A Crisis of Care: Addressing the Shortage of Child and Adolescent Psychiatrists in New York State

Executive Summary
There are nearly one million children in New York State with emotional, behavioral, or substance abuse disorders. Most of these disorders are treatable, and recovery is possible. Unfortunately, most children and youth who need mental health services do not have access to high-quality treatment and support. Barriers to access are due to a number of factors, including inadequate service capacity, a shortage of child psychiatrists, lack of adequate insurance coverage, lack of cultural competence, and stigma surrounding mental illness and its treatment.

This policy paper will address just one of these access issues—the crisis-level shortage of child and adolescent psychiatrists (CAPs). It will examine the reasons behind the shortage, discuss how New York is currently tackling the problem, and lay the groundwork for future recommendations.

Background
According to the American Academy of Child and Adolescent Psychiatry (AACAP), a child and adolescent psychiatrist (CAP) is, “a Doctor of Medicine or Doctor of Osteopathy who specializes in the diagnosis and, if indicated, the treatment of disorders of thinking, feeling and/or behavior affecting children, adolescents, and their families. A CAP offers families the advantages of a medical education, the medical traditions of professional ethics, and medical responsibility for providing comprehensive care.”

There is a critical shortage of CAPs in New York State that mirrors the shortage across the United States and abroad. As in the rest of the nation, New York’s shortage is much worse in the rural areas of the State—there are 24 counties with no CAPs at all and seven counties with only one CAP. Of the 62 counties in the State, 44 have less than four CAPs. The inadequate representation of CAPs is influenced by many factors including an increased need for these specialists, inadequate reimbursement, the increased administrative and legal demands of serving this population, and a lack of awareness and understanding of this profession by medical students.

Increased Need
There is some dispute over whether there are more children with mental health disorders now than ever before, or an increase in need due to expanding awareness of mental illnesses and better identification of those illnesses in children. There may also be a growing acceptance of the use of psychotropic drugs to treat children. In turn, this use of medication has served to identify these children (to schools, etc.) as having a mental illness. In New York State, passage of Timothy’s Law and implementation of Child and Family Clinic Plus are responses to both the growing need and to the increased awareness of the prevalence of children’s mental health issues.

Whatever the reason for the increased need, it is real and staggering. Paradoxically, with more children in need of treatment, comes a shortage of CAPs. There are currently about 7,000 CAPs in this country. The federal government has designated more than 1,600
communities as Mental Health Professional Shortage Areas. To heighten the concern, the U.S. Bureau of Health projects that there will be approximately 8,300 CAPs in 2020—only two-thirds of the 12,600 necessary to cope with demand.ii

As reported previously, there are 24 counties in New York without any CAPs. One report described the findings when focus groups of Medicaid families were convened in three areas of the State—Manhattan, Schoharie County, and Onondaga County—and asked about the impact this shortage had on their children. The focus groups noted that the “dearth of psychiatrists, psychologists and other mental health providers” was a problem. Although greater in rural regions, it also had a negative impact in more urban areas. In addition, transportation for families in rural districts “posed a significant barrier”. According to the report, some parents who seek treatment are forced to find it outside the county, or even the State.iii Waiting lists for treatment out-of-state are often shorter than those in-state. As with other illnesses, time is of the essence when dealing with mental illnesses. It is nothing short of a tragedy that families lose valuable time and must go to such great lengths to secure necessary services.

During the 2005-06 school year, the State Education Department sent 477 children with emotional disturbances out-of-state for treatment. In 2006-07, that number declined dramatically, with 286 in out-of-state placement in New York State-approved schools. The decline occurred because New York intensified its residential and academic capacities. However, even those 286 children are 286 too many—and their placement is a direct result of the CAPs shortage. Out-of-state programs utilize CAPs to provide necessary wrap-around psychiatric services. These wrap-around services are not available in New York State, which considers psychiatric services “consulting”, not direct care.iv

Children and adolescents who are unable to find consistent care frequently end up presenting in emergency rooms, where treatment comes later than needed and may be provided by medical professionals not specifically equipped to deal with mental illnesses. Emergency rooms are also fast-paced places that are not ideally suited to the thoughtful diagnosis of mental health disorders. Furthermore, treatment in emergency room settings is not optimum because costs are exceedingly high, as opposed to the cost of appropriate psychiatric treatment.

➢ **Inadequate Reimbursement**

Reimbursement of services is frequently inadequate for the provision of those services. Managed care, public and private, does not promote access to CAPs. Psychiatry has long been a specialty with the largest proportion of physicians without managed care
contracts. In 2004-05, 35% of psychiatrists did not contract with managed care organizations. Reimbursement and utilization reviews play a role in this, since most managed care plans provide the same reimbursement for children as for adults even though it takes more time to diagnose a child. This discrepancy makes it less attractive for psychiatrists to provide services to children and adolescents.

Medicaid reimbursement is also the second-largest source of funding for graduate medical education (GME) which, in turn, provides training for CAPs. In 2005, 47 states used Medicaid money to pay for GME—a total of $3.2 billion. Some states subsidize medical residency programs by making direct payments to teaching hospitals using Medicaid funds. Others make payments to medical schools. Sixteen states carve-out Medicaid payments to managed care plans and re-channel them into teaching programs. The President’s FY08 budget would eliminate Medicaid as a source of GME funding over the next 10 years. Such a policy change would have a decidedly negative impact on GME and on the courses that teaching hospitals offer—including training for CAPs.

- **Increased Administrative and Legal Demands**

  There is a great deal of paperwork, time, and effort associated with getting HMOs to pay for psychiatric services. However, while other specialties certainly have this administrative burden, reimbursements tend to be more clear-cut for physical ailments. There appears to be less red tape when billing for a broken arm than for a mental illness. In addition, many insurers capitate mental health benefits. When a consumer has used their quota they are either obligated to pay for treatment themselves or stop treatment—unless their CAP comes up with another diagnosis that will result in extended visits. Applying for approval of that diagnosis from an insurer is a time-consuming process. With reimbursement rates low to begin with, there does not appear to be much incentive, financial or otherwise, for providing services to children and adolescents.

  In addition, medical malpractice insurance rates have increased for all physicians. Nationwide, malpractice insurance premiums for general practitioners increased by 15% in 2004, with a 22% increase for higher-risk specialties. Some now suggest that rates in general may be moderating. However, over the last few years, rates in New York have averaged only one-third of the increases sought by insurers. With this in mind, State Insurance Superintendent Dinallo recently approved a 14% increase in medical malpractice insurance rates and Governor Spitzer established a task force to consider ideas for controlling costs. Possible solutions include risk management, legal reform, and regulatory changes. The task force will recommend short- and long-term reform options.

- **Lack of Awareness and Understanding**

  Why aren’t more people going into the field? Often students are simply not educated about the opportunities, or encouraged to pursue them. Unfortunately, even within the medical profession there are still those who think in terms of medical illnesses and mental illnesses—with the belief that the two are separate entities. Therefore, the people who choose to study and practice child psychiatry are often interested prior to entering medical school. Those who come to it later may have been introduced to the field as part of their medical school education or during a residency rotation.
However, even those who initially pursue a specialty in CAP sometimes abandon training for a specialty in adult psychiatry, because the educational requirements for CAP are so rigorous and time-intensive. Training in the field requires a real commitment—four years of medical school; at least three years of approved residency training in medicine, neurology, and general psychiatry with adults; and an additional two years of training in psychiatric work with children, adolescents, and their families in an accredited residency in CAP. Nearly a decade of training following a four-year bachelor’s degree can appear daunting, especially after factoring in the costs associated with pursuing such a degree. It may be that the additional two years of training following Board certification in psychiatry hardly seems worth the time or energy.

In addition, the medical education system has not been particularly responsive to meeting the need for more CAPs. In fact, GME funding limits CAP training support to a portion of the full residency, whereas a specialty such as geriatric psychiatry is fully funded. Intentional or not, this policy reflects a lack of respect for the specialty within the educational system. Out of school, CAPs may still feel underappreciated. Of 28 medical specialties, CAP ranks 20th in terms of median income.

Those that do pursue certification in the specialty may not do so in New York. Although the Accreditation Council for Graduate Medical Education lists 17 accredited programs in CAP in the State, this number may not hold steady. In fact, the CAP program at Albany Medical College recently shut down because there was not enough interest on the part of the school, its faculty, and its applicants to make it financially viable. That closure proves the point that, just because institutions in the State offer such programs does not mean that people utilize them. In addition, the CAPs these programs do produce may not stay in the State, or in the State’s high-need areas, to practice. Many do not want to practice in rural areas, and so find jobs in cities. Others, from states with few (Wisconsin) or no (Delaware, Wyoming) accredited programs, return to those states after school to find jobs.

Therefore, the shortage in New York is only becoming more serious. The average age of a CAP has shifted, with fewer under age 35. This means that most CAPs are older professionals with an eye toward retirement. In addition, the number of residents training to be CAPs has not changed much in more than a decade. In 1990, that number was 712; in 2000, it dropped to 669; in 2005, it stands at 720. According to the American Board of Medical Specialties (ABMS), there are 4,649 physicians certified in psychiatry in New York State. With a population of approximately 20 million, if every resident required psychiatric services, each psychiatrist would have about 4,300 patients. Using 2004 data, New York’s 898 CAPs are currently responsible for treating the one million children in the State with known mental health disorders. That amounts to approximately 1,113 children per CAP.

Addressing the Problem
The integration of mental health care into primary care (including pediatrics) is essential. Training primary care physicians to screen for, refer, and even treat mental illnesses is a step in the right direction (and will be discussed in a later section). However, this practice should not take the place of recruiting and training child psychiatrists.
“...because there are never going to be enough child psychiatrists, eventually, we’re going to train thousands of pediatricians a year in identifying and treating depression, anxiety, ADHD and autism as a routine part of their practice.”

—Dr. Harold S. Koplewicz, director of the Child Studies Center at New York University; The New York Times, February 2006

AACAP has formed a steering committee on workforce issues that is concentrating its efforts on increasing recruitment of CAPs by 10% each year over the next 10 years (the project began in 2004). The committee is focusing on three areas: attraction, expansion, and support. To begin, AACAP is collecting data regarding existing programs and recruitment statistics to serve as a baseline as the project moves forward. Next, the organization is addressing attraction and stigma through a variety of public relations efforts. In terms of expansion, AACAP is concentrating on multiple portals of entry and developing alternative paths to CAP, including integrated child and adolescent and adult psychiatry training tracks. Finally, AACAP is supporting and advocating for federal legislation relevant to this issue.xiv

In New York, demand for CAPs will continue to increase as Timothy’s Law and Child and Family Clinic Plus are implemented. Governor Spitzer’s creation of a Children’s Cabinet acknowledges that children’s issues must be a top priority in this State and for the State’s agencies. How can the policymakers and the people of New York work together to address the problem most effectively? On September 10th, we are seeking input from STEPS Roundtable attendees, so that we may begin to develop solutions.

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xiv Cole, A M.D.; Psychiatric Service Provision in Broome County: Concerns and Suggestions; Broome County Mental Health Department; February 2007.
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