (including
payment for these media); greater public education about mental health, signs and symptoms of mental illness; and destigmatization of psychiatric disorders and individuals suffering with mental illness.

The scope of changes facing the field of child & adolescent psychiatry over the coming decade is profound. Within each of the challenges and issues lie true opportunities to improve the delivery of mental health care. CAPs will be challenged to change fundamental aspects of how they have traditionally worked. It is doubtful that opportunities to work in private practice will altogether disappear. Still if we are to meet the mental healthcare needs of our nation’s children and adolescent, rather than resisting the changes that will occur, we have to opportunity to assist in the design, development and implementation of models of care that hold the promise of greatly increasing access to effective treatment for the large number of children who currently receive none.

As a professional medical organization AACAP exists to serve its members. In the coming decade AACAP will be challenged to both help protect the interests of CAPs and also assist and support CAPs in adapting to the changes that will occur within nation’s healthcare systems. The opportunity here lies in the adaptation of our historic training and skills to newer models of delivering care. Just as the individual is challenged to adapt to the changes within his/her environment, so will the basic identity of CAP’s be challenged to develop new ways of viewing ourselves.

How Are These Issues, Challenges and Opportunities Addressed in Back to Project Future?

The Back to Project Future Steering Committee and Subgroups have created a set of “Goals” with “Recommendations” and “Action Steps” to be a road-map for the coming decade – this becomes an action plan for the field of child and adolescent psychiatry.

In this report we recommend an increased emphasis on preparing our trainees and workforce to practice in new and emerging healthcare systems. This may be through innovative clinical rotations during residency and fellowship or through in-service and life-long learning as practitioners in the workforce. These experiences should cover a broad array of multidisciplinary and multisystem settings, including primary care consultation and integration and telepsychiatry. As we develop these new training experiences, we must also develop appropriate tools for assessment that meet the standards of national accrediting bodies and the learning needs of our trainees and workforce.

New and evolving models of healthcare delivery will be population based within integrated systems of care. In order for child and adolescent psychiatrists to lead this process as pediatric mental health experts trained in medicine, public health, child development, and the diagnosis and treatment of psychiatric disorders, they must be prepared to collaborate in teams and
understand the financial models that are the basis of healthcare reform. The ACA expands healthcare coverage and increases the number of young patients seeking mental health services, particularly in the Medicaid population. Child and adolescent psychiatry should be prepared to meet this need by making a commitment to these patients and by addressing issues related to prevention and early intervention as well as treatment. The emphasis will be on caring for more patients with less money while providing evidence of better clinical outcomes. This is also an opportunity for child and adolescent psychiatry to provide entrepreneurial leadership and advocate for models of payment that cover not only Medicaid but also insurance networks. ACA financing models will become increasingly complex and will include partial capitalization, bundled payments, shared savings and other interventions aimed at reducing overall healthcare costs. Added to this will be the introduction of payment systems based on meeting specific parameters regarding efficiency and quality of delivered care. Initially the greatest impact of these changes will be on those CAPs working within larger systems of care, however, eventually many of these innovations will affect CAPs solely in private practice.

Access to care will involve new models that extend the reach of child and adolescent psychiatry through collaboration with primary care and pediatric subspecialty physicians, with child based systems of care including education, juvenile justice, and welfare, and by expanding the knowledge and clinical skills of other providers. Mental health care for children will be shared among multiple professionals and the roles of child and adolescent psychiatrists will include those of educator, consultant, collaborator, and specialist in the assessment and treatment of recurrent and debilitating psychiatric disorder.

We recommend continued efforts to address the shortage and mal-distribution of CAPs. This will involve improving knowledge, skills, and attitudes of primary care clinicians and mid-level practitioners related to children’s mental health care. We will need to continue our outreach to bright and passionate undergraduate students, medical students and residents, including development of undergraduate courses and programs in child and adolescent mental health, outreach to osteopathic medical students and international medical graduates. This may involve increased flexibility in developing pathways towards producing well-prepared CAPs, including shortening training and increasing opportunities for non-traditional clinicians (e.g. Post-Peds Portal), and in funding mechanisms to support CAP training. We will also need to continue our work with government agencies to incentivize CAP involvement in underserved areas through mechanisms including loan repayment and visa waivers for international medical graduates. While there has been an increase in the number of CAPs completing training over the last decade, the numbers of funded CAP resident positions needs to be increased to help address the serious shortage of CAPs.

In this report we also recommend increased development of resources to promote life-long learning. In an environment of changing educational and accreditation processes, we will need to support members with their preparation and certification. We recommend developing resources
that centralize access to excellent educational and training materials. CAPs need to be mentored throughout their careers, from trainees to mid- and senior-level positions.

As we start the decade, we believe child and adolescent psychiatrists are well positioned to assume leadership roles in providing mental health services to children, adolescents and families. Approving and implementing the Goals, Recommendations and Action steps in this report’s “Plan for the Coming Decade” will start the Academy and its members on our “journey” to address the many complex issues, challenges and opportunities that lie ahead in the coming decade.