

# AACAP WORK FORCE FACT SHEET

*“There is a dearth of child psychiatrists...Furthermore, many barriers remain that prevent children, teenagers, and their parents from seeking help from the small number of specially trained professionals... This places a burden on pediatricians, family physicians, and other gatekeepers to identify children for referral and treatment decisions.” (Mental Health: A Report of the Surgeon General, 1999)*

## **Prevalence and Magnitude of Child and Adolescent Psychiatric Problems**

- About 20% of U.S. children and adolescents (15 million), ages 9 to 17, have diagnosable psychiatric disorders (the Surgeon General, 1999, CDC 2013). The prevalence of certain severe disorders such as bipolar, MDD (8%, 12-17 yrs, SAMHSA, 2012), ADHD (11%, CDC, 2013), and autism spectrum disorders (1 per 2500 in 1966 to 1 per 100, 88, 68, 59 children, CDC, 2012-18 and 40 children, NSC, 2018) have markedly increased in recent years.
- The Center for Mental Health Services (1998) estimated that 9 to 13% of U.S. children and adolescents, ages 9 to 17, meet the definition of “serious emotional disturbance” and 5 to 9% of U.S. children and adolescents, “extreme functional impairment.” The pooled prevalence of SED with domain-specific impairment was 10.06% and prevalence of SED with global impairment was 6.36% (Williams et.al., 2017)
- Only about 20% of emotionally disturbed children and adolescents receive some kind of mental health services (the Surgeon General, 1999, CDC 2013), and only a small fraction of them receive evaluation and treatment by child and adolescent psychiatrists.
- The demand for the services of child and adolescent psychiatry is projected to increase by 100% between 1995 and 2020, and for general psychiatry, by 19% (U.S. Bureau of Health Professions, DHHS, 2000).
- The population of children and adolescents under age 20 is projected to grow by about 33% in the next 40 years from about 84 million to 112 million by 2050 (U.S. Bureau of the Census, 2010).
- Children and adolescents with intellectual and developmental disabilities have 3 to 4 times higher rates of mental, emotional, and behavioral disorder than the general population (NIH, 2001).

## **Supply of Child and Adolescent Psychiatrists**

- There are currently about 8,300 child and adolescent psychiatrists practicing in the U.S. (AMA, 2017).
- In 1980, GMENAC recommended that the number of child and adolescent psychiatrists be increased to 8,000 - 10,000 by 1990 in order to meet the projected needs for treatment of child mental disorders.
- In 1990, COGME reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000, based on increasing rates of child mental illnesses and managed care staffing models.
- There is a severe maldistribution of child psychiatric services in the U.S., with children in rural areas and areas of low SES having significantly reduced access. The ratio of child and adolescent psychiatrists per 100,000 youth ranges from 1 in South Dakota to 35 in Massachusetts (60 in DC) with an average of about 11 (AMA, AACAP Workforce Map, 2017).
- While the U.S. Bureau of Health Professions (2000) projects that the number of child and adolescent psychiatrists will increase by about 30% to 8,312 by 2020 only if funding and recruitment remain stable, this is far less than the estimated 12,624 needed to meet demand.
- For special populations such as those with intellectual and developmental disabilities who have higher rates of developmental neuropsychiatric disorders, there are few child and adolescent psychiatrist specifically trained to meet their needs.

## **Recruitment Problems**

- There was a steady decline in the recruitment of PGYI USMG's into general psychiatry in the 90's through the NRMP, from 664 in 1990 to 481 in 2000. The match numbers steadily increased in the 2000's and are closing from low 3% to 5.5% of U.S. graduates; 524, 564, 597, 641, 653, 643, 633, 595, 656, 670, 643, 616, 681, 685, 774, 850, 923, 982 from 2001 to 2018. However, the total number of psychiatric residents has remained relatively stable, about 6000.
- The number of child and adolescent psychiatry residents did not increase in the last decade of the 20<sup>th</sup> century; 712 in 1990, 718 in 2000, 673 in 2003. The number of child and adolescent psychiatry training programs had decreased by 5 to 114 in the same period. However, the numbers have been increasing significantly in the last 14 years; 709, 723, 734, 772, 781, 810, 807, 834, 855, 853, 820, 826, 858 in 2004-17 and 20 new programs opening (ACGME, 2017).
- The proportion of IMG's in child and adolescent psychiatry residency programs has substantially increased from about 20% in 1990 to close to 40% in early 2000 and then gradually decreasing to 31.4% (JAMA, 2011) because of a declining interest by USMG's. The reliance on IMG's to meet the nation's workforce need is threatened by the current climate of restrictive immigration and the recommendations by many organizations that would limit the immigration of the U.S. trained IMG's for all specialties.
- It is estimated that about 20% 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% of them taking clerkship rotation, a critical void in the recruitment and education of future physicians (Dingle, 2008).
- Increasing educational debt, pressure and incentives to pursue a primary care career, a long training period, and further specialization of medicine including psychiatry subspecialties and reimbursement problems in the managed care era are some of the factors that discourage medical students in choosing a career in child and adolescent psychiatry.

## **Funding Problems**

- Governmental agencies and the medical community have promoted a decrease in the overall physician workforce, an increase of primary care workforce, a reduction of specialty workforce, and a decrease in the number of IMG's entering graduate medical education— a so called 50-50-10 model; 50% generalists, 50% specialists, 10% IMG's (COGME, 1992, 1994, 1995; Pew Health Professions Commission, 1995; the 1997 consensus statement by AAMC, AACOM, AMA, AOA, AAHC, NMA).
- The Balanced Budget Act (BBA) of 1997 reduced direct GME funding by 50% for subspecialty training beyond the primary specialty board eligibility. This is an additional cut to child and adolescent psychiatry that had not received indirect GME funding in the past.
- The 1997 BBA provided incentives to teaching hospitals for reduction of GME positions. It also resulted in the severe reduction of Medicare reimbursement to teaching hospitals. The reductions in the health care services and health professions training grants in 2001 have affected negatively, and the on-going state and federal budgetary problems will further affect negatively teaching hospitals, the GME programs, and especially child and adolescent psychiatry residency programs.

**SUMMARY:** The need and voice of child and adolescent psychiatry have been buried under the sweeping forces of the federal mandates and continuing, even worsening with the recent economic downturn, state and federal budgetary constraints. They have failed to recognize the continuing critical shortage of child and adolescent psychiatrists. The serious undersupply of practitioners has resulted in children receiving inadequate care from mental health professionals and primary care physicians who lack the necessary training. However, there has been increasing recognition of shortage of child and adolescent psychiatrists, resulting in public attention and increasing numbers of new residents and training programs.

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