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American Academy of Child and Adolescent Psychiatry (AACAP)
Testimony of Warren Y.K. Ng, MD, MPH
to the
U.S. Senate Health Education Labor and Pensions
Subcommittee on Primary Health and Retirement Security

A Crisis in Mental Health and Substance Use Disorder Care: Closing Gaps in Access by Bringing Care and Prevention to Communities

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Chairman Markey, Ranking Member Marshall, and members of the Senate HELP Subcommittee on Primary Health and Retirement Security, the members of the American Academy of Child and Adolescent Psychiatry, AACAP, thank you for hosting this hearing and for the opportunity to share our thoughts on how to bridge the gap in access to pediatric mental health and substance use disorder care. I am Warren Ng, AACAP President, and Director of Outpatient Behavioral Health for New York Presbyterian Hospital in New York City.

AACAP represents over 10,000 child and adolescent psychiatrists and trainees all of whom grasp the gravity of our nation's pediatric mental health crisis and have been responding. Our members work in every child-facing system of care, in urban and rural communities, from hospitals to schools, and across the lifespan. No one in our nation has been spared the impact of the COVID-19 pandemic, and child and adolescent psychiatrists and their teams have been on the frontlines. In fact, in October 2021, AACAP along with the American Academy of Pediatrics and the Childrens' Hospital Association, declared a national state of emergency in children's mental health.[1] While there are many factors that contribute to poor access to pediatric behavioral health care, my testimony today will focus on the impact the insufficient behavioral health workforce has on access to care and potential solutions.

There has been a silent pediatric mental health pandemic building for decades, disproportionately impacting minoritized groups including racial, ethnic, and gender diverse youth, and those living in poverty. The social disruptions, fear and grief caused by the COVID-19 pandemic turned the world upside down for all children, especially those vulnerable to mental illness and substance use disorders. The escalating rates of suicide and mental illness-related morbidity and mortality are well documented. Behavioral health workforce shortages are also chronic and well

[1] Pediatricians, CAPs, and Children's Hospitals Declare National Emergency (aacap.org)

documented, especially for children. We, in collaboration with our federal and state policymakers, must support immediate short and long-term strategies.

In the short-term to increase access, we can extend the reach of the child and adolescent psychiatry workforce by supporting primary care and school-based providers in identifying, assessing, and stabilizing pediatric behavioral health disorders and in escalating to specialty behavioral healthcare when the patient's needs require a higher level of care. Pediatric Mental Healthcare Access (PMHCA) consultation programs, school based mental health care, integrated behavioral health and primary care models, and telepsychiatry have all proven to be effective means of connecting patients to behavioral health care. AACAP is grateful for recent Congressional investments in these models and urges Congress to promote state financing innovation and provider adoption to ensure these models are sustainable. We must meet children where they are and eliminate additional barriers.

We can also supplement our physician supply by recognizing the invaluable contributions of our international medical graduate (IMG) colleagues. These American trained physician experts are an important part of our mental health care teams, particularly in rural and underserved areas. In fact, recent data shows that 31% of child and adolescent psychiatrists are IMGs.[2] We encourage Congress to reauthorize the Conrad 30 Waiver and extend for another 3 years.

Long-term strategies to address access gaps must include building a strong pipeline of pediatric mental health providers, including child and adolescent psychiatrists. Long before the COVID-19 pandemic, the workforce shortages of pediatric mental health providers were significant. This is especially true for child and adolescent psychiatrists, whose educational requirements as physician subspecialists are extensive and costly. Targeted student loan repayment programs that support pediatric mental health professionals and programs that defer student loan payments, interest-free, while training, help mitigate the barrier of student debt. Research has shown that these solutions directly influence physician practice choices.

The field of behavioral health care will not attract qualified, highly trained providers, reduce stigma, nor accommodate the growing demand for such services until it is on equal footing with physical health and surgical care. In addition to extensive time in training and student debt, poor reimbursement is a disincentive to recruiting medical students into psychiatry and building robust psychiatric services. This contributes to limited in-network psychiatry access, longer wait times, and higher expenses for patients– who are often forced to go out of their insurance networks to find any care. Full parity in insurance coverage and reimbursement rates for mental health and substance use treatment in Medicare and Medicaid would support children's access to high quality and timely mental health care by covering the full range of evidence-based behavioral health care services.

AACAP recommends that the Centers for Medicare & Medicaid Services (CMS) and other insurance regulators require health plans to use nationally recognized service intensity tools developed by professional organizations in making medical necessity determinations. These

[2] Active Physicians Who Are International Medical Graduates (IMGs) by Specialty, 2021 | AAMC

standardized assessment tools provide determinations of the appropriate level of service intensity needed by a particular patient and could assist payers in making appropriate coverage determinations relating to mental health and substance use services.

Lastly, we must acknowledge that America is becoming more racially and ethnically diverse and that the current pediatric mental health care system does not sufficiently serve the needs of our communities. The COVID-19 pandemic amplified pre-existing mental health disparities in minoritized children and adolescents, including gaps in access to high quality mental health care. To truly bridge the gap in all children's access to mental health and substance use disorder care, we need a behavioral health workforce that understands and identifies with their patient's experiences, language, and background. We can do this by investing in the recruitment, training, and broader distribution of a more diverse and representative workforce. Physicians who understand, speak the language, and identify with their patient's life experiences lead to better outcomes and are better equipped to overcome stigma and address inequities. AACAP encourage Congress to support programs that improve health equity by supporting the training of racial and ethnically diverse pediatric behavioral health professionals through scholarship, tuition assistance, and professional development opportunities.

Thank you, again, for the opportunity to testify on this important topic. AACAP appreciates the opportunity to provide input as the Senate HELP Subcommittee on Primary Health and Retirement Security works to close gaps in access to life-saving behavioral healthcare for all Americans who need it, including those who hold our promise for the future, our children.